

Riverview

PSYCHIATRIC CENTER



PERFORMANCE IMPROVEMENT REPORT

FIRST QUARTER FISCAL YEAR 2010
July, August, September 2009

Mary Louise McEwen, SUPERINTENDENT

October 15, 2009



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INTRODUCTION

For this quarter, most departments continue to show good results for their key performance indicators—meeting or exceeding planned goals for performance. Where minor variations in performance are identified, each department has established monitoring or improvement goals for the upcoming quarter that addresses identified deficiencies.

One major change to the performance measurement process includes the re-engineering of the client satisfaction survey. This survey has been redesigned to take advantage of existing resources and data collection systems so an effective comparison can be made between the satisfaction measures at Riverview Psychiatric Center and other State operated psychiatric facilities throughout the country.

Comparative Statistics are presented on the core and non-core measures reported to the Joint Commission through our data analysis contract with the National Association of State Mental Health Program Directors Research Institute. Measures that are monitored through this process include client injury rate, elopement rate, medication error rate, 30-day readmit rate, percent of clients restrained, restraint hours, percent of clients secluded, and seclusion hours. All measures are consistent with the Joint Commission standards published through the National Hospital Inpatient Quality Measures-Hospital-Based Inpatient Psychiatric Services Core Measure Set

COMMUNITY FORENSIC ACT TEAM

Aspect: Descriptive Report on various components

CASE MANAGEMENT:

Clients enrolled in the ACT program	
1st Quarter	Number of ACT clients
July 2009	35
August 2009	35
September 2009	35

CRISIS MANAGEMENT:

1st Quarter	Client incidents	Hospitalized RPC	Hospitalized Medical
July 2009	3	1	0
August 2009	3	2	0
Sept 2009	4	4	0

SUBSTANCE ABUSE:

1st Quarter	Client with Substance Abuse as a Clinical Focus	Percent of ACT Clients In SA treatment
July 2009	13	36%
August 2009	12	30%
September 2009	15	40%

A Co-occurring disorder specialist works with persons served by ACT and also provides a weekly group. All team members are working to become more proficient in co-occurring disorders.

ACT Clients Living Situation				
1st Quarter	Clients in Supervised Settings	Clients in own apt. or with family	% of clients Supervised Settings	% of Clients in own home or with family
July 2009	24	8	72%	28%
August 2009	22	9	62%	33%
Sept 2009	25	9	74%	33%

VOCATIONAL / EDUCATIONAL:

Regarding Clients working or volunteering in the community			
	# Client Community Site Work involved with VOC/ED	# of Client who offer Community Volunteer Services	# Hours worked in Community
July 2009	10	2	708
August 2009	9	2	732
Sept 2009	9	2	752

CAPITOL COMMUNITY CLINIC

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

Indicators	Findings	Compliance	Threshold Percentile
a. All clients with tooth extractions, will be assessed and have teaching post procedure, on the following topics, as provided by the Dentist or Dental Assistant <ul style="list-style-type: none"> • Bleeding • Swelling • Pain • Muscle soreness • Mouth care • Diet • Signs/symptoms of infection 	July three extractions. Post instructions verbalized to each client. Client repeated back to Dental Assistant. Understood the Instructions without difficulty.	100%	100%
	August two extractions. Post care instructions verbalized to each client. Repeated back to Dental Assistant. Client understood the instructions without difficulty.	100%	100%
b. The client, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by the Dental Assistant/Hygienist.	September one extraction. Post instructions verbalized to each client. Client repeated back to Dental Assistant. Understood the instructions without difficulty.		

Summary: There were six extractions in the first quarter. All clients had been educated on each topic listed above with post extraction, after care instructions were given both orally and in writing. Clients had no issues repeating and understanding the oral instructions.

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

CAPITOL COMMUNITY CLINIC

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

Indicators	Findings	Compliance	Threshold Percentile
1. After all dental extractions, the client will receive a followup phone call from the clinic within 24hrs of procedure to assess for complications.	<p>July there were three extractions with follow-up 24-hour phone call. The patients had no complications post extractions.</p> <p>August there were two extractions with 24 hour follow-up phone call. The patients had no post procedure complications</p> <p>September there was one extraction with a 24 hour follow-up post extraction call with no complications reported.</p>	100%	100%

Summary: There were six dental clients in the first quarter that were called 24 hours after extraction. Each client that was called reported no post procedure complications. Review of monthly staff meetings and forward reports quarterly to Riverview Psychiatric Center.

CAPITOL COMMUNITY CLINIC

ASPECT: Medical Clinic Appointment Assessment Fiscal Year 2009-2010

Indicators	Findings	Compliance	Threshold Percentile
All outpatient clients will have vital signs and weight recorded upon arrival for appointment.	<p>There were thirty clients in July. Of the 30 that came in for appointments, two did not have their vitals taken before their clinic apt.</p> <p>There were thirty-three clients scheduled in the month of August. All thirty-three clients had vitals taken before their appointment with the PA.</p> <p>In Sept there were forty-two clients scheduled. Two did not have their vitals taken before their clinic appointment.</p>	96%	100%

Summary: For the first quarter there were 4 clients that did not have their vitals taken before their appointment. Two of the four clients that didn't have their vitals taken were at the beginning of the month before the decision was made to evaluate this measure. On the next appointment in August, they would have the vitals done prior to the appointment. Two of the clients in September were evaluated after the clinic appointment. Review of monthly staff meetings and forward reports quarterly to Riverview Psychiatric Center.

Actions: Clients coming in late, conflicts with next appointment. Have clients come in earlier than their scheduled appointment. Doctors using the exam room at time of clients appointments. Will set up the lab office to do vitals when necessary.

CAPITOL COMMUNITY CLINIC

ASPECT: Clinic Consult Timeliness Fiscal Year 2009-2010

Indicators	Findings	Compliance	Threshold Percentile
<p>All clients from RPC Units to be seen in the clinic will have a completed consult received in the clinic 24hrs prior to the clinic visit or sent with client and staff at time of visit.</p>	<p>July had twenty-eight in-house clients. Out of the twenty-eight, five of the clients did not have consults at the time of visit.</p> <p>August had twenty-four in-house clients. Out of the twenty-four there two consults not received at the time of visit.</p> <p>Sept. had eighteen in-house clients three of the clients did not have consults at the time of dental visit.</p>	<p style="color: #0000FF;">86%</p>	<p>90%</p>

Summary: In **July** there were twenty-eight RPC clients. Of the twenty-eight, five did not have consults at the time of the dental visits. Two from Upper Saco, two from Upper Kennebec, and one from Lower Saco.

In **August** there were twenty-four RPC clients of the twenty-four clients two did not have the consult at time of dental visit. One from Lower Kennebec and one from Lower Saco.

In **September** there were eighteen in-house clients and three did not have consults at the time of dental visit. All three were from Lower Saco.

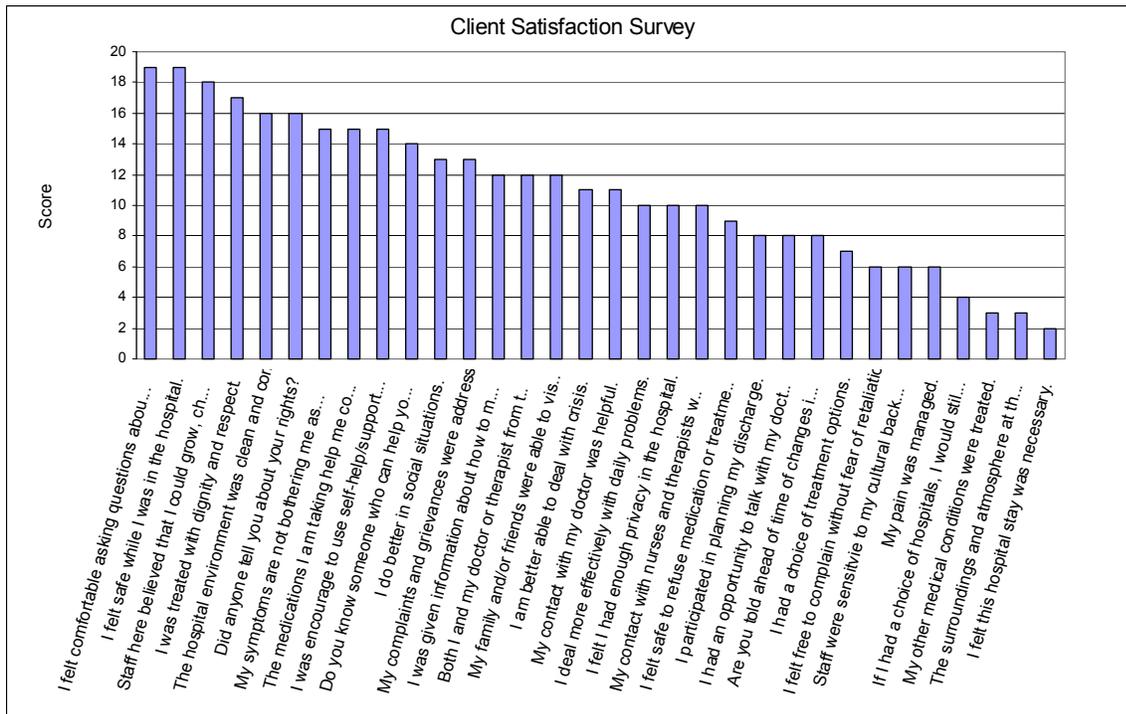
Actions: A memo was sent to each unit reminding them of the consult policy. Our medical care coordinator calls the day before to remind them of the paper work needed for the visit and if the in-house clients comes without proper documentation the visit is held or rescheduled until the appropriate paper work is presented.

CLIENT SATISFACTION SURVEY

ASPECT: Client satisfaction with care

Indicators	Findings
I felt comfortable asking questions about my treatment and medications.	19
I felt safe while I was in the hospital.	19
Staff here believed that I could grow, change and recover.	18
I was treated with dignity and respect.	17
The hospital environment was clean and comfortable.	16
My pain was managed.	6
If I had a choice of hospitals, I would still choose this one.	4
My other medical conditions were treated.	3
The surroundings and atmosphere at the hospital helped me get better.	3
I felt this hospital stay was necessary.	2

Summary: The client satisfaction survey changed from last quarter to the NRI/MHSIP Inpatient Consumer Survey in order to benchmark against other facilities. There are four additional questions added to the survey that address additional areas. The survey is comprised of 32 questions. Surveys are offered to clients within one week of discharge, annually, or randomly based on unit population. The five highest and five lowest measures are indicated above. Scores are measured on a Likert Scale (1= Strongly Disagree to 5 = Strongly Agree) and produce a weighted total score. The highest possible score is 64.



COMPARATIVE STATISTICS

Comparative Statistics include measures that evaluate the performance of Riverview Psychiatric Center as compared to other State operated psychiatric facilities. The measures that are evaluated include:

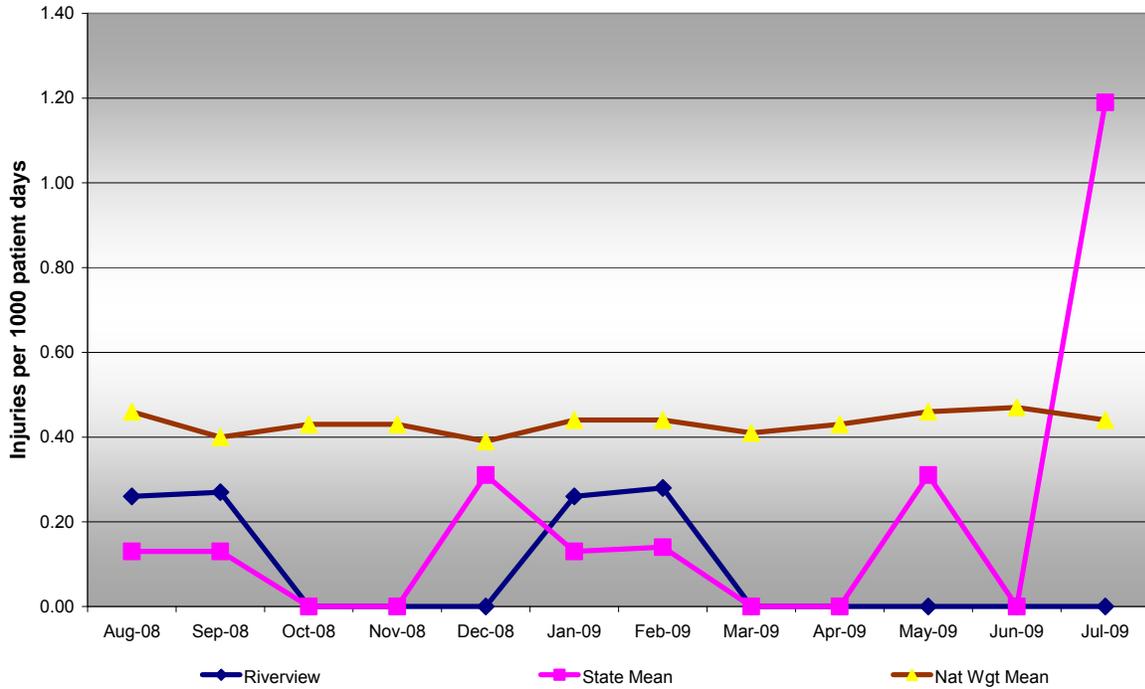
- Client Injury Rate
- Elopement Rate
- Medication Error Rate
- 30-day Readmit Rate
- Percent of Clients Restrained
- Restraint Hours
- Percent of Clients Secluded
- Seclusion Hours

The charts shown include data elements that have been processed by the NASMHPD Research Institute. These performance measures are utilized by the Riverview Psychiatric Center to evaluate its performance in maintaining a safe and therapeutic environment for its clients as compared to the performance of other treatment centers within the State of Maine and throughout the country.

Normal process delays in data upload and analysis prevent timely review of the measures. The charts shown in this section display the last available processed data elements for the period ending July 2009.

COMPARATIVE STATISTICS

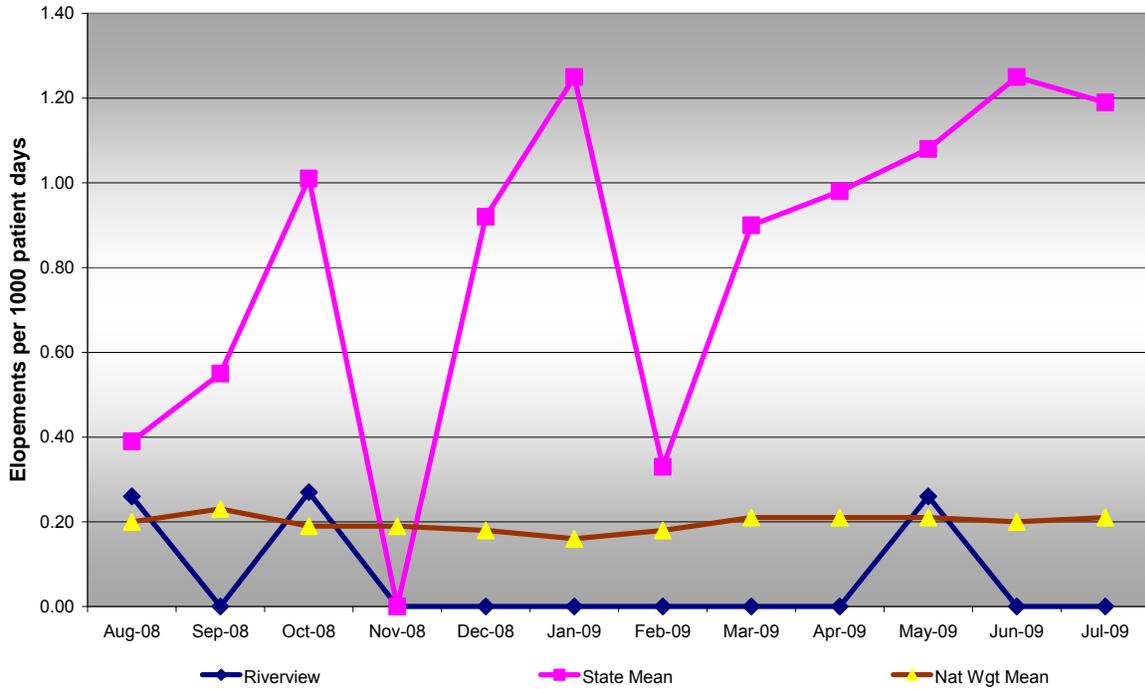
Client Injury Rate



Measure Description: 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.

COMPARATIVE STATISTICS

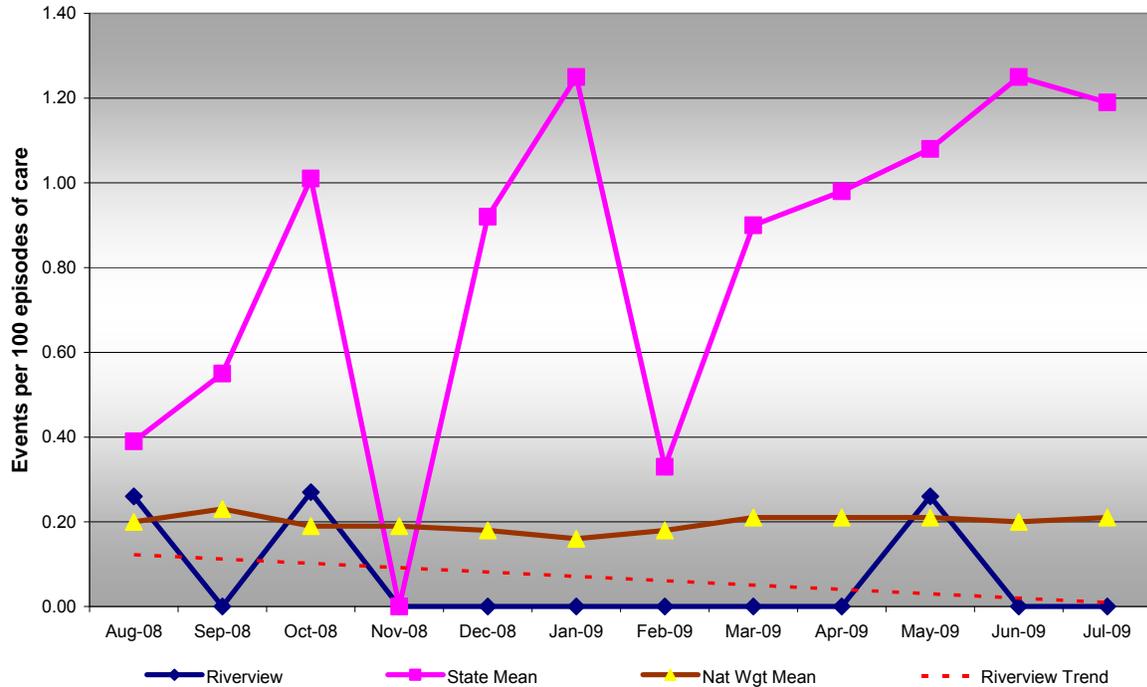
Elopement



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

COMPARATIVE STATISTICS

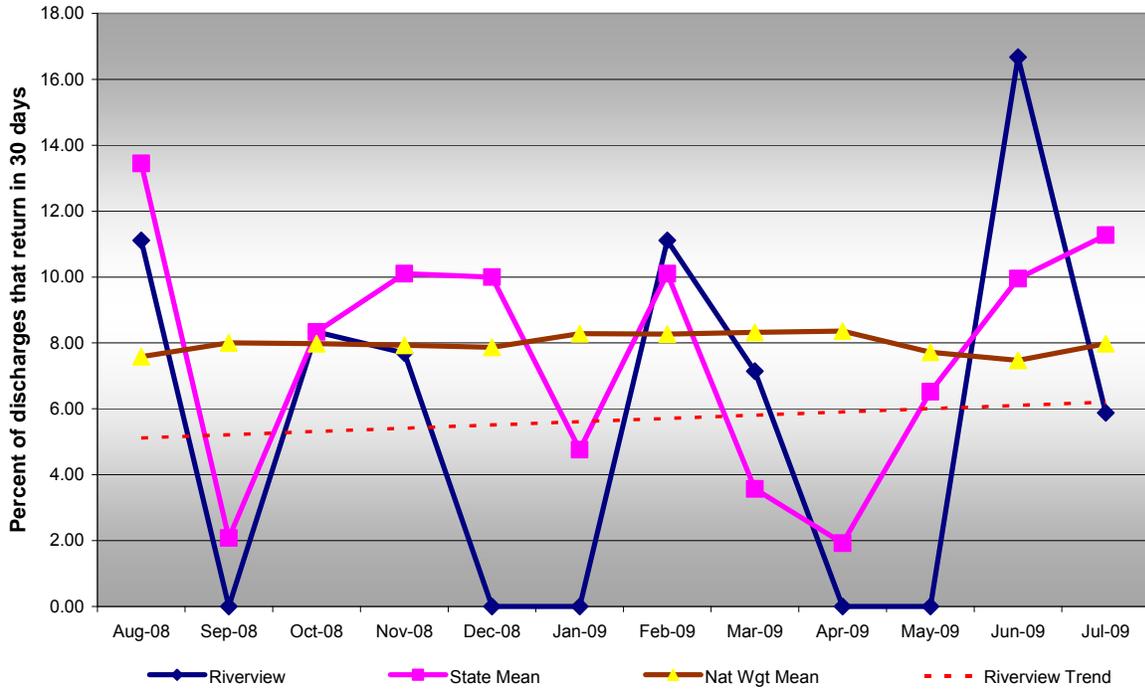
Medication Errors



Measure Description: 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.

COMPARATIVE STATISTICS

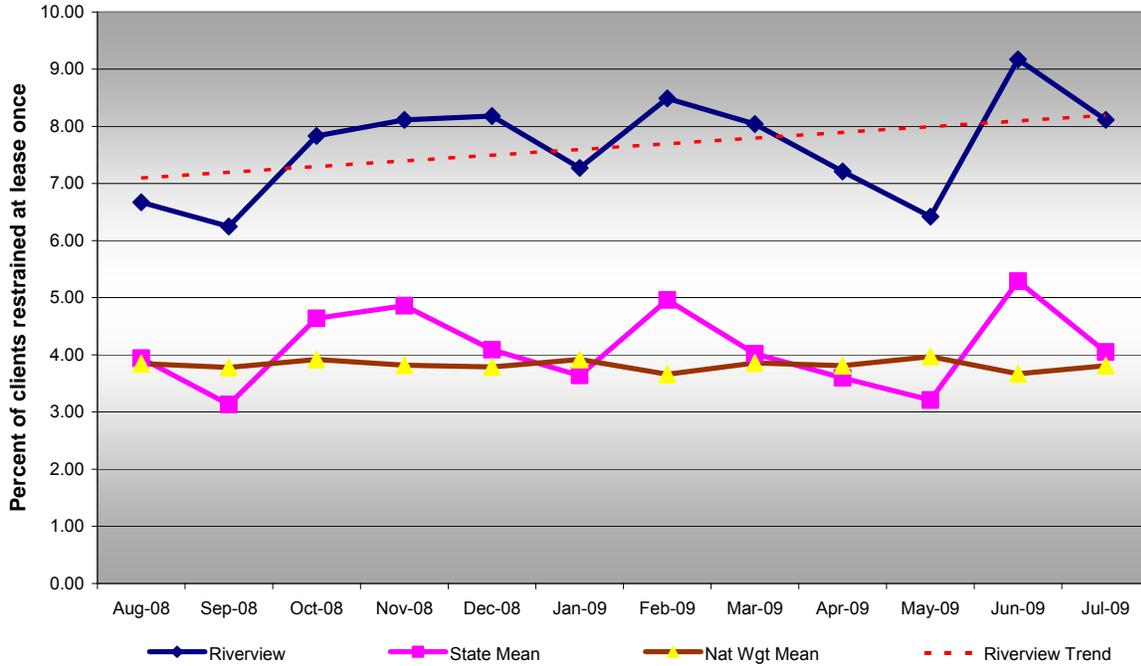
30 Day Readmit



Measure Description: Percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility. For example, a rate of 10.0 means that 10% of all discharges were readmitted within 30 days.

COMPARATIVE STATISTICS

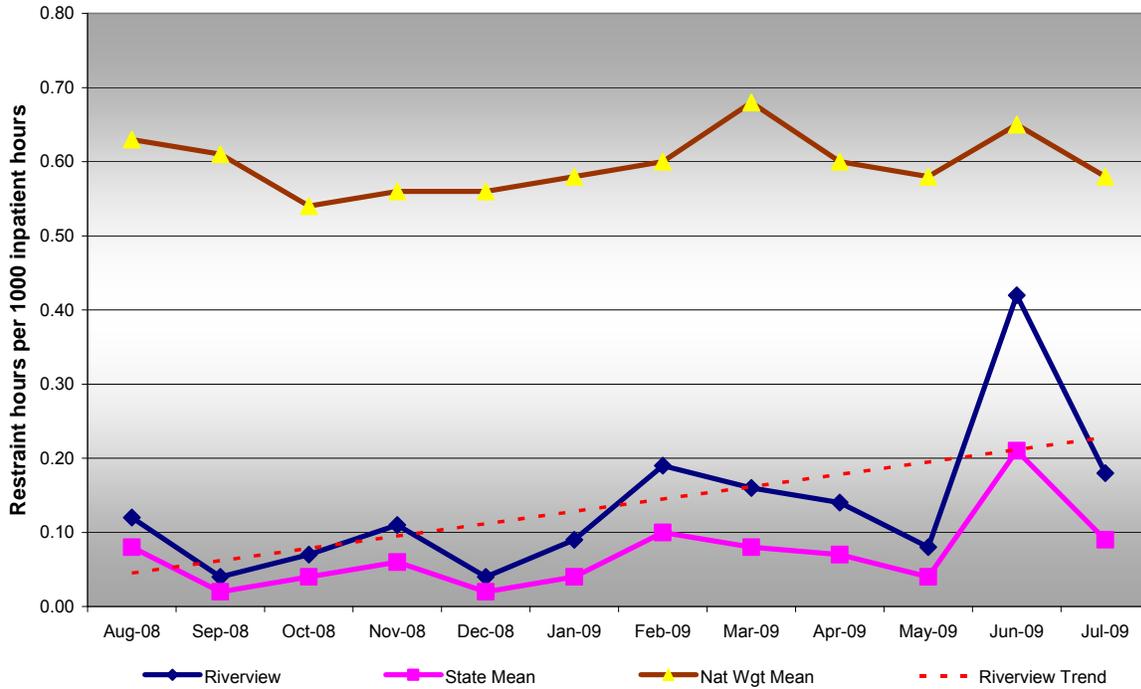
Percent of Clients Restrained



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

COMPARATIVE STATISTICS

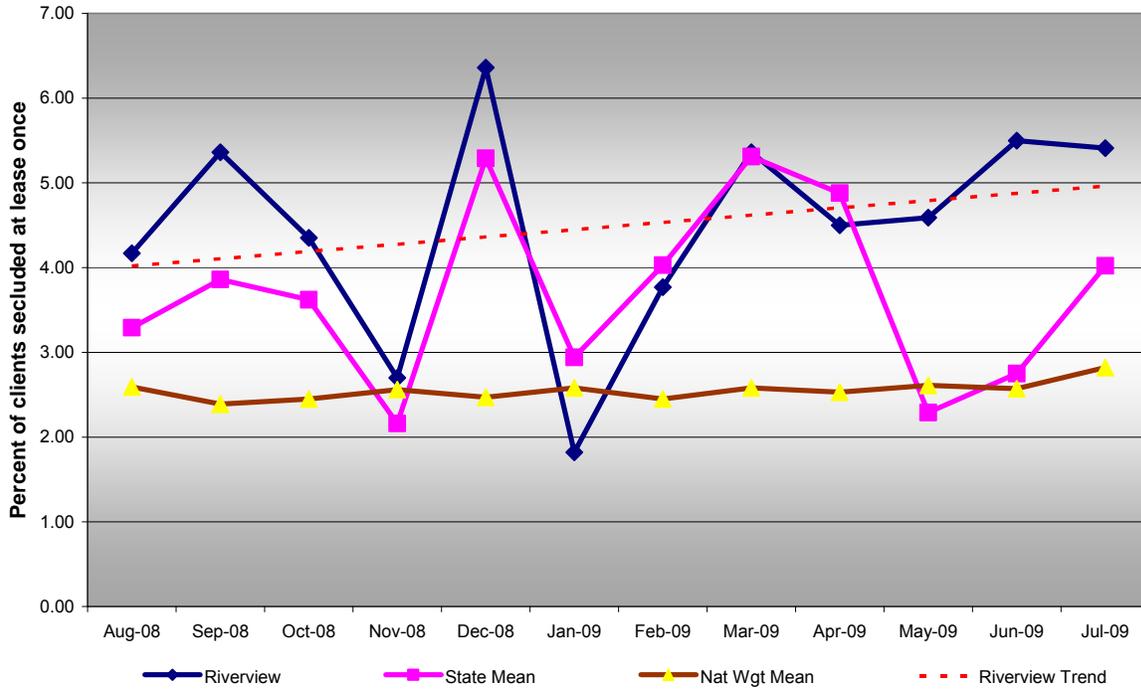
Restraint Hours



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

COMPARATIVE STATISTICS

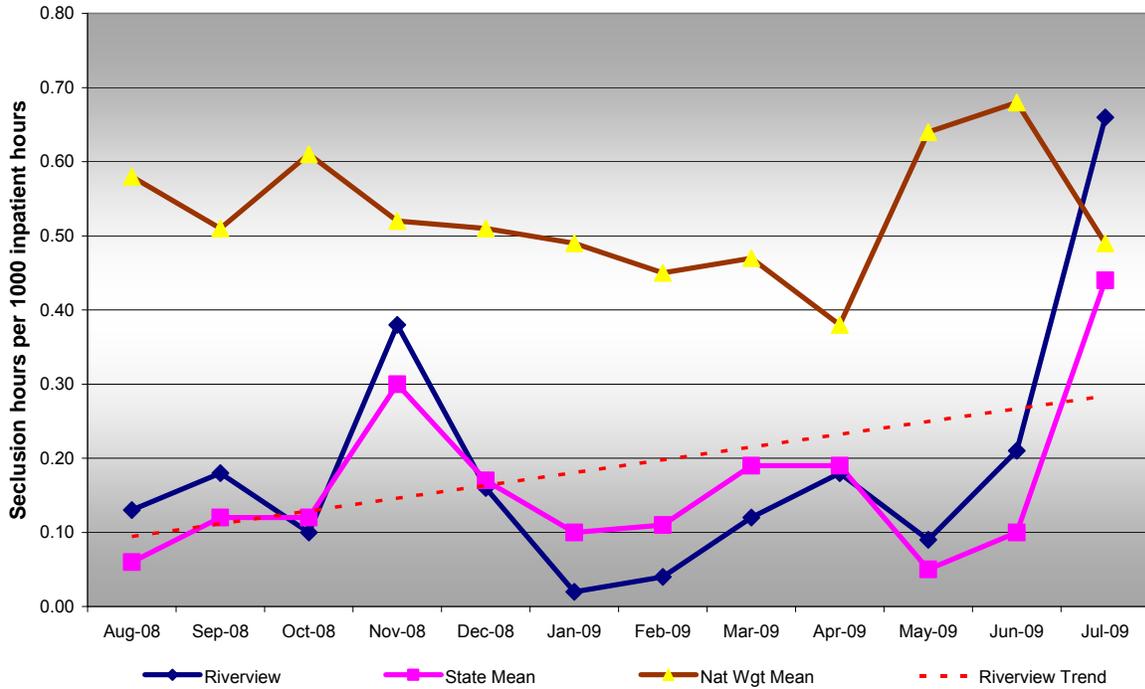
Percent of Clients Secluded



Measure Description: Percent of unique clients who were secluded at least once. For example, a rate of 3.0 means that 3% of the unique clients served were secluded at least once.

COMPARATIVE STATISTICS

Seclusion Hours



Measure Description: 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.

DIETARY

ASPECT: Cleanliness of Main Kitchen

Indicators	Findings	Compliance	Threshold Percentile
1. All convection ovens (4) were thoroughly cleaned monthly.	10 of 12	83%	100%
2. Walk in coolers were cleaned thoroughly monthly.	5 of 6	83%	100%
3. Steam kettles (2) were cleaned thoroughly on a weekly basis	24 of 24	100%	95%
4. All trash cans (5) and bins (1) were cleaned daily	405 of 546	74%	95%
5. All carts(9) used for food transport (tiered) were cleaned daily	692 of 819	84%	100%
6. Dish machine was de-limed monthly	3 of 3	100%	100%
7. Shelves (6) used for storage of clean pots and pans were cleaned monthly	18 of 18	100%	100%
8. Racks(3) used for drying dishes were cleaned daily	243 of 273	89%	100%
9. Knife cabinet was thoroughly cleaned monthly	3 of 3	100%	100%
10. All hand sinks (4) were cleaned daily	328 of 364	90%	95%

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

Threshold percentiles were not met regarding: Convection ovens, one not thoroughly cleaned in the months of July and September. One of the walk-in coolers was not cleaned thoroughly in the month of September. All trash cans and bins were not cleaned daily; July-September. All tiered carts used for food transport were not cleaned daily; August or September. Racks used for drying dishes were not cleaned daily; July-September. All hand sinks were not cleaned daily July-September.

Improvements were shown in the following areas: All steam kettles were cleaned weekly; July-September. The cleaning of trash cans increased from 34% to 74%. Food transport

DIETARY

carts were cleaned with 74% compliance the first quarter. The second quarter shows an 84% compliance rate. Shelves used for storage of clean pots and pans shows an improvement from 89% to 100%. Racks used for drying dishes were 58% are now 89% Hand sinks showed a 12% improvement; 78% first quarter to 90% second quarter. The dish machine has been de-limed every month since January. The knife cabinet has been thoroughly cleaned every month since January.

Daily tasks were not being completed due to increased amounts of food preparation during the summer season. I.e.: picnics and bag lunch requests. There was a change in staff responsibility due to cook resignation that was not noticed until the second week of the month. This resulted in the steam kettles not being cleaned one week. There was a change made without prior discussion that impacted the frequency of cleaning of the trash cans/bins. Despite a staff shortage of 3 F.T.E's, summer vacations, and sick calls the overall compliance for this indicator increased 21% from last quarter.

Current method of completing cleaning tasks must be re-evaluated for timeliness, consistency and feasibility. Overall Compliance: 83.7%

Actions: The cleaning schedule will be revised and posted using a color coded format that highlights the importance of the tasks. The general staff meeting will include discussion and staff suggestions for successful completion of these tasks. The cleaning schedule is reviewed on a daily basis to assure that essential cleaning is completed. The Housekeeping Department has provided some assistance with accomplishing certain tasks, when requested. The D.S.M. will share results of this CPI indicator with staff. Also, Dietary employees will be trained to effectively manage their time on a daily basis. This training will include review of the daily meals. Training will increase available time on days that meals are less labor intensive, thus enabling more time for cleaning.

Next Reporting Date: *January 2010*

HEALTH INFORMATION

ASPECT: Documentation & Timeliness

Indicators	Findings	Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 61 discharges in quarter 1 2010. Of those, 45 were completed by 30 days. Note: There were 4 incomplete records from the previous reporting period.	74%	80%
Discharge summaries will be completed within 15 days of discharge.	60 out of 61 discharge summaries were completed within 15 days of discharge during quarter 1 2010.	98%	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	0 forms were revised in quarter 1 2010 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 501 dictated reports, 497 were completed within 24 hours.	99%	90%

Summary: The indicators are based on the review of all discharged records. There was 74% compliance with record completion, with 4 incomplete records from a previous reporting period. There was 98% compliance with discharge summary completion. Weekly “charts needing attention” lists are distributed to medical staff, including the Medical Director, along with the Superintendent, Chief Operating Officer, Risk Manager and the Quality Improvement Manager. There was 99% compliance with timely & accurate medical transcription services.

Actions: Continue to monitor.

HEALTH INFORMATION

ASPECT: Confidentiality

Indicators	Findings	Compliance	Threshold Percentile
All client information released from the Health Information department will meet all Joint Commission, State, Federal & HIPAA standards.	3735 requests for information (210 requests for client information and 2199 police checks) were released for quarter 4 2009.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	11 new employees/contract staff in quarter 1 2010.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	0 privacy-related incident reports during quarter 1 2010.	100%	100%

Summary: The indicators are based on the review of all requests for information, orientation for all new employees/contract staff and confidentiality/privacy-related incident reports. No problems were found in quarter 3, however compliance with current law and HIPAA regulations need to be strictly adhered to requiring training, education and policy development at all levels.

Actions: The above indicators will continue to be monitored.

HOUSEKEEPING

ASPECT: Linen Cleanliness and Quality

Indicators	Findings	Compliance	Threshold Percentile
1. Was linen clean coming back from vendor?	27 of 27	100%	100%
2. Was linen free of any holes or rips coming back from vendor?	24 of 27	89%	95%
3. Did we have enough linen on units via complaints from unit staff?	27 of 27	100%	90%
4. Was linen covered on units?	22 of 27	81%	95%
5. Did vendor provide a 24 hr. turn around service as specified in the contract?	27 of 27	100%	100%
6. Did we receive an adequate supply of mops and rags from vendor?	27 of 27	100%	95%
7. Was linen bins clean returning from vendor?	27 of 27	100%	100%

Summary: 7 different criteria are to be met for acceptability. The indicators are based on the inspections of linen closets throughout the facility including the returned linen from the vendor. All linen types were reviewed randomly this quarter. All indicators are within threshold percentiles except for #2 and #4. The overall compliance for this quarter was 96%. This shows a 1% decrease from last quarters report.

1. During random inspections, L. Saco had linen racks that were left uncovered.
2. U. Kennebec and L. Saco reported having ripped wash cloths delivered to them.

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

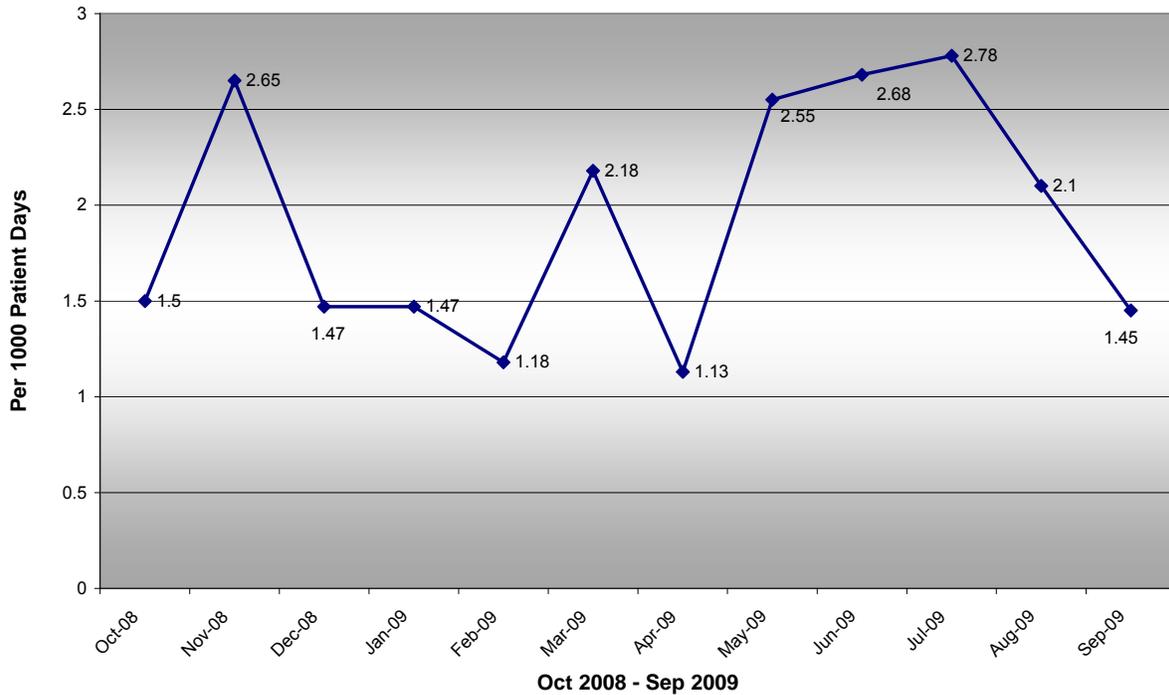
- ✓ The housekeeping staff on each unit will monitor the quality of wash cloths delivered to their respective units.
- ✓ The housekeeping staff on each unit will monitor the linen racks to assure the racks are consistently covered.
- ✓ Housekeeping supervisor will report in staff meetings these results to make the Housekeeping staff aware of the status of this indicator.
- ✓ Housekeeping supervisor contacted linen vendor and advised them of the problem of the ripped wash cloths.
- ✓ Housekeeping supervisor will meet with the L. Saco unit leadership to solicit their help in keeping the linen racks covered at all times.

Next Reporting Date: *January 2010*

HUMAN RESOURCES

ASPECT: Direct Care Staff Injuries

Reportable (Lost Time & Medical) Direct Care Staff Injuries

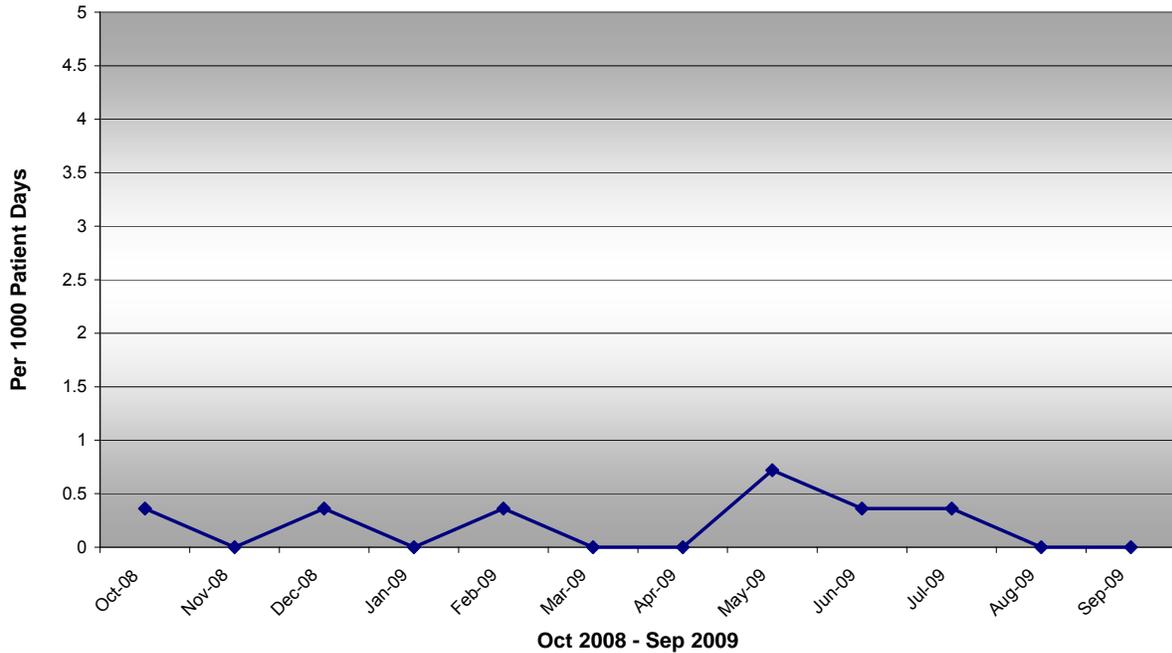


Summary: This quarter reveals that percent of direct care staff injuries for this quarter has remained static at 2.12% per 1000 patient days. This number represents 18 direct care staff that sought medical attention or lost time from work as compared to 17 last quarter.

HUMAN RESOURCES

ASPECT: Non-Direct Care Staff Injuries

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



Summary: This quarter reveals that percent of direct care staff injuries for this quarter has decreased from an average of 0.36% per 1000 patient days to 0.12% per 1000 patient days. This number represents 1 direct care staff that sought medical attention or lost time from work as compared to 3 last quarter.

HUMAN RESOURCES

ASPECT: Management of Human Resources – Performance Evaluations

Indicator	Findings	Compliance	Threshold Percentile
Employee performance evaluations expected to be completed within 30 days of the due date			
July 2009	29 of 30	96.67%	85%
August 2009	20 of 25	80.00%	85%
September 2009	29 of 37	78.38%	85%

Summary: As compared to last quarter (63.08%) this quarter increased to 84.78%. Follow-up efforts by the human resources department as well as frequent reminders at leadership meetings regarding the performance evaluation standard resulted in significant improvement in overall performance.

Actions: Ongoing efforts to encourage compliance with hospital standards will continue and monitoring of this standard will continue with particular focus on ensuring the accountability of supervisors in their role through performance rating and feedback.

INFECTION CONTROL

ASPECT: Hospital Acquired Infection

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the first quarter of the fiscal year, per 1000 patient days	35/4.1	100 % within standard	5.8 or less
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	16/1.9	100% within standard	5.8 or less

Summary: The hospital maintains total house surveillance. Data is collected via antibiotic reports, lab and/or radiology reports, chart review and clinical findings. The rate of hospital infections is well below threshold percentile and the accepted two (2) standard deviations. The rate of hospital acquired (healthcare associated) infections is within the threshold percentile and well within the accepted two (2) standard deviations.

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

Employee Health is in the midst of vaccinating employees against seasonal influenza. The medical staff on the units has been offering seasonal influenza vaccine to clients as well. Clients and employees will be offered the H1N1 vaccination once the vaccine comes in.

Employee and client surveillance is ongoing.

LIFE SAFETY

ASPECT: Life Safety

OVERALL COMPLIANCE: 99%

Indicators	Findings	Compliance	Threshold Percentile
1. Total number of fire drills and actual alarms conducted during the quarter compared to the total number of alarm activations required per Life Safety Code, that being (1) drill per shift, per quarter.	3/3	100%	100%
2. Total number of staff who knows what R.A.C.E. stands for.	352/352	100%	95%
3. Total number of staff who knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	342/352	97%	95%
4. Total number of staff who knows the emergency number.	352/352	100%	95%
5. During unannounced safety audits conducted by the Safety Officer, this represents the total number of staff who display identification tags.	354/358	98%	95%
6. During unannounced safety audits conducted by the Safety Officer, this represents the total number of direct care staff who carry a personal duress transmitter.	105/107	98%	95%

Summary: The (3) alarms reported for the hospital meets the required number of drills per JCAHO and Life Safety Code. Indicators 2 through 4 are indicators used for the purpose of evaluating the knowledge and skills of staff as it relates to critical skills and knowledge necessary to carry out functions in the event of a fire and/or smoke emergency. #'s 2-5 also reflect the response during a recent training fair held on September 23, 2009.

Actions: We continue our initiative by conduct a hospital-wide census during such events utilizing two-way radios. The NOD's have also been assisting in that initiative by immediately securing a two-way radio and initiating the census. Drills continue to show an improvement in that area. The Safety Officer is also conducting mini presentations to various units as a continuing education in the use of utilizing the remote annunciator panels located through facility. For the second quarter in a roll, and as noted in Indicator #3, one drill actually demonstrated that some staff were not sure how to acknowledge the location. The Safety Officer, assisted by the unit supervisor, performed an in-service on that unit following the drill. We continue with environmental tours and safety audits to assure that staff is in possession of required safety equipment and facility ID's. We have also asked Supervisors to be vigilant in regard to their staff not carrying the required equipment. We continue to monitor these indicators during safety fairs, along with those during the tours and audits.

LIFE SAFETY

ASPECT: Fire Drills Remote Sites

COMPLIANCE: 100 %

Indicators	Findings	Compliance	Threshold Percentile
1. Total number of fire drills and actual alarms conducted at Portland Clinic compared to the total number of alarm activations required per Life Safety Code (3) drills per year based on the fact that it is business occupancy.	1 drill	100%	100%

Summary: During an unannounced drill conducted by the Safety Officer this past quarter, staff performed exceptionally well indicating that we continue to meet our objectives with regard to the staff's knowledge on what to do during such an event. We will continue to perform environmental tours during which time we ask them questions as it relates to what actions they must take in the event of a fire and/or smoke emergency. It will be planned that the next drill conducted will involve pulling the building alarm and collaborating with the property owner, the other building occupants, and the local emergency services.

Actions: There are no required actions at this time other than coordinate the next planned drill with other participants.

LIFE SAFETY

ASPECT: Securitas/RPC Security Team

OVERALL COMPLIANCE: 98%

Indicators	Findings	Compliance	Threshold Percentile
1. Security Officer "foot patrols" during Open Hospital times. (Total # of "foot patrols" done vs. total # of "foot patrols" to be done.) for April & May 2009. (Stats not available during last quarter reporting)	1325/1348	98%	95%
2. Security Officer "foot patrols" during Open Hospital times. (Total # of "foot patrols" done vs. total # of "foot patrols" to be done.)	1955/2024	96%	95%
3. Security/safety checks done of the "lower" client units during the hours of 8:00 am thru 8:00 pm. (To be done 6 times in this 12 hour period.)	552/552	100%	95%

Summary: #1 These findings, not available during the last report, . Foot patrols continue to be done despite those rare times that the officers are on other details which take priority over the "foot patrol".

Actions: Securitas and the Safety Officer are in the process of formulating new indicators and will attempt to roll them out during the next reporting period.

MEDICAL STAFF

ASPECT: Completion of Abnormal Involuntary Movement Scale Testing

Indicators	Findings	Compliance	Threshold Percentile
Charts of clients at Riverview for six or more months are reviewed. Each client should have an AIMS exam done upon admission and every six months thereafter.	Over a 3-mo period 109 of 142 were in compliance	77%	90%

Summary: AIMS testing is being done upon admission, but follow-up tests every six months are not, therefore, making the hospital non-compliant with its policy. Clients' charts were reviewed for completion of AIMS in July, August and September. By the end of the 1st quarter the 3-month totals showed 109 of 142 charts were in compliance. The compliance rate increased from 29% in the 3rd quarter of FY09 to 77% for the 1st quarter of FY10.

Actions: We will continue to monitor AIMS testing on clients at the hospital for six months or more. Psychiatrists will be provided with a monthly list indicating which clients are due for AIMS testing each month. Feedback to individual psychiatrists is given at the Peer Review Committee.

ASPECT: Completion of Medication Reconciliation Admission/Transfer/ Discharge Sheet

Indicators	Findings	Compliance	Threshold Percentile
Charts of clients admitted at Riverview are reviewed. Each client should have a Medication Reconciliation done upon admission, transfer and discharge.	From Aug. 1 through mid Sept. there were 27 admissions with 19 forms completed.	70%	90%

Summary: Starting in August, the committee reviewed completion of the Medication Reconciliation form upon admission. From August 1 through September 18, there were 19 completed forms for 27 admissions.

Actions: The committee will continue to monitor Medication Reconciliation forms completed upon admission. Eventually the committee will monitor the forms use during transfers and discharges. Psychiatrists will be provided with a monthly list. Feedback to individual psychiatrists is given at the Peer Review

NURSING

ASPECT: Seclusion and Restraint Related to Staffing Effectiveness

Indicators Seclusion/Restraint related to staffing effectiveness:	Findings	Compliance
1. Staff mix appropriate	72 of 72	100%
2. Staffing numbers within appropriate acuity level for unit	72 of 72	100%
3. Debriefing completed	72 of 72	91%
4. Dr. Orders	72 of 72	100%

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

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

ASPECT: Injuries related to Staffing Effectiveness

Indicators Injuries related to staffing effectiveness:	Findings	Compliance
1. Staff mix appropriate	12 of 12	100%
2. Staffing numbers within appropriate acuity level for unit	12 of 12	100%

Summary: Overall staff injuries are monitored by Risk Management and Human Resources for Direct care and by Human Resources' and Environment of Care for staff injuries due to the environment. Injuries have decreased from last quarter. The staffing numbers are within the appropriate level for the current staffing plan and the acuity level.

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

NURSING

ASPECT Medication errors as it relates to Staffing Effectiveness (OLD)

NURSING: Staffing levels during medication errors – July to September 2009

NASMHPD reportable variances

Date	Omit	Co-mission	Float	New	O/T	Unit Acuity	Staff Mix
8/16/09	√		N	N	No	US 3-11	2 RN, 2 LPN, 5 MHW (+ 1 above)
8/11/09	√		N	N	No	US 3-11	3 RN, 0 LPN, 4 MHW, 1:1 =1, 0 appointments + ½ MHSW 7-11
8/08/09	√		N	N	No	LS-7-3	2 RN, 1 LPN, 7 MHW (regular staffing)

Summary: There were a total of 3 reportable errors. None involved pharmacy and did not involve staffing effectiveness evaluation. Nursing reportable medication variances data indicated the following:

No errors were commissions, 3 were omissions. Two (2) were by the same RN and involved improper following of protocols. A recommendation was made to review protocols with Nursing Educator. The third involved a client refusing to come to the med room for insulin resulting in omission. This was to be reviewed with the nurse by the RN IV.

Action: The Nursing Dept will educate the individual nurses involved in Med errors and add the issues to the Annual Competency updates.

ASPECT: Pain Management

Indicator		Findings	Compliance
Pre-administration	Assessed using pain scale	1117 of 1122	99%
Post-administration	Assessed using pain scale	960 of 1122	85%

Summary: This indicator is about the same as last quarter with pre-assessment at 99% and post-assessment at 85% Post-assessment has come up 2% but is not statistically significant,

Action: Nursing will continue to place a great deal of attention and effort on post administration assessment. Nursing will continue to track this indicator and strive for increase an in post assessment in the next quarter. The two ADONs will continue to work with unit nursing staff to assure that this is done more consistently.

NURSING

ASPECT: Chart Review

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	38 of 51	75%
2. MHW notes co-signed by RN	28 of 51	55%
3. STGs/Interventions are written, dated and numbered.	41 of 51	96%
4. STGs are measureable and observable	51 of 51	100%
5. STGs/Interventions are modified / met as appropriate.	34 of 44	77%
6. STGs/Interventions tie directly to documentation.	24 of 48	50%
7. Weekly Summary note completed.	35 of 50	70%
8. Progress notes/flow sheets document a level of functional skill support provided, consistent with the identified area of need, delivered within last 24 hours.	34 of 50	68%

Summary: The compliance in this quarter has varied greatly from the previous quarter. Overall compliance last quarter was 80% with overall compliance this quarter at 74%. There was a slight decrease in MHW notes co-signed from 59% last quarter to 55% this quarter. GAP notes written in appropriate manner at least every 24 hours decreased from 83% to 75%. Short-term goals/interventions are written, dated, and numbered in creased from 95% to 96%. Short-term goals tie directly to documentation increased from 96% to 100%. Weekly summary notes have increased from 35% to 70%. The weekly summary note has received a lot of attention and education in this quarter with positive results. The audit nurse was different for all three quarters which may represent the varying numbers. The nurse will remain the same for the next quarter with better results due to the consistency. Need continued monitoring and education.

Action: Actions from last quarter will continue. The unit RNs will audit 1 chart per RN and discuss during supervision. The Nurse Educator responsible for chart audit will meet with individual nurses following each chart audit. The PSD/ Nurse IV will continue to discuss and review chart audit results at staff meetings. The RN IVs assisted by the Assistant Directors of Nursing will ascertain if Unit Nurses are aware of documentation requirements and review with each using the CSP manual and nursing documentation policy. Documentation education and expectations will continue in areas needing attention. This documentation area will continue to be a high focus for the next quarter.

PEER SUPPORT

ASPECT: Integration of Peer Specialists into client care

Indicators	Findings	Compliance	Threshold Percentile
1. Attendance at Comprehensive Treatment Team meetings.	407 of 477	85%	80%
2. Grievances responded to by RPC on time.*	45 of 90	50%	100%
3. Attendance at Service Integration meetings.	56 of 56	100%	100%
4. Contact during admission.	57 of 57	100%	100%
5. Grievances responded to by peer support on time.	90 of 90	100%	100%
6. Client satisfaction surveys completed.	17 of 34	50%	75%

Summary: Overall compliance is 84%, up 6% from last quarter. The most significant drop in compliance was in RPC's response to grievances, dropping 12% from last quarter. Of the 45 late grievances, 25 have not been responded to as of the date of this report. There was a decrease in the number of satisfaction surveys completed, down by 10%. The most significant increase in compliance was attendance at comprehensive treatment team meetings, up 10%, as a result of staffing levels being stabilized.

***Action:** A Process Improvement Task Team (PITT) is being formed to evaluate the process flow of the grievance system in an attempt to identify barriers to timely, consistent, and effective response to clients needs. The ultimate objective of this team is to identify ways in which to integrate the grievance process at Riverview Psychiatric Center with the process used at Dorothea Dix Psychiatric Center and in the greater community treatment program managed by the Office of Adult Mental Health Services.

PHARMACY & THERAPEUTICS

ASPECT: AcuDose Override Medication Audit

Date	Kennebec		
	Upper	Lower	Special Care
2/6/2009	100%	100%	100%
3/4/2009	100%	100%	100%
7/13/2009	100%	100%	100%

Date	Saco		
	Upper	Lower	Special Care
2/6/2009	100%	100%	100%
3/4/2009	100%	100%	100%
7/10/2009	100%	100%	100%

The AcuDose override function is integral in the medication dispensing system at Riverview. The override function gives access to medication during emergency situations where medication therapy is indicated immediately.

The medications allowed and processed followed are described in policy MM.4.40.3 AcuDose Rx Medication Cabinets. The goal of this review was to make sure all AcuDose override medications were available from the AcuDose machines and no medications not approved by MM.4.40.3 were available.

The medications available on each AcuDose machine's override were reviewed. The review was done for 2 consecutive months then repeated after 6 months.

We found 100% compliance with MM.4.20.3 during all 3 time periods.

PROGRAM SERVICES

Aspect -Active Treatment

Indicator	Findings	Compliance	Threshold
1. Documentation in progress notes and / or flow sheets demonstrate identified functional need/s including present Level of Support and what Level of Support the goal is.	117 of 120	97%	80%
2. Progress notes / flow sheets document a level of functional skill support provided, consistent with the identified area of need, delivered within the last 24 hours.	101 of 120	84%	70%
3. Documentation reveals that the client attended 50%of assigned psycho-social-educational interventions within the last 24 hours.	78 of 120	65%	70%
4. A minimum of three psychosocial educational interventions are assigned daily.	114 of 120	95%	70%
5. A minimum of four groups is prescribed for the weekend.	113 of 120	86%	70%
6. The client is able to state what his assigned psycho-social-educational interventions are and why they have been assigned.	85 of 116	73%	60%
7. The client can correctly identify assigned RN and MHW. (Or where the information is available to him / her)	112 of 120	93%	75%
8. The medical record documents the client's active participation in Morning Meeting within the last 24 hours.	73 of 115	64%	70% LK/LS 85% UK/US
9. The client can identify personally effective distress tolerance mechanisms available within the milieu.	118 of 120	92%	65%
10. Level and quality of client's use of leisure within the milieu are documented in the medical record over the last 7 days.	120 of 120	100%	75%
11. Level and quality of social interactions within the milieu are documented in the medical record over the last 7 days.	120 of 120	100%	75%

PROGRAM SERVICES

12. Potential for violence assessed upon admission	116 of 120	97%	100%
13.a Suicide potential assessed upon admission. (TASR)	119 of 120	99%	100%
b. Suicide potential moderate or above incorporated into CSP	51 of 82	62%	90%
14a. Fall risk assessed upon admission. (Universal assessment)	118 of 120	98%	100%
b. Score of 5 or above incorporated into CSP as fall potential	9 of 40	22%	90%
15. Medication reconciliation completed upon admission / transfer / discharge.	37 of 105	35%	100%
16. Allergies displayed on order sheets and on spine of medical record.	119 of 120	99%	100%

Summary: Overall compliance for all indicators is 85% Seven indicators have improved compliance. Number 2 is 84% which is up from 80% last quarter; Number 3 is 65% up from 62%. Number 5 is 86% up 1% from last quarter; Number 7 is 93% up from 87%; Number 9 is 92% up from 91%; Number 13 is 98% up from 96%; Number 15 is 35% up from 28%. Indicators number 8, 12, and 14 have fallen slightly. Indicators 1, 4, 7, 10, 11, and 16 have remained the same. Nine of the 18 indicators are at or above established compliance levels. Two are 1-3% below compliance levels.

Action: Continue to focus on the 3 areas that have been consistently below threshold over the next quarter. This will be addressed through staff meetings and community meetings. As we look at the next quarter, indicators will be revised as will compliance levels thresholds.

PROGRAM SERVICES

Aspect-Milieu Treatment

Indicator	Compliance	Threshold
1. Percentage of clients participating in Morning Meeting	63%	70% LK /LS 80%UK /US
2. Percentage of clients who establish a daily goal.	78%	80%
3. Percentage of clients who attend Wrap Up group in the evening or address with primary staff, the status of their daily goal.	73%	70%LK / LS 80%UK /US
4. Percentage of clients attending Community Meeting	75%	70%

Summary Overall compliance in this area is 66%. Two indicators have improved compliance; Number 3, 73% up from 68%; Number 4, 75% up from 62% Two had decreased. Number 1, 63% from 73%; Number 2, 78% from 82%.

REHABILITATION SERVICES

ASPECT: Readiness Assessments, Comprehensive Service Plans and Progress Notes
OVERALL COMPLIANCE: 83%

Indicators	Findings	Compliance
1. Readiness assessment and treatment plan completed within 7 days of admission.	27/28	96%
2. Rehabilitation short term goals on Comprehensive Service Plan are measurable and time limited.	27/28	96%
3. Rehabilitation progress notes indicate treatment being offered as prescribed on Comprehensive Service Plan.	20/28	71%
4. Rehabilitation progress notes indicate progress towards addressing identified goals on the Comprehensive Service Plan.	19/28	69%

Summary: This is the quarterly review of the above indicators. The Director of Rehab Services will remind all RT's to keep running list of assessments that need to be done and the date due, so that the covering RT will be aware of the work that needs to be completed. The Director will meet with Clinical Council to discuss the new changes for treatment planning that occurred on one of the units. The change made it difficult for Rehab staff to identify the Rehab goal for each client that they were documenting on. The Director will also meet with the Rehab staff to review individualized treatment planning and progress note writing at the next monthly department meeting to ensure quality progress notes.

SOCIAL WORK

Aspect: Preliminary Continuity of Care Meeting & Comprehensive Psychosocial Assessments

Indicators	Findings	Compliance	Threshold Percentile
1. Preliminary Continuity of Care meeting completed by end of 3 rd day	30/30	96%	100%
2. Service Integration form completed by the end of the 3rd day	30/30	100%	100%
2a. Director of Social Services reviews all readmissions occurring within 60 days of the last discharge and for each client who spent fewer than 30 days in the community, evaluated the circumstances of the readmission to determine an indicated need for resources or a change in treatment and discharge planning or the need for alternative resources. In cases where such a need or change was indicated that corrective action was taken.	2/2	100%	100%
3a. Client Participation in Preliminary Continuity of Care meeting.	30/30	100%	90%
3b. CCM Participation in Preliminary Continuity of Care meeting.	30/30	100%	100%
3c. Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation in Preliminary Continuity of Care meeting.	30/30	100%	90%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	8/15	53%	90%
3e. Correctional Personnel Participation in Preliminary Continuity of Care Meeting.	0/15	0%	90%
4a. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	25/30	83%	100%
4b. Annual Psychosocial Assessment completed and current in chart	30/30	100%	100%

Summary: Indicator 3d is up slightly from the 4th quarter but remains low under the threshold percentile. We will continue to work on the aspect area with the department to brainstorm community participation in this preliminary meeting. The challenge is the short time frame in which occurs during admission and we have a higher percentage of participation at the 7 day treatment meeting and on-going meetings over the course of the clients entire stay at the facility. Indicator 3e has remained at 0 for numerous quarters for varying reasons most clients refuse participation from jail personnel in their treatment meetings and the lack of mental health resources in the jails impacts participation. We are having on-going meetings regarding forensic issues and can continue to discuss this on-going issue with the mental health liaison.

SOCIAL WORK

Indicator 4a This area has been a challenge for this last quarter due to the high volume of admissions and having a vacant position on the lower admission unit. We have hired a new staff and anticipate this area will demonstrate improvement in the next quarter.

Aspect: Institutional and Annual Reports

Indicators	Findings	Compliance	Threshold Percentile
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	3/7	43%	95%
2. The assigned CCM will review the new court order with the client and document the meeting in a progress note or treatment team note.	9/9	100%	100%
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually	N/A	N/A	100%

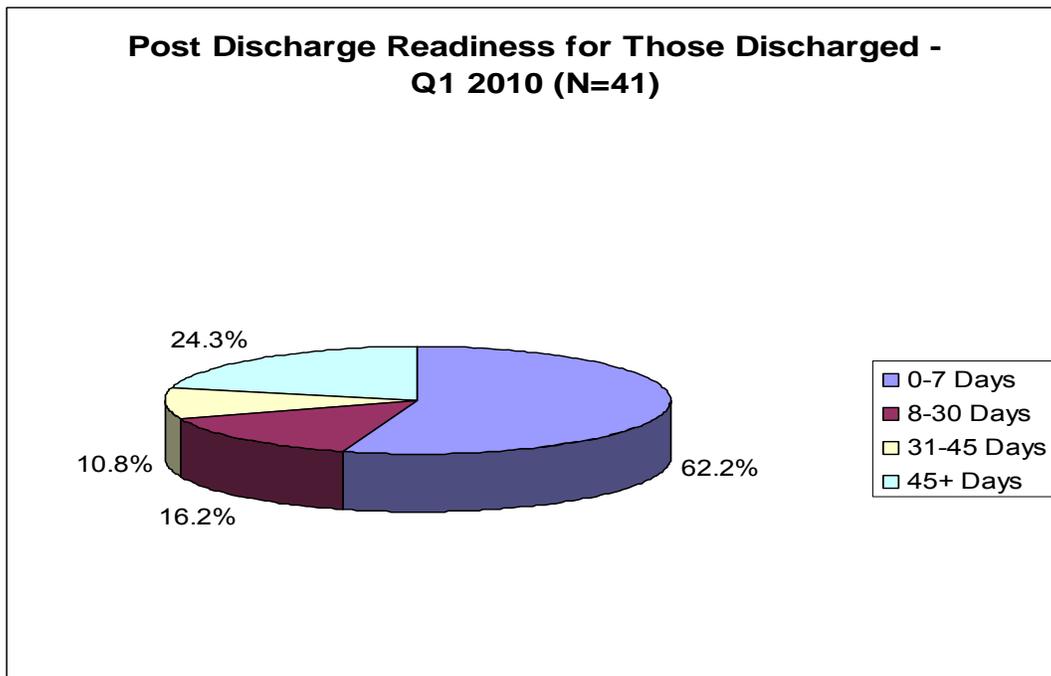
Summary: Indicator 1 increased 23% from last quarter and we continue to streamline the institutional report process with the use of better predicting and tracking of petitions. In addition the Forensic drive and the on-going Forensic projection and forecasting meetings have assisted in improving the process.

SOCIAL WORK

Aspect: Client Discharge Plan Report/Referrals

Indicators	Findings	Compliance	Threshold Percentile
1. The Client Discharge Plan Report will be updated/reviewed by each Social Worker minimally one time per week.	13/13	100%	95%
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	12/13	92%	100%
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	12/13	92%	100%
3. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	12/13	92%	100%

Summary: Indicators 2, 2a and 3 Director was on vacation one week and a report capturing 2 weeks was sent out the subsequent week.



This chart shows the percent of civil clients who were discharged within 7 days of their discharge readiness to be at 62.2% for this first quarter. Cumulative percentages and targets are as follows:

- Within 7 days = 62.2% (target 75%)
- Within 30 days = 78.4% (target 90%)
- Within 45 days = 89.2% (target 100%)

SOCIAL WORK

Aspect: TREATMENT PLANS AND PROGRESS NOTES

Indicators	Findings	Compliance	Threshold Percentile
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned CCM caseload.	42/45	93%	95%
2. On Upper Saco progress notes in GAP/Incidental format will indicate at minimum bi- weekly 1:1 meeting with all clients on assigned CCM caseload	15/15	100%	95%
3. Treatment plans will have measurable goals and interventions listing client strengths and areas of need related to transition to the community or transition back to a correctional facility.	57/60	95%	95%

Summary: Indicator 1 is up from the 4th quarter of 88% and will continue to be monitored.

STAFF DEVELOPMENT

ASPECT: New Employee and Mandatory Training

Indicators	Findings	Compliance	Threshold Percentile
1. New employees will complete new employee orientation within 60 days of hire.	8 of 8 completed orientation	100%	100 %
2. New employees will complete CPR training within 30 days of hire.	8 of 8 completed CPR training	100%	100 %
3. New employees will complete NAPPI training within 60 days of hire.	8 of 8 completed Nappi training	100%	100 %
4. Riverview and Contract staff will attend CPR training bi-annually.	312 of 313 are current in CPR certifications	99%	100 %
5. Riverview and Contract staff will attend NAPPI training annually. Goal to be at 100% by end of fiscal training year 2010 on June 30th. Fiscal year 09 at 100%	109 of 356 have completed annual training	30%	100 %
6. Riverview and Contract staff will attend Annual training. Goal is to be at 100% by end of fiscal training year 2010 on June 30th. Fiscal year 09 at 100%	258 of 370 have completed annual training	70%	100 %

Findings: The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. **8 out of 8 of** (100%) new Riverview/Contracted employees completed these trainings. **312 of 313** (99%) Riverview/Contracted employees are current with CPR certification. **109 of 356** (30%) Riverview/Contracted employees are current in Nappi training. **258 of 370** (70%) employees are current in Annual training. All indicators remained at 100% compliance for quarter 1-FY 2010.

Problem: One staff is not in compliance with CPR due to being out on workman's comp.

Status: This is the first quarter of report for these indicators. Continue to monitor.

Actions: Staff will be schedule when they return to work for the next available CPR class.