

# Riverview

PSYCHIATRIC CENTER



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PERFORMANCE IMPROVEMENT REPORT

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1ST QUARTER FISCAL YEAR 2011  
Jul, Aug, Sep 2010

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October 20, 2010



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## INTRODUCTION

Over the past few months increasing concerns have emerged regarding the acuity of clients and the perception of an increase in the number of events that result in both client and staff injuries as well as an increase in the number of seclusion and restraint events as staffs attempt to manage outbursts of aggressive and potential dangerous actions by the acute clients.

While initial results from the last quarter showed a high frequency of short duration manual holds utilized to redirect clients, the results this month indicate a reversal of this trend with a higher incidence of longer-term manual restraint. The frequency of these events and duration can be attributed to attempts to manage the care of and protect from harm a very small number of clients—a minor percentage of all clients served.

Analysis of the incidence of restraint and seclusion events reveals that 85% of all incidents can be attributed to events involving just 10 of the most acute clients—most of these clients being cared for in the civil units. To provide insights into the factors of causation related to these violent outbursts and the seclusion and restraint events that often result as an effort to protect the agitated client and others in the milieu from injury, an ongoing analysis of trends, common elements, and timeframes is being conducted. The first phase of this analysis is to identify those clients with the highest incidence of violent behavioral events and attempt to identify timelines or trends surrounding these events. Trends may include elements related to the time of day and any relationships with meal, medication, or recreational activities. Information identified as a potential trend is being communicated to nursing leadership and clinical leaders for consideration and potential modification of treatment plans or integration of information on triggers and coping mechanisms into staff to client interactions.

The human resources department has achieved great progress in improving the level of compliance with the completion of performance evaluations. For the 1<sup>st</sup> quarter of 2011, the department has achieved a level of compliance that exceeds the planned threshold of performance (85%). Efforts to maintain a compliance level higher than 85% will be ongoing with a goal of further improving performance incrementally over time.

Staffing levels have stabilized as a result of an aggressive recruitment and training campaign. There are few open positions and recruitment activities are focused on filling critical open positions that result from normal attrition.

# COMMUNITY FORENSIC ACT TEAM

## ASPECT: REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

Indicators	Findings	Compliance	Threshold Percentile
1. The ACT Team Director will review all client cases of re-hospitalization from the community for patterns and trends of the contributing factors leading to re-hospitalization each quarter. The following elements are considered during the review: <ul style="list-style-type: none"> <li>a. Length of stay in community</li> <li>b. Type of residence (ie: group home, apartment, etc)</li> <li>c. Geographic location of residence</li> <li>d. Community support network</li> <li>e. Client demographics (age, gender, financial)</li> <li>f. Behavior pattern/mental status</li> <li>g. Medication adherence</li> <li>h. Level of communication with ACT Team</li> </ul>	3 new admissions (2 clients)	100%	100%
2. ACT Team will work closely with inpatient treatment team to create and apply discharge plan incorporating additional supports determined by review noted in #1.	6 discharges	100%	100%

### Summary

1. Two total clients were re-hospitalized this quarter, (one of whom was re-hospitalized twice this quarter,) all of whom were male. Three clients were discharged during this period who had been re-hospitalized prior to July 2010. There were six discharges, two of which were for the same client. Of the two who were re-hospitalized, both lived in supportive housing (one in a 24/7 group home, one in a supervised apartment). Both have been in the community several years and have established histories of re-hospitalizations due to increased symptoms of mental illness while adhering to medication regimen. Of the three clients who were hospitalized prior to July 1, 2010, 2 were in supervised apartments and one was living in an independent apartment in the community; One was in the PTP and 2 were forensic clients. The PTP client appeared to be experiencing a cyclic recurrence of psychosis and the two forensic clients were non-compliant with treatment and psychiatrically unstable, respectively.
2. The ACT Team has become more consistent in attending treatment team meetings while clients are in the hospital, specifically including increased communication between ACT Psychiatrist and inpatient treatment providers, and with re-starting therapy with ACT Psychologist prior to discharge. The ACT Team Peer Support Specialist has also been particularly adept at meeting with clients prior to discharge in both treatment team settings and individually.

# COMMUNITY FORENSIC ACT TEAM

## ASPECT: INSTITUTIONAL AND ANNUAL REPORTS

Indicators	Findings	Compliance	Threshold Percentile
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of notification of submitted petition.	4/6	67%	95%
2. The assigned case manager will review the new court order with the client and document the meeting in a progress note or treatment team note.	N/A	100%	100%
3. Annual Reports (due Dec) to the commissioner for all out-patient Riverview ACT NCR clients are submitted annually	n/a this quarter	100%	100%

### Summary

1. Six clients petitioned, of those, two withdrew petition. Four of six had Institutional reports completed on time.
2. ACT Team Leader delivers all new Court Orders to Case Managers upon receipt, who then reviews with both client and supported housing staff involved in compliance with order. This is documented in progress notes and/or reviewed in ISP treatment team.

## ASPECT: INDIVIDUAL SERVICE PLANS AND PROGRESS NOTES

Indicators	Findings	Compliance	Threshold Percentile
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly contact with all clients assigned on an active status caseload.	32/40	75%	95%
2. Individual Service Plans will have measurable goals and interventions listing client strengths and areas of need related to community integration and increased court ordered privileges based on risk reduction activities.	40/40	100%	95%
3. Case notes will indicate at minimum monthly contact with all NCR clients who remain under the care of the Commissioner. These clients receive treatment services by community providers and RPC ACT monitors for court order and annual report compliance only.	9/9	100%	95%

### Summary

1. Team now offers two groups, (decreased by two because of loss of Psychology Intern and Psychologist) with the expectation that 2 more will be added in the next quarter. This will again create increased capacity for face-to-face contacts and supporting documentation.
2. ISPs also contain group attendance goals, especially with clients who are petitioning for increased court ordered privileges. An extensive chart review was conducted to ensure all clients who attended groups were identified as either having or needing specific group attendance goals. Case managers were made aware of need for consistency in group attendance and ISP goals.

# COMMUNITY FORENSIC ACT TEAM

## ASPECT: SUBSTANCE ABUSE AND ADDICTIVE BEHAVIOR HISTORY

Indicators	Findings	Compliance	Threshold Percentile
1. Age of onset documented in Comprehensive Assessment	40/40	100%	95%
2. Duration of behavior documented in C.A. and progress notes	40/40	100%	95%
3. Pattern of behavior documented in C.A. and progress notes	40/40	100%	95%

### Summary

Our randomization of urinalyses for drug/alcohol detection has been improved to both increase total number of tests (rather than minimum) as well as decreased predictability for clients. As reported on the previous quarterly report, observed urinalyses testing for alcohol within an 80hr window is recommended but thus far not implemented. The ACT PSD must consult with Maine PreTrial and Mercy Recovery Center (at minimum) to determine cost and implementation strategy.

## ASPECT: PEER SUPPORT

Indicators	Findings	Compliance	Threshold Percentile
1. Engagement attempt with client within 7 days of admission.	3/3	100%	95%
2. Documented offer of peer support services.	3/3	100%	95%
3. Attendance at treatment team meetings as appropriate.	10/11	95%	95%

### Summary

As in prior report, Peer Support Specialist makes every effort to attend treatment team meetings at ACT offices and in hospital; absent only if client expresses desire not to have Peer Support present when asked or due to unanticipated schedule conflict/change. Of particular note is the rate at which the peer Support Specialist is able to engage with clients while still in the hospital and to an even greater degree when they are living in the community. The number and quality of contacts with clients by Peer Support contributes in large measure to the ACT Teams goal of seeing clients face to face three times per week.

# CAPITOL COMMUNITY CLINIC

## ASPECT: DENTAL CLINIC SURVEY

Indicators	Findings	Compliance	Threshold Percentile
Clients from RPC as well as clients in the community will receive a survey to fill out at the time of appt. The survey has several questions and in those questions we are asking the client how we can better serve there needs.	July  Forty surveys done by in-house clients as well as outpatient. Of the forty surveys, thirty-nine surveys were positive. One survey was negative. Client stated on the survey that he received old dentures from the dentist.	93%	90%
	August  Twenty client surveys received. All twenty were positive.	100 %	90%
	September  There were seventeen clients' surveys. Of the seventeen surveys returned, all were positive.	100%	90%

### Summary

Surveys returned were Seventy-seven for the quarter one report. Seventy-six were positive. Only one reported negative results. Client stated he received old dentures from Dr. Ingrid.

### Actions

Will continue the client surveys to monitor and evaluate weekly as well as monthly with staff.

# CAPITOL COMMUNITY CLINIC

## ASPECT: DENTAL CLINIC 24 HOUR POST EXTRACTION FOLLOW-UP

Indicators	Findings	Compliance	Threshold Percentile
After dental extractions, the clients will receive a follow-up phone call from the clinic within 24hrs of procedure to assess for post procedure complications.	<b>July</b> There were six extractions. A 24-hour phone call for post procedure. The patients experienced no complications post extractions.	100%	100%
	<b>August</b> Three extractions with 24 hour follow up phone call. The patients that were called, had no post procedure complications.	100%	100%
	<b>September</b> Three extractions with a 24 hour fellow up post extraction call with no complications reported.	100%	100%

### Summary

There were twelve extractions in the first quarter. Clients were called 24 hours post extraction. All twelve clients that were called reported no post procedure complications.

### Action

Results will be reviewed monthly by staff and will continue to report monthly to RPC.

# CAPITOL COMMUNITY CLINIC

## ASPECT: DENTAL CLINIC TIMEOUT/IDENTIFICATION OF CLIENT

Indicators	Findings	Compliance	Threshold Percentile
National Patient Safety Goals  Goal 1: Improve the accuracy of Client Identification.  Capital Community Dental Clinic assures accurate client identification by asking the client to state his/her name and date of birth.  Goal 2: Verify the correct procedure and site for each procedure.  A time out will be taken before the procedure to verify location and number of the tooth to be extracted. The time out section is in the progress notes of the patient chart. This page will be signed by the Dentist as well as the dental assistant.	<b>July</b>  There were six extractions done for the month. A time out was taken prior to the procedure to identify the extraction site and the client was asked to state their name and date of birth to verify identification of the client.	100 %	100%
	<b>Aug</b>  There were three extractions done for the month. A time out was taken prior to each procedure to identify the extraction site and the client was asked to state their name and date of birth to verify identification of the client.	100%	100%
	<b>September</b>  There were three extractions done for the month. A time out was taken prior to each procedure to identify the extraction site and the client was asked to state their name and date of birth to verify identification of the client.	100%	100%

### Summary:

In July, August and September twelve clients had extractions. All twelve procedures included a time out to identify the extraction site. Each client was asked to state their full name and date of birth in order to verify the identity of the client.

### Actions

The dental clinic staff will continue to report and monitor progress.

# CAPITOL COMMUNITY CLINIC

## ASPECT: MED MANAGEMENT CLINIC APPOINTMENT ASSESSMENT

Indicators	Findings	Compliance	Threshold Percentile
All Outpatient clients will have Vital Signs and Weight recorded upon arrival for appointment.	July  There were thirty-six clients scheduled for the month. Of the thirty-six that came in for appointments, one did not have their vitals taken before their clinic appointment.	97%	100%
	August  There were thirty-five clients scheduled in the month. Thirty-four clients had vitals taken before their appointment. with the P.A	97%	100%
	September  There were thirty-two clients scheduled. Two did not have their vitals taken before their clinic appointment.	94%	100%

### Summary

For the first quarter there were one hundred and three clients. Two did not have their vitals taken before their appointment. One of the two clients that didn't have their vitals taken is MRCD and refuses to have the vitals done. At times vitals are taken prior to the appointment at clients home. One of the clients had their vitals taken after the clinic appointment.

### Actions

Review of monthly staff meetings and forward reports quarterly to RPC.

# CLIENT SATISFACTION

## ASPECT: CLIENT SATISFACTION WITH CARE

#	Indicators	Findings LK		Findings UK		Findings LS		Findings US		Findings Total
1	I am better able to deal with crisis.	50%	+25%	77%	+35%	100%	+21%	100%	+100%	75%
2	My symptoms are not bothering me as much.	83%	+8%	64%	+37%	100%	+36%	100%	+100%	72%
3	The medications I am taking help me control symptoms that used to bother me.	33%	-9%	59%	+17%	100%	+21%	100%	+100%	59%
4	I do better in social situations.	25%	-25%	73%	+31%	100%	+43%	100%	+100%	70%
5	I deal more effectively with daily problems.	67%	+9%	55%	+17%	100%	+50%	100%	+100%	63%
6	I was treated with dignity and respect.	33%	+16%	50%	+15%	100%	+43%	50%	+50%	50%
7	Staff here believed that I could grow, change and recover.	67%	+42%	85%	-35%	100%	+64%	100%	+100%	83%
8	I felt comfortable asking questions about my treatment and medications.	67%	+17%	65%	+15%	100%	+57%	50%	+50%	67%
9	I was encouraged to use self-help/support groups.	-33%	-66%	65%	+27%	100%	+29%	50%	+50%	47%
10	I was given information about how to manage my medication side effects.	-33%	-16%	40%	+17%	100%	+42%	0%	0%	27%
11	My other medical conditions were treated.	-50%	-92%	75%	+75%	100%	+43%	-100%	-100%	34%
12	I felt this hospital stay was necessary.	0%	+20%	70%	+24%	100%	+64%	100%	+100%	60%
13	I felt free to complain without fear of retaliation.	-50%	+50%	65%	+53%	100%	+71%	-50%	-50%	43%
14	I felt safe to refuse medication or treatment during my hospital stay.	0%	+17%	60%	+60%	100%	+79%	-50%	-50%	50%
15	My complaints and grievances were addressed.	0%	-17%	50%	+8%	100%	+79%	-50%	-50%	43%
16	I participated in planning my discharge.	17%	+9%	75%	+25%	100%	+100%	0%	0%	60%
17	Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.	0%	-50%	55%	+28%	100%	+86%	0%	0%	43%
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	17%	-33%	55%	+24%	100%	+114%	0%	0%	47%

# CLIENT SATISFACTION

#	Indicators	Findings LK		Findings UK		Findings LS		Findings US		Findings Total
19	The surroundings and atmosphere at the hospital helped me get better.	-17%	-34%	65%	+7%	100%	+71%	50%	+50%	50%
20	I felt I had enough privacy in the hospital.	0%	-33%	75%	+33%	100%	+57%	0%	0%	57%
21	I felt safe while I was in the hospital.	17%	-8%	60%	+10%	100%	+36%	50%	+50%	53%
22	The hospital environment was clean and comfortable.	17%	-25%	70%	+47%	100%	+21%	50%	+50%	60%
23	Staff were sensitive to my cultural background.	17%	-8%	40%	+36%	100%	+57%	0%	0%	37%
24	My family and/or friends were able to visit me.	25%	-33%	65%	+3%	0%	-57%	100%	+100%	57%
25	I had a choice of treatment options.	33%	+33%	45%	+30%	-50%	-71%	-50%	-50%	36%
26	My contact with my doctor was helpful.	33%	-50%	67%	+25%	100%	+21%	50%	+50%	61%
27	My contact with nurses and therapists was helpful.	50%	+8%	80%	+21%	100%	+36%	50%	+50%	73%
28	If I had a choice of hospitals, I would still choose this one.	0%	-8%	65%	+32%	100%	+64%	100%	+100%	57%
29	Did anyone tell you about your rights?	-17%	0%	60%	+46%	0%	-50%	50%	+50%	40%
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	-17%	-25%	65%	+65%	100%	+57%	-100%	-100%	34%
31	Do you know someone who can help you get what you want or stand up for your rights?	17%	0%	80%	+21%	100%	+36%	100%	+100%	70%
32	My pain was managed.	25%	-8%	80%	+66%	0%	-57%	-100%	-100%	47%

## Summary

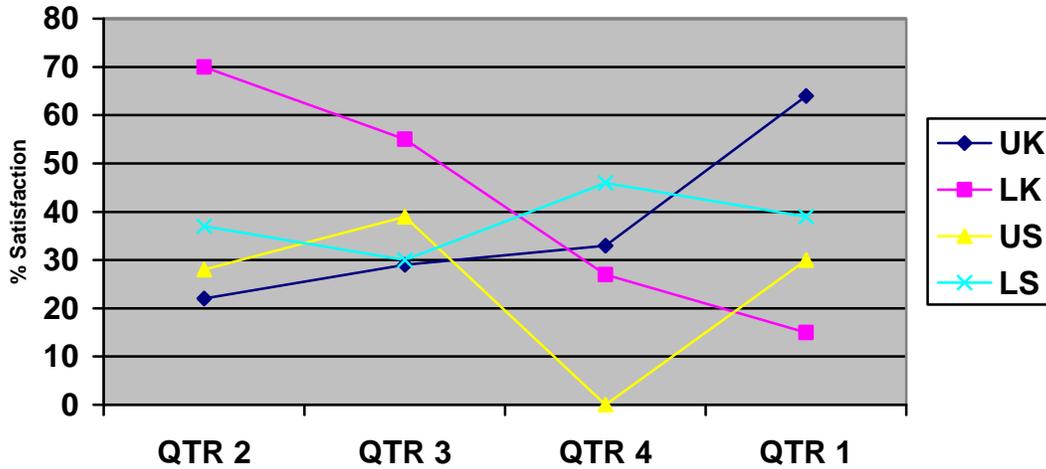
Positive scores indicate satisfaction, while negative scores indicate dissatisfaction. Percentages are calculated using actual weighted scores and highest possible score for each indicator. The first column for each unit indicates the score for 1<sup>st</sup> quarter and the second column for each unit shows increases/decreases from 4<sup>th</sup> quarter. Overall satisfaction for 1<sup>st</sup> quarter increased significantly, 18%.

Lower Saco, Upper Saco, and Lower Kennebec had a very low response rate, therefore the scores may not reflect satisfaction accurately across the unit. Upper Kennebec had a 31% increase from 4<sup>th</sup> quarter of last year.

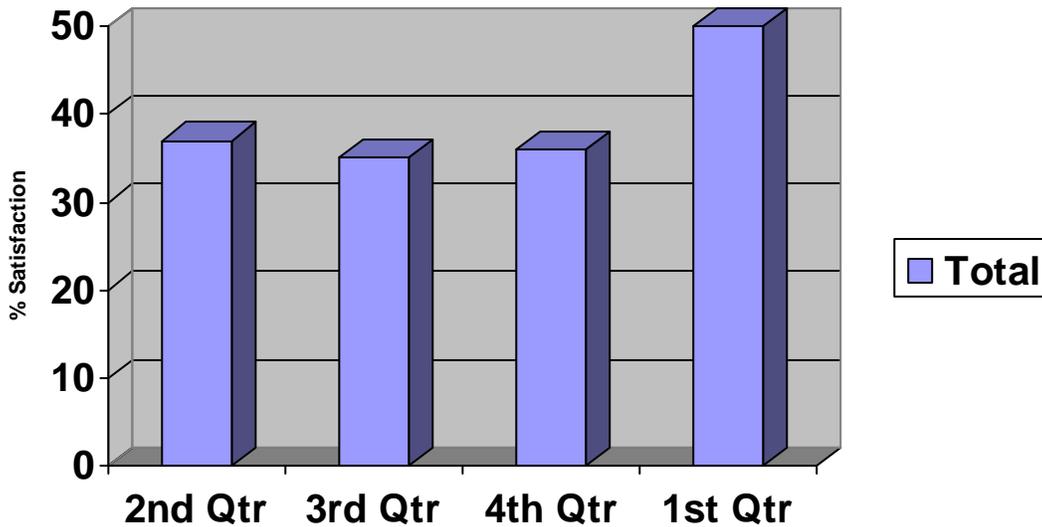
All indicators increased except two: "My family and/or friends were able to visit me" and "My contact with my doctor was helpful." Both of these indicators only dropped slightly. The rights domain continues to be the lowest satisfaction. There has also been a decline in the dignity domain. Participation has steadily increased over the quarter.

# CLIENT SATISFACTION

Satisfaction by Unit



Total Satisfaction



## Actions

1. Department heads will make recommendations and changes on how to improve satisfaction of care in areas that are indicated
2. Superintendent will utilize client forums to get input from clients for areas of improvement
3. Peer support will implement new strategies for soliciting responses from clients related to satisfaction with care.

# COMPARATIVE STATISTICS

The comparative statistics reports include the following elements:

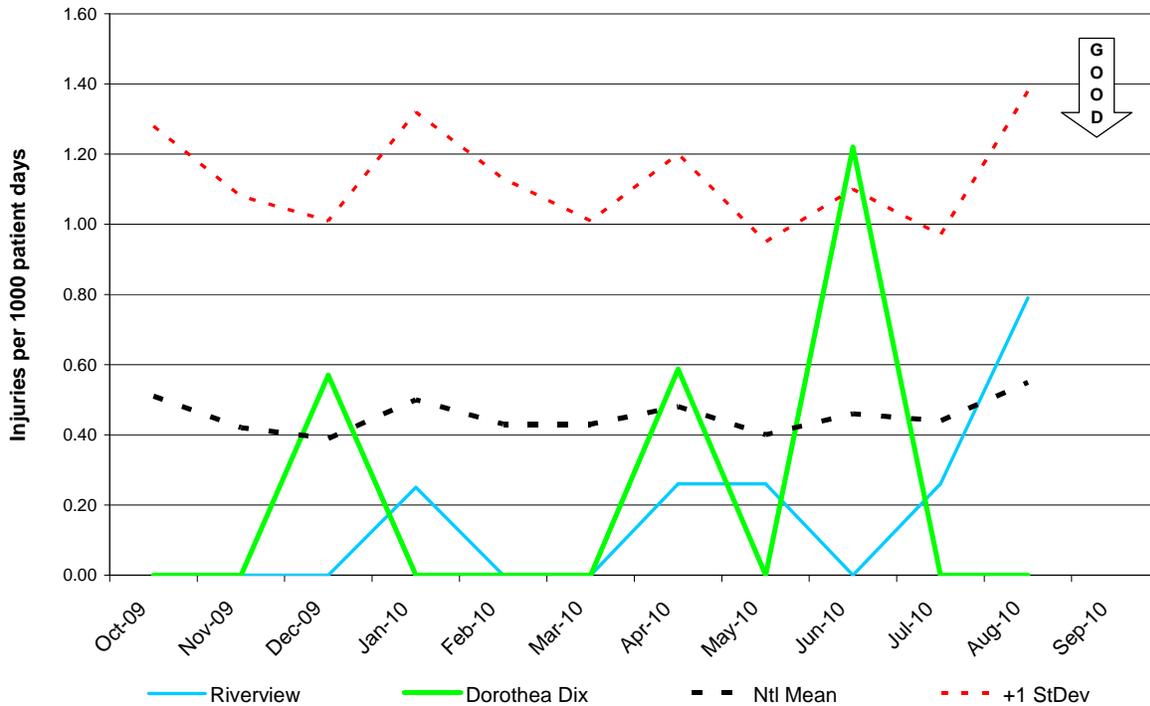
- Client Injury Rate
- Elopement Rate
- Medication Error Rate
- 30 Day Readmit Rate
- Percent of Clients Restrained
- Hours of Restraint
- Percent of Clients Secluded
- Hours of Seclusion
- Prevalence of Co-occurring Psychiatric and Substance Abuse Disorders

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

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

# COMPARATIVE STATISTICS

## Client Injury Rate



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

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

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

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

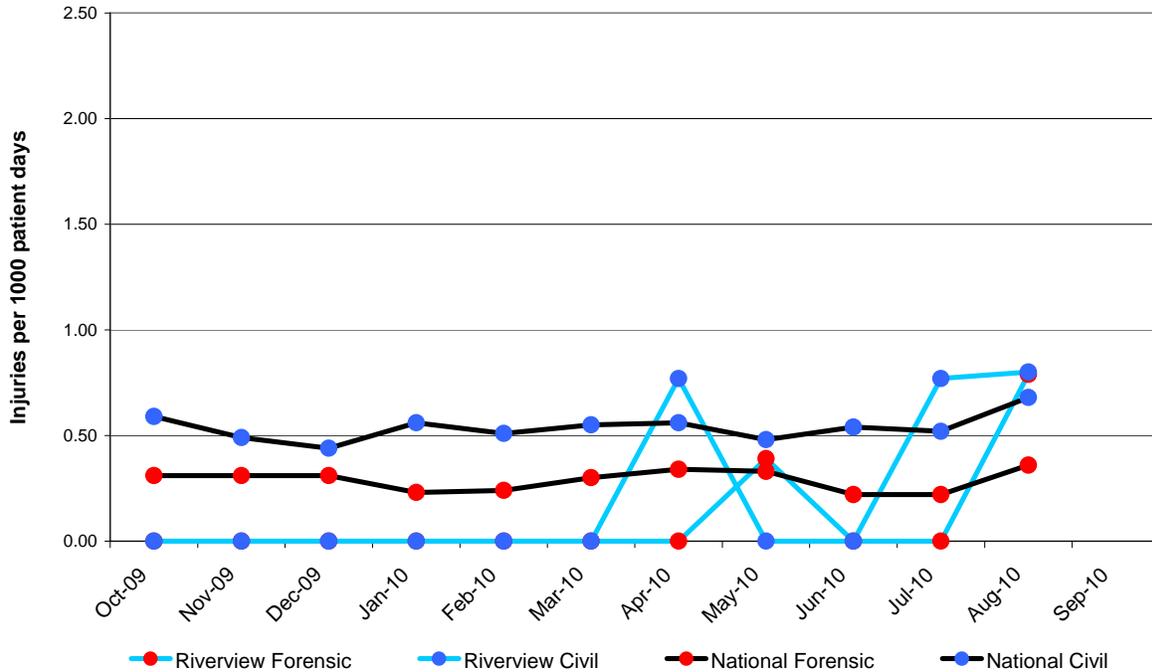
- No Treatment – The injury received by a client may be examined by a clinician but no treatment is applied to the injury.
- Minor First Aid – The injury received is of minor severity and requires the administration of minor first aid.
- Medical Intervention Needed – The injury received is severe enough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

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

# COMPARATIVE STATISTICS

## Client Injury Rate

Forensic Stratification



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

Client Injuries	July	Aug	Sep	1 <sup>st</sup> Qtr 2011
Total	22	7	7	36

### ASPECT: SEVERITY OF INJURY BY MONTH

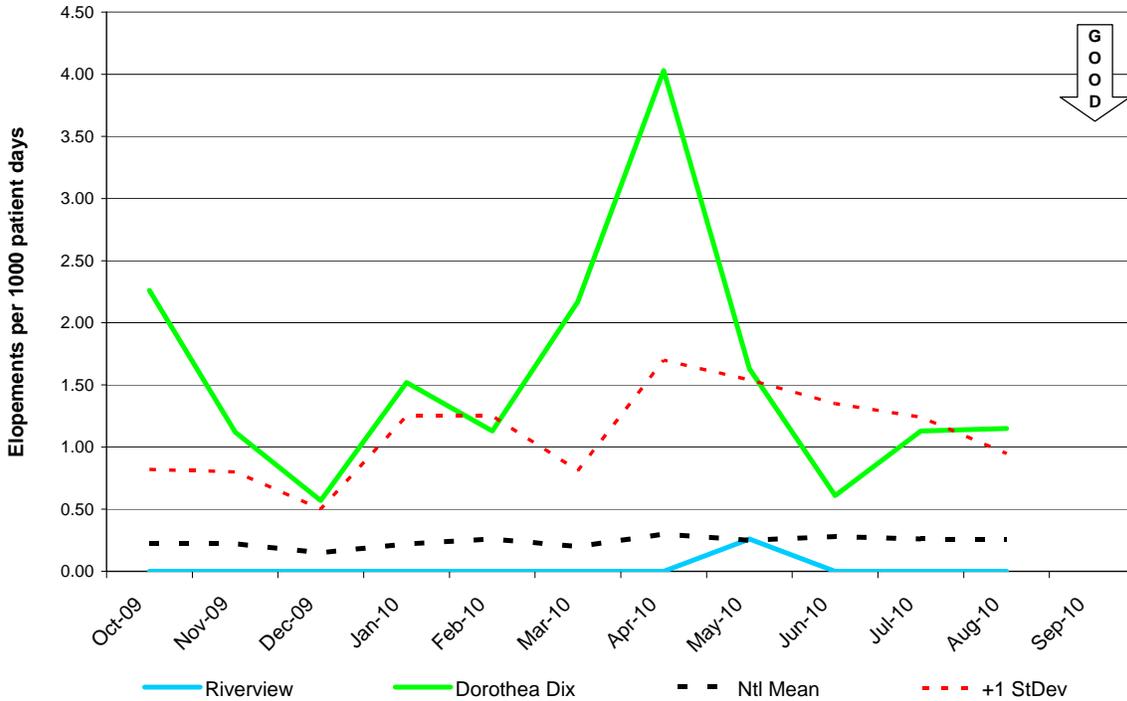
Severity	July	Aug	Sep	1 <sup>st</sup> Qtr 2011
No Treatment	18	3	6	27
Minor First Aid	3	1	1	5
Medical Intervention Required	1	3	0	4
Hospitalization Required	0	0	0	0
Death Occurred	0	0	0	0

### ASPECT: TYPE AND CAUSE OF INJURY BY MONTH

Type - Cause	July	Aug	Sep	1 <sup>st</sup> Qtr 2011
Accident – Unwitnessed Fall	2	1	1	4
Accident – Witnessed Fall	2	3	1	6
Accident – Other	1	0	0	1
Assault – Unwitnessed Fall	0	1	0	1
Assault – Patient to Staff	0	1	0	1
Self Injury – Agitation	2	0	3	5
Self Injury – Unwitnessed Fall	5	1	0	6
Self Injury – Witnessed Fall	3	0	2	5
Self Injury – Other	7			7

# COMPARATIVE STATISTICS

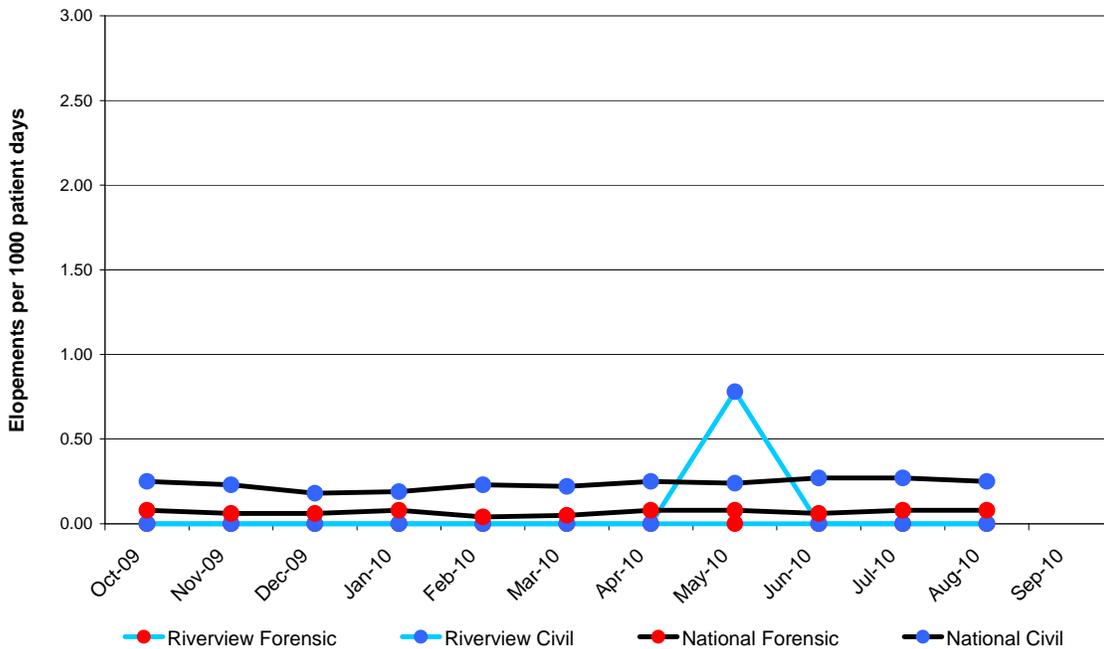
## Elopiement



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

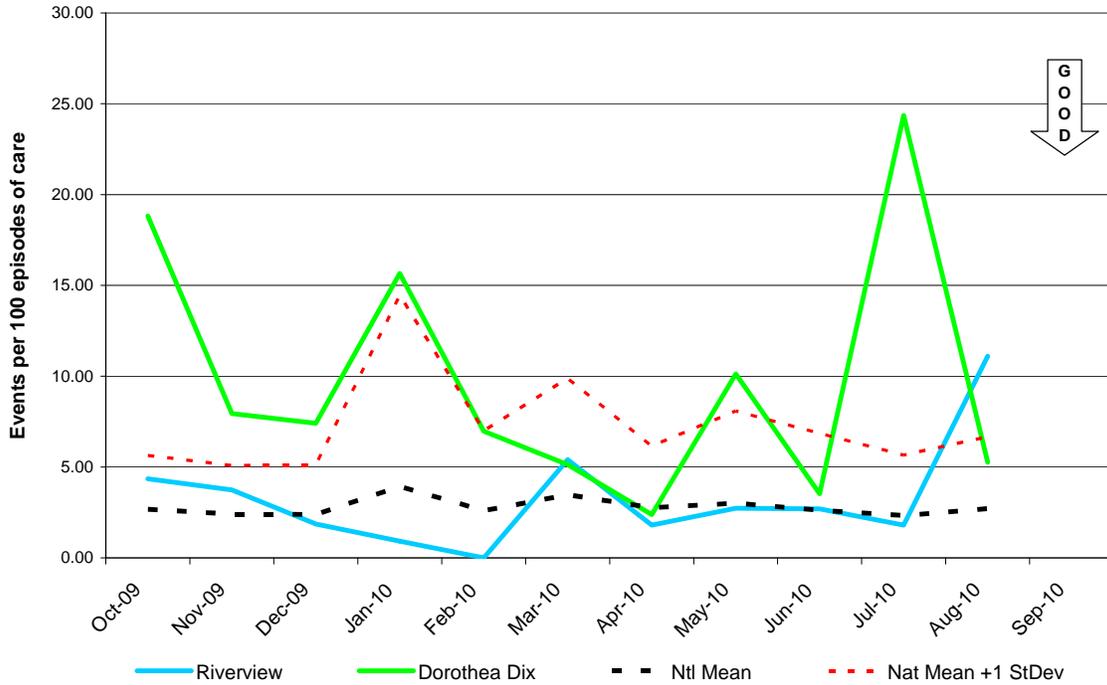
## Elopiement

### Forensic Stratification



# COMPARATIVE STATISTICS

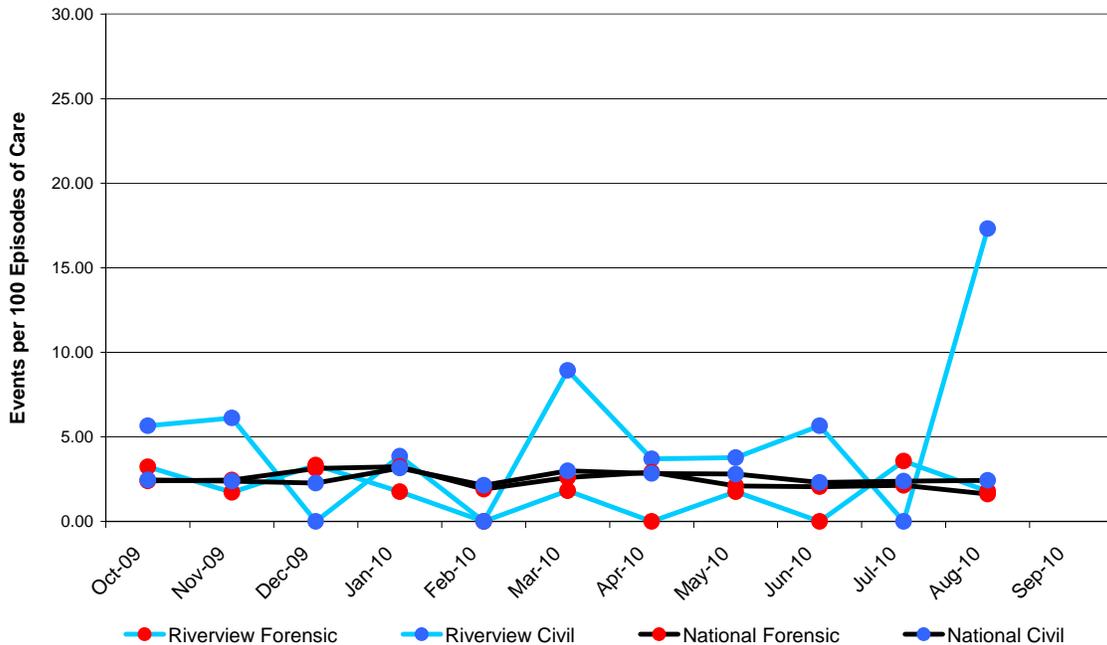
## Medication Errors



Number of medication error events that occurred for every 100 episodes of care (duplicated client count). For example, a rate of 1.6 means that 2 medication error events occurred for each 125 episodes of care.

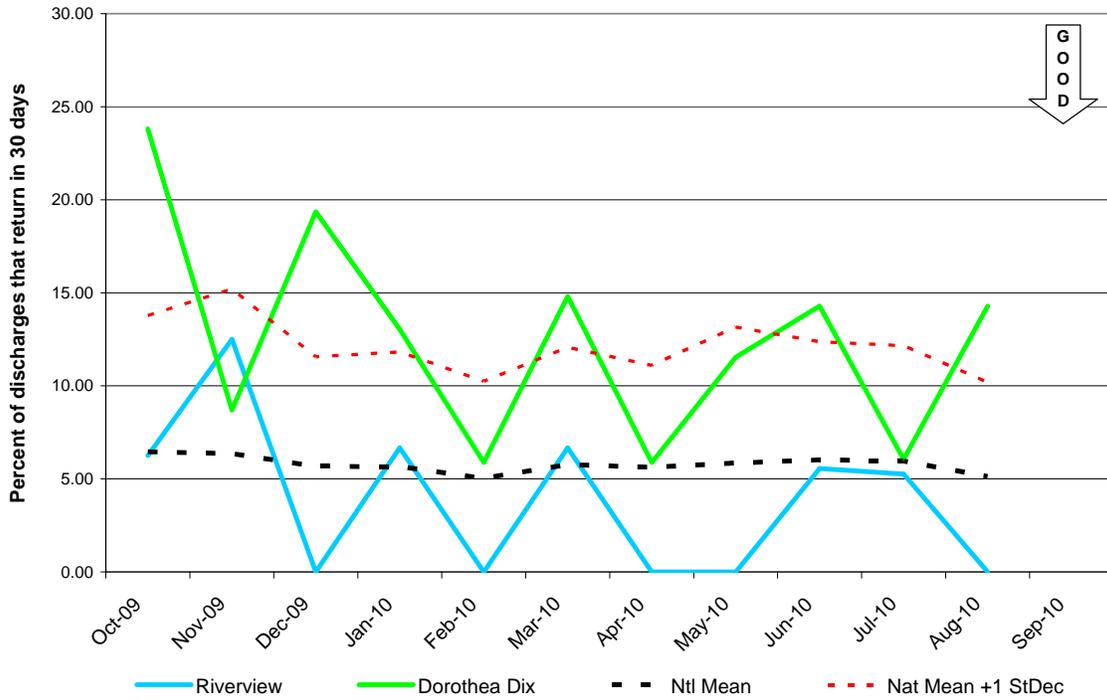
## Medication Errors

Forensic Stratification



# COMPARATIVE STATISTICS

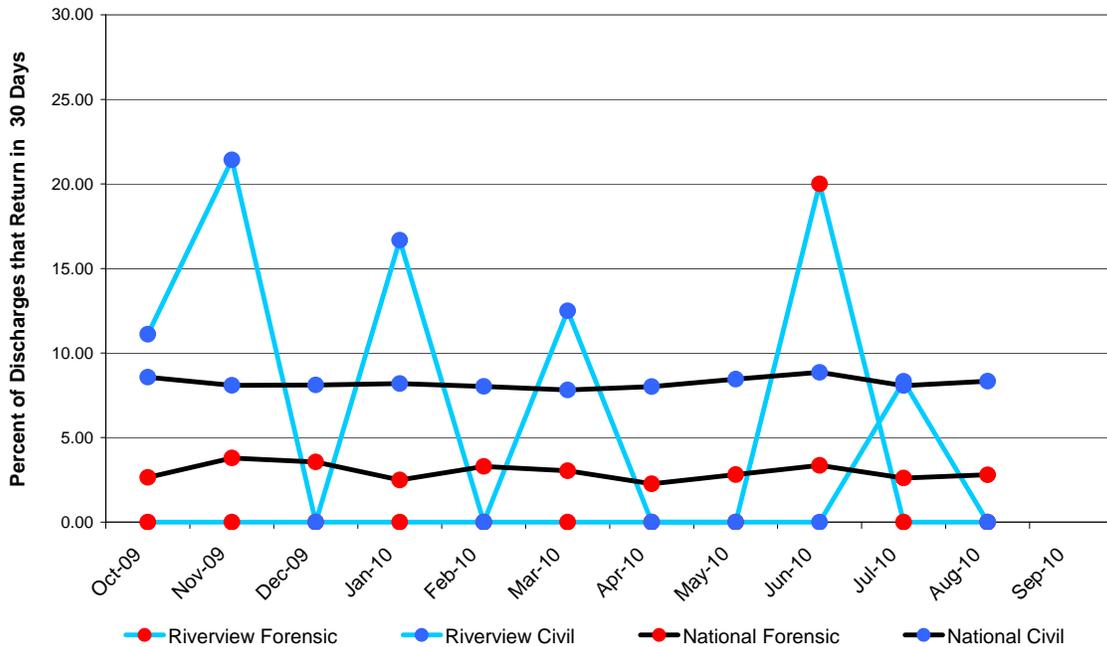
## 30 Day Readmit



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

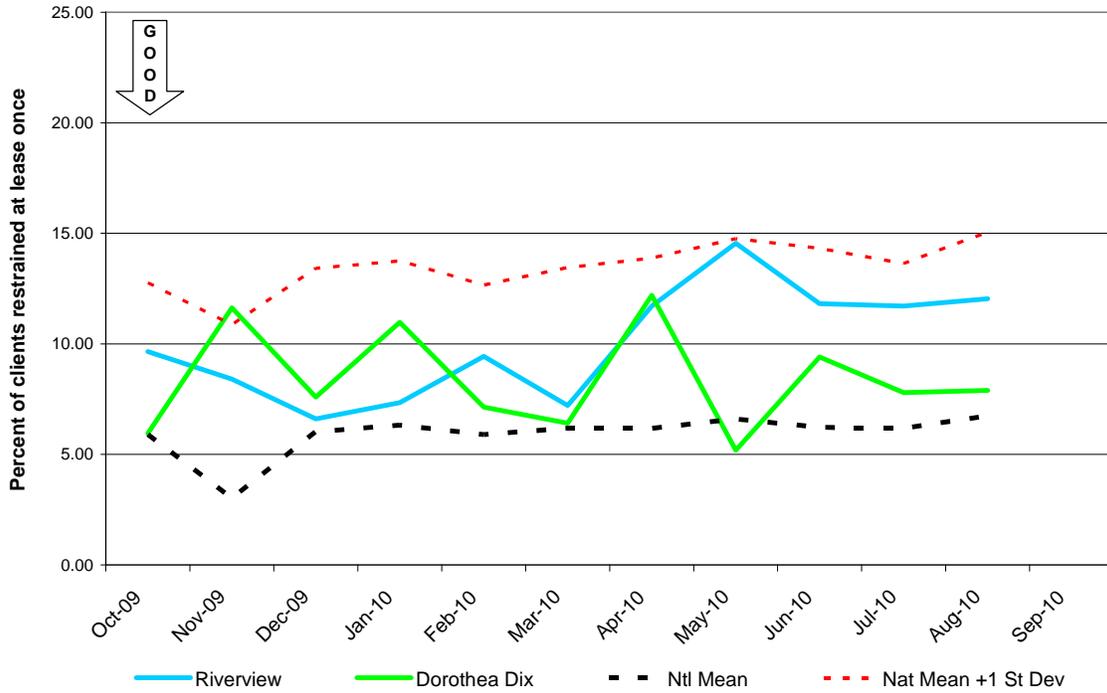
## 30 Day Readmit

### Forensic Stratification



# COMPARATIVE STATISTICS

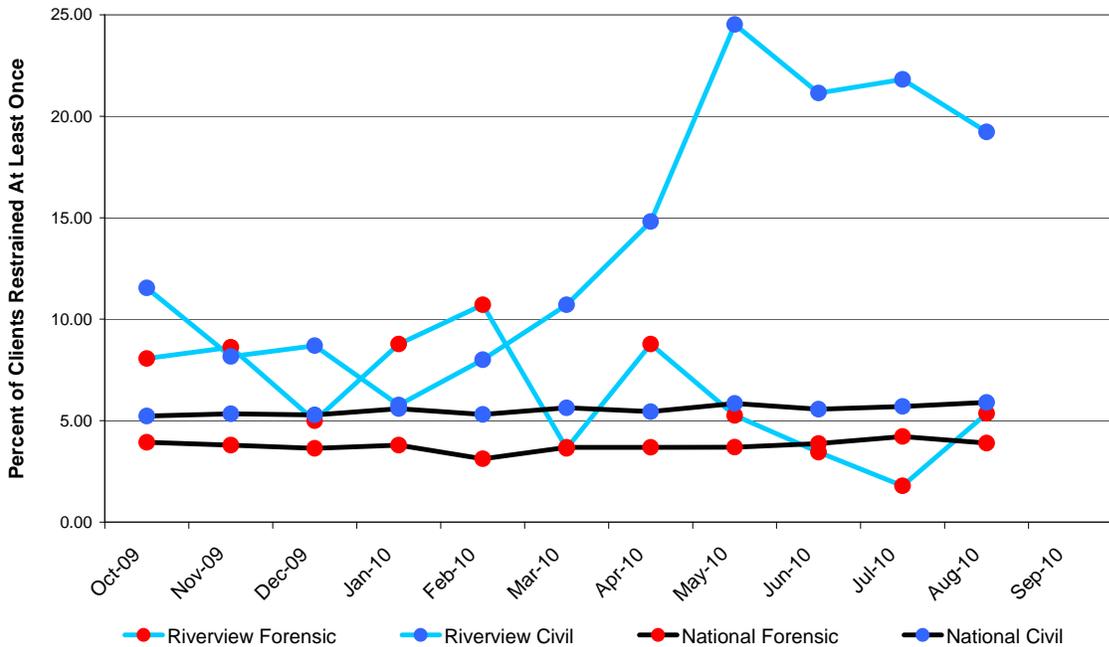
## Percent of Clients Restrained



Percent of unique clients who were restrained at least once – includes all forms of restraint of any duration. For example, a rate of 4.0 means that 4% of the unique clients served were restrained at least once.

## Percent of Clients Restrained

Forensic Stratification



# COMPARATIVE STATISTICS

## Clients Status and Coercive Event Breakdown

	Civil/ Forensic	Manual Hold	Mech Restraint	Locked Seclusion	Open Seclusion	Grand Total	% of Total	Cum %
Client 1	C	26		9		35	22%	22%
Client 2	C	24				24	15%	37%
Client 3	C	14		1		15	9%	46%
Client 4	C	9		5		14	9%	55%
Client 5	F	5	4	1		10	6%	61%
Client 6	C	6	1	2		9	6%	67%
Client 7	C	6		2		8	5%	72%
Client 8	C	7		1		8	5%	77%
Client 9	C	7				7	4%	81%
Client 10	C	4		1	1	6	4%	85%
Client 11	C	5				5	3%	88%
Client 12	C	3		2		5	3%	91%
Client 13	C	2		2		4	3%	94%
Client 14	F	2		2		4	3%	96%
Client 15	C			1		1	1%	97%
Client 16	C	1				1	1%	98%
Client 17	C	1				1	1%	98%
Client 18	F	1				1	1%	99%
Client 19	C	1				1	1%	99%
Client 20	F		1			1	1%	100%

26% (20/77) of average hospital population experienced some form of confinement/coercive event during 1<sup>st</sup> quarter 2011. Ten of these clients (13% of the average hospital population) accounted for 85% of the containment/coercive events.

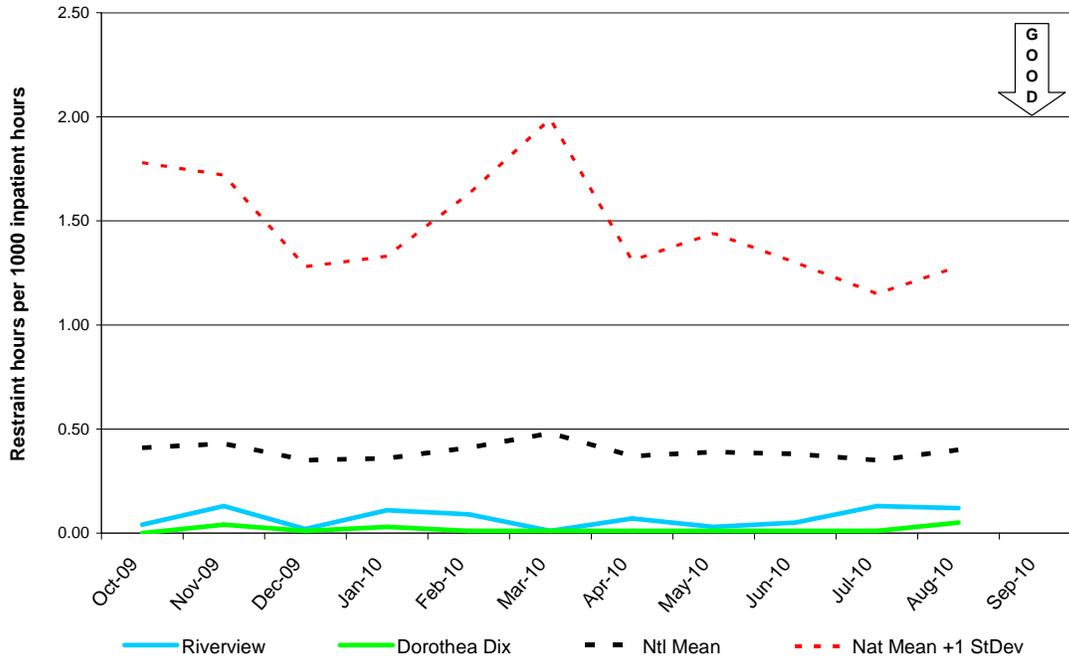
## Coercive Events by Time of Day

	0000-0359	0400-0759	0800-1159	1200-1559	1600-1959	2000-2400
Client 1		6	29			
Client 2		6	5	6	6	1
Client 3	1	2	6	2	4	
Client 4			11	3		
Client 5		1		7	1	1
Client 6		1	1	3	2	2
Client 7			2	5	1	
Client 8				3	4	1
Client 9				2	5	
Client 10			5			1
Client 11		1	1	2	1	
Client 12		3	1		1	
Client 13			2			2
Client 14		1	3			
Client 15						1
Client 16			1			
Client 17			1			
Client 18						1
Client 19				1		
Client 20			1			
	1	21	69	34	25	10

Analysis of coercive events by client and time of day are beginning to reveal trends related to client triggers and coping mechanisms that the treatment team can use to modify treatment modalities in an effort to reduce the incidence of escalating behaviors and the use of confinement techniques that often result from efforts to protect clients and staff from injury during aggressive outbursts.

# COMPARATIVE STATISTICS

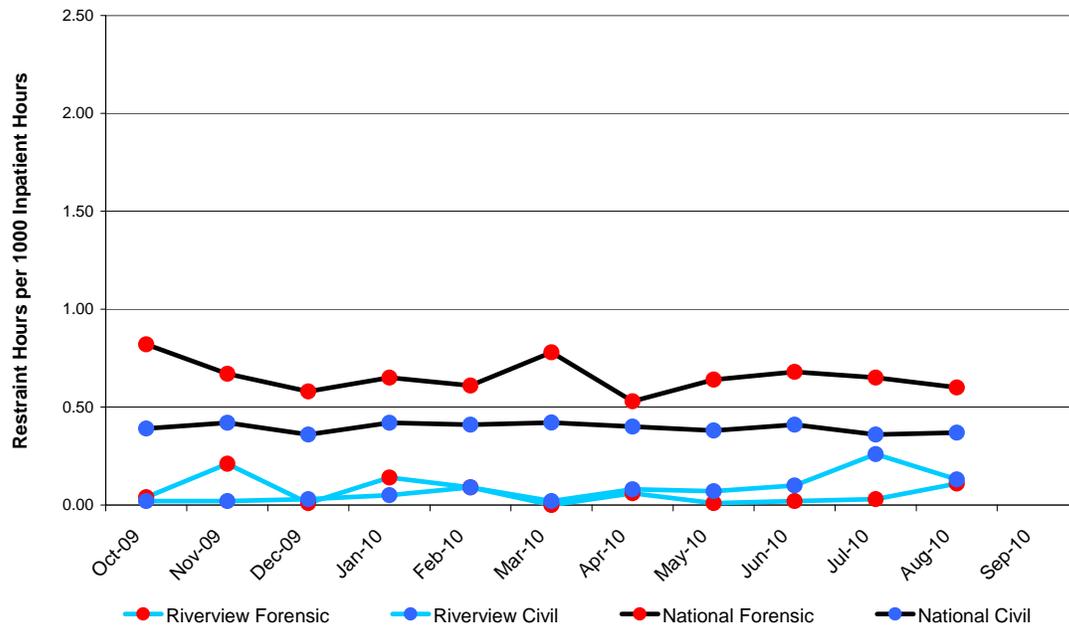
## Restraint Hours



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

## Restraint Hours

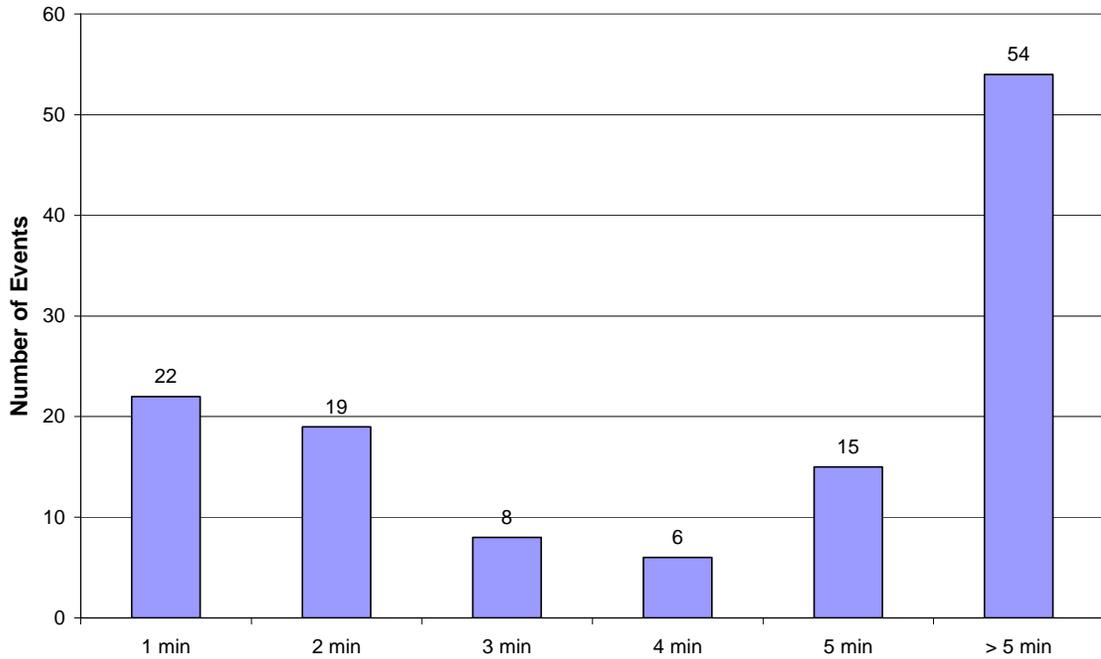
### Forensic Stratification



# COMPARATIVE STATISTICS

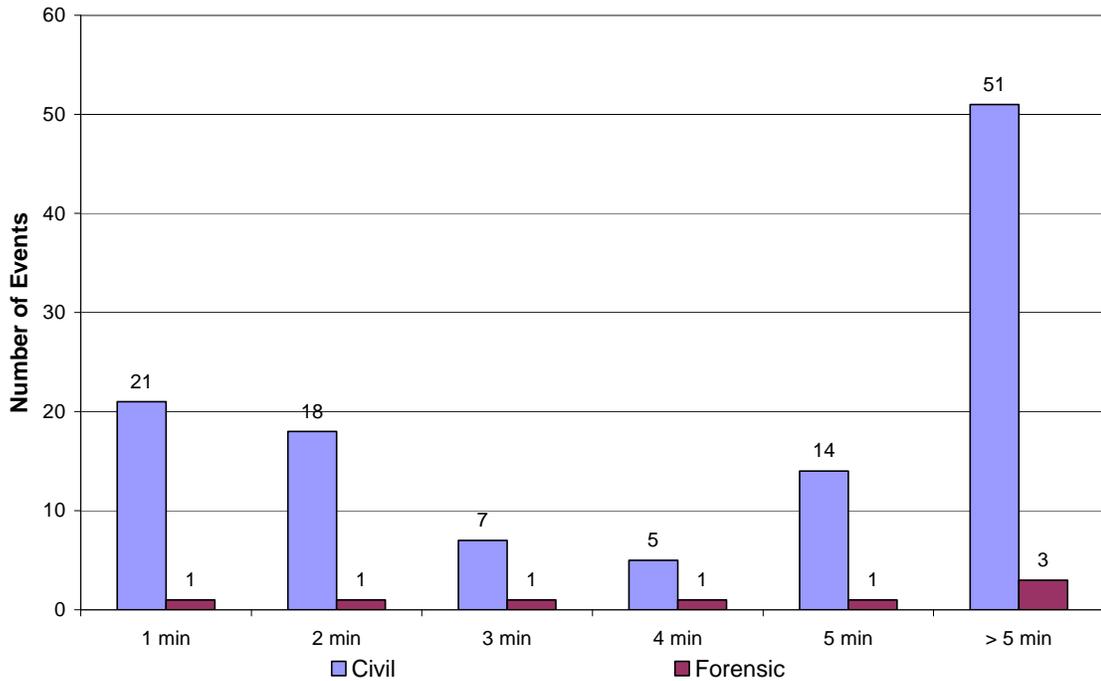
## Duration of Manual Hold (Restraint) Events

July - September 2010



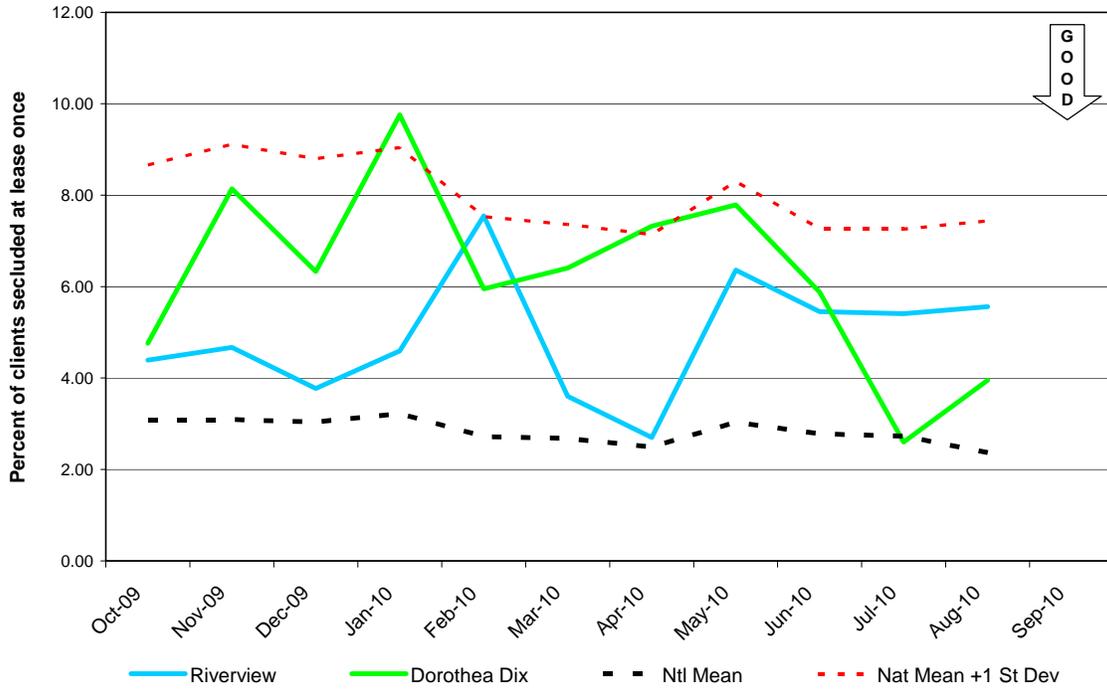
## Duration of Manual Hold (Restraint) Events

July - September 2010



# COMPARATIVE STATISTICS

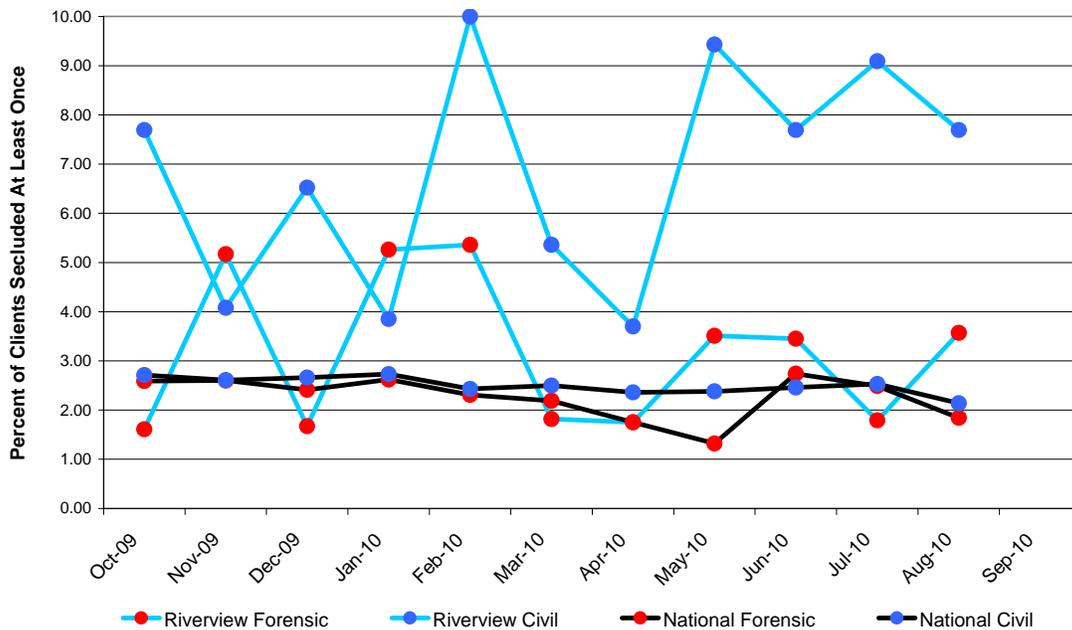
## Percent of Clients Secluded



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

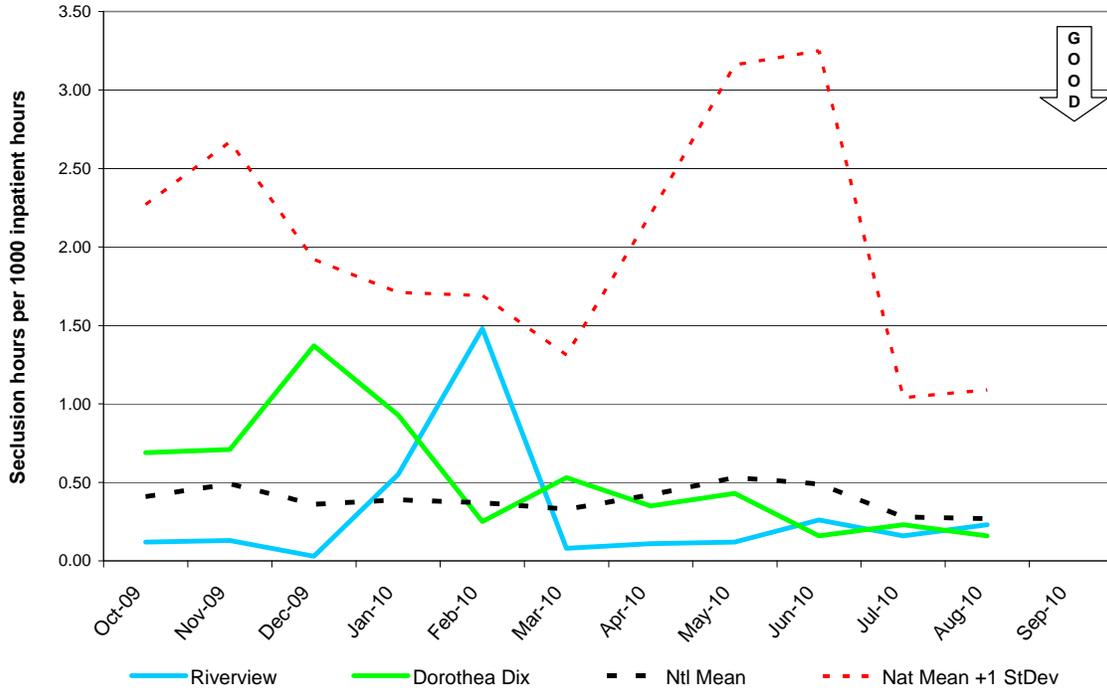
## Percent of Clients Secluded

Forensic Stratification



# COMPARATIVE STATISTICS

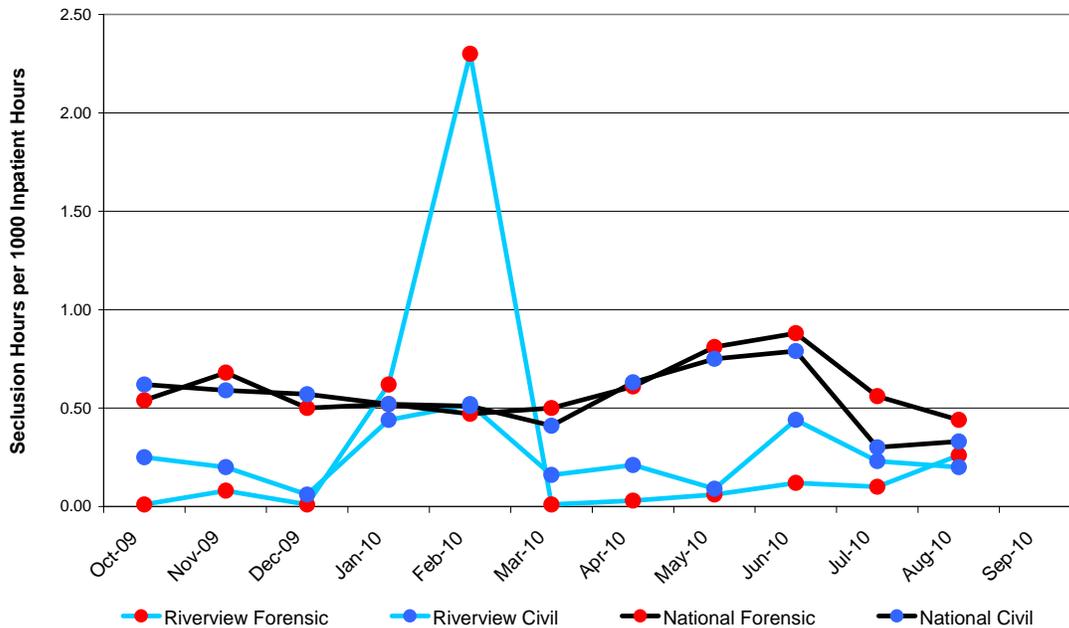
## Seclusion Hours



Number of hours clients spent in seclusion for every 1000 inpatient hours. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

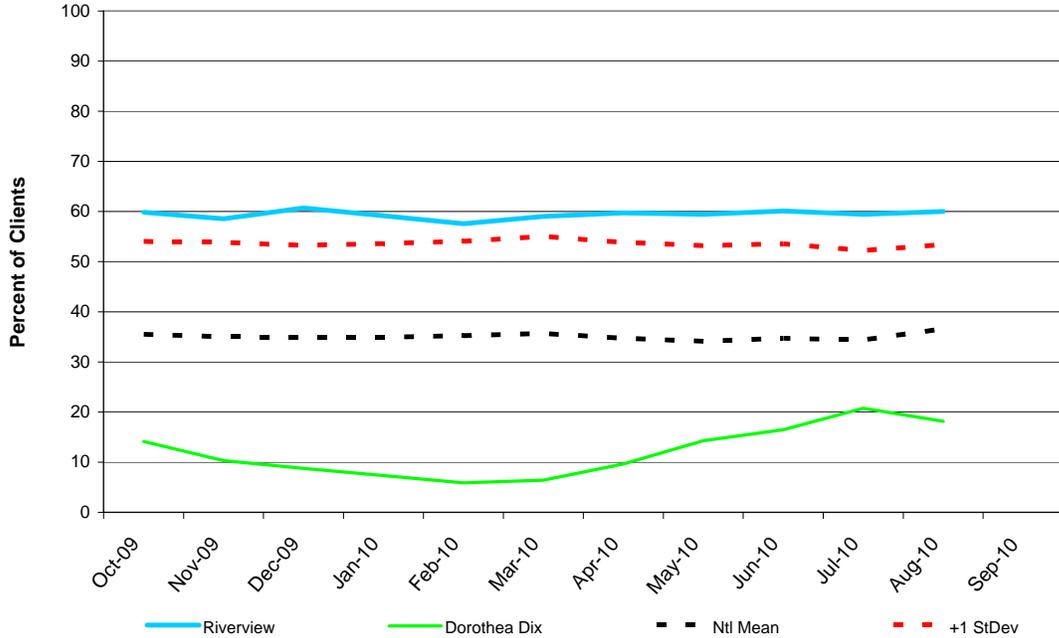
## Seclusion Hours

Forensic Stratification



# COMPARATIVE STATISTICS

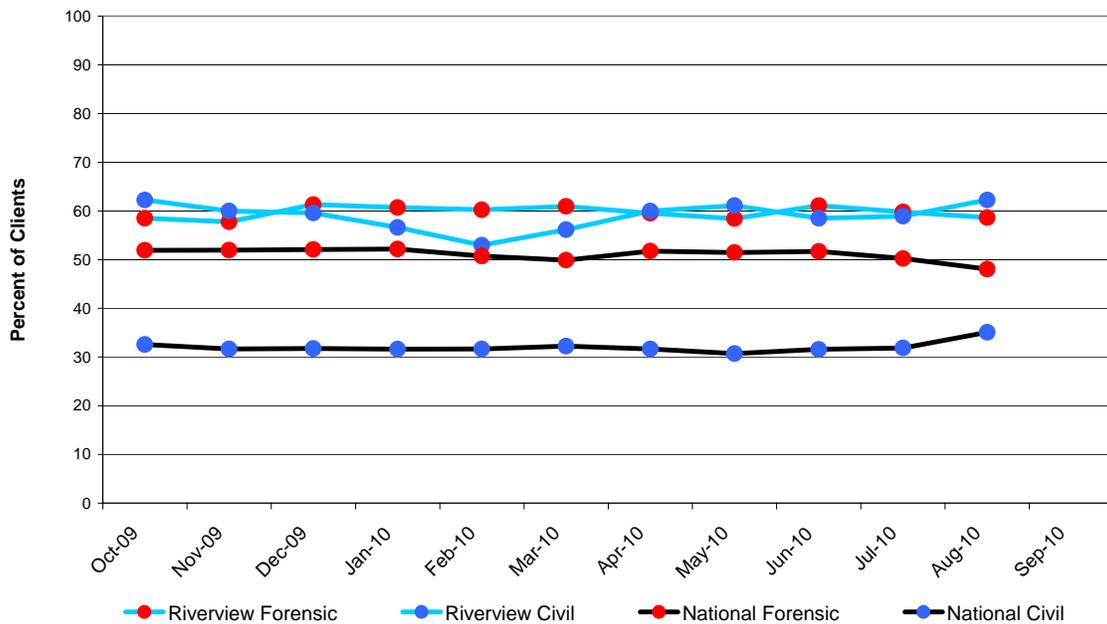
## Prevalence of Co-occurring Psychiatric and Substance Abuse Disorders



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

## Prevalence of Co-occurring Psychiatric and Substance Abuse Disorders

Forensic Stratification



# DIETARY

## ASPECT: CLEANLINESS OF MAIN KITCHEN

Indicators	Findings	Compliance	Threshold Percentile
1. All convection ovens (4) were thoroughly cleaned monthly.	11 of 12	92%	100%
2. Dish machine was de-limed monthly	3 of 3	100%	100%
3. Shelves (6) used for storage of clean pots and pans were cleaned monthly	18 of 18	100%	100%
4. Knife cabinet was thoroughly cleaned monthly	3 of 3	100%	100%
5. Walk in coolers were cleaned thoroughly monthly.	6 of 6	100%	100%
6. Steam kettles (2) were cleaned thoroughly on a weekly basis	26 of 28	93%	95%
7. All trash cans (4) and bins (1) were cleaned daily	445 of 460	97%	95%
8. All carts(9) used for food transport (tiered) were cleaned daily	811 of 828	98%	100%
9. All hand sinks (4) were cleaned daily	360 of 368	98%	95%
10. Racks(3) used for drying dishes were cleaned daily	273 of 276	99%	100%

### Summary

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

Threshold percentiles were not met regarding: Convection ovens, 92%. Steam kettles 93%. Carts used for food transport 98%, Racks used for drying dishes 99%.

Improvements were shown in the following areas: Convection ovens were cleaned 92%; an increase of 9%. Trash cans increased 12%, Carts used for food transport increased 1%. Hand sinks improved 6%. Racks for drying dishes improved 18%.

Vacant positions July-September 2010: PT Food service worker, FT Food Service Worker, PT Cook I FML. The Dietary team has shown improvement working together to successfully complete federal and state mandated regulations regarding food safety and sanitation.

### Actions

1. FSM will reviews all cleaning schedules on a daily basis to assure staff completion.
2. Cleaning schedules have been modified to reflect changes in staff availability.
3. Weekly staff meetings include discussion and staff suggestions for successful completion of tasks.
4. Weekly staff meetings include review of the past weeks completion rates.
5. Results of this CPI indicator will be discussed with staff.
6. There are currently no vacant positions within the Dietary Department.

# DIETARY

Indicator	Findings	Compliance	Threshold Percentile
A nutrition assessment is completed within 5 days of admission when risk is identified via the nutrition screen.	59 of 59	100%	100%

**Summary**

Initial nutritional assessments were completed, by the Registered Dietitian/Dietetic Technician Registered, on clients with identified nutritional need within 5 days of admission.

**Actions**

The nutrition screen, which is part of the Initial Nursing Assessment and Admission Data, will be completed by nursing within 24 hours of admission.

The Dietitian reviews the nutrition screening to determine whether the client is at nutrition risk

Nursing will contact the Dietary Department at 287-7248 if an Urgent consult is required. Dietary staff will then contact the Registered Dietitian/Dietetic Technician Registered. This includes weekends and holidays. The RD/DTR will respond by telephone or with an on-site follow-up as deemed appropriate within 24 hours. Nursing must document in the progress notes any recommendations made by the RD/DTR.

# HEALTH INFORMATION MANAGEMENT

## ASPECT: DOCUMENTATION & TIMELINESS

Indicators	Findings	Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 68 discharges in quarter 1 2011. Of those, 53 were completed by 30 days.	78 %	80%
Discharge summaries will be completed within 15 days of discharge.	68 out of 68 discharge summaries were completed within 15 days of discharge during quarter 1 2011.	100 %	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	4 forms were approved/ revised in quarter 1 2011 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 864 dictated reports, 752 were completed within 24 hours.	87%	90%

### Summary

The indicators are based on the review of all discharged records. There was 78% compliance with record completion. There was 100% compliance with discharge summary completion. Weekly "charts needing attention" lists are distributed to medical staff, including the Medical Director, along with the Superintendent, Risk Manager and the Quality Improvement Manager. There was 87% compliance with timely & accurate medical transcription services.

### Actions

Continue to monitor.

# HEALTH INFORMATION MANAGEMENT

## ASPECT: CONFIDENTIALITY

Indicators	Findings	Compliance	Threshold Percentile
All client information released from the Health Information department will meet all Joint Commission, State, Federal & HIPAA standards.	2920 requests for information (112 requests for client information and 2808 police checks) were released for quarter 1 2011.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	16 new employees/contract staff in quarter 1 2011.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	0 privacy-related incident reports during quarter 1 2011.	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 1, 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?	23 of 24	96%	100%
2. Was linen free of any holes or rips coming back from vendor?	22 of 24	92%	95%
3. Did we have enough linen on units via complaints from unit staff?	22 of 24	92%	90%
4. Was linen covered on units?	24 of 24	100%	95%
5. Did vendor provide a 24 hr. turn around service as specified in the contract?	19 of 24	79%	100%
6. Did we receive an adequate supply of mops and rags from vendor?	24 of 24	100%	95%
7. Was linen bins clean returning from vendor?	24 of 24	100%	100%
8. Was the linen manifest accurate from the vendor	5 of 16	31%	85%

### Summary

Eight 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 #1, #2, #5, & #8.

The overall compliance for this quarter was 86%. This shows a 10% decrease from last quarters' report.

1. During random inspections, Linen returned from vendor was worn out and not taken out of service.
2. During random inspections, Linen returned from vendor did not meet cleanliness standards and not taken out of service.
3. Linen was not coming back from the vendor with accurate manifests
4. Linen coming back from the vendor were not delivered to Riverview in a timely fashion.

### Actions

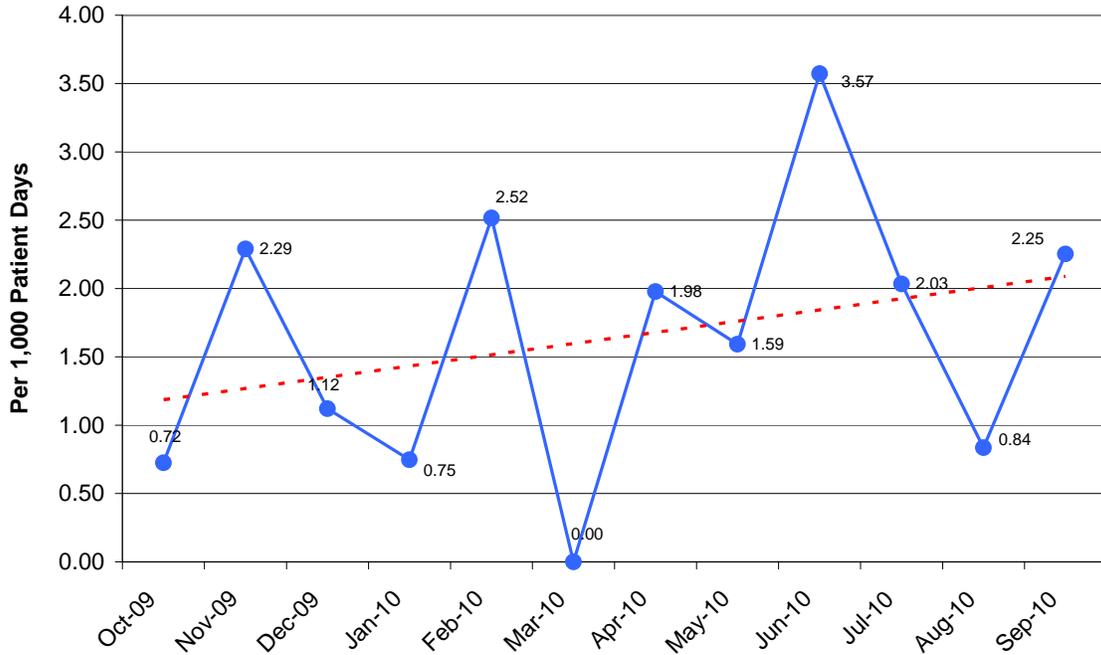
The Housekeeping Department has done the following actions to remedy the above problem indicators:

- ✓ The housekeeping staff will continue to monitor the linen holes and cleanliness.
- ✓ The housekeeping staff will check linen rooms daily to ensure that all linen is in good condition and adequately stocked.
- ✓ Communicate to all Housekeeping staff to be aware of the status of this indicator.
- ✓ Housekeeping supervisor contacted linen vendor and advised them of the problem of the worn out linens and the timeliness of their deliveries.
- ✓ Housekeeping supervisor will assign a staff member to document all information regarding to inventory and manifest statistics from the vendor.
- ✓ Housekeeping supervisor will communicate with vendor to make them aware of the different problems occurring during this period and resolve issues.

# HUMAN RESOURCES

## ASPECT: DIRECT CARE STAFF INJURIES

Reportable (Lost Time & Medical) Direct Care Staff Injuries



### Summary

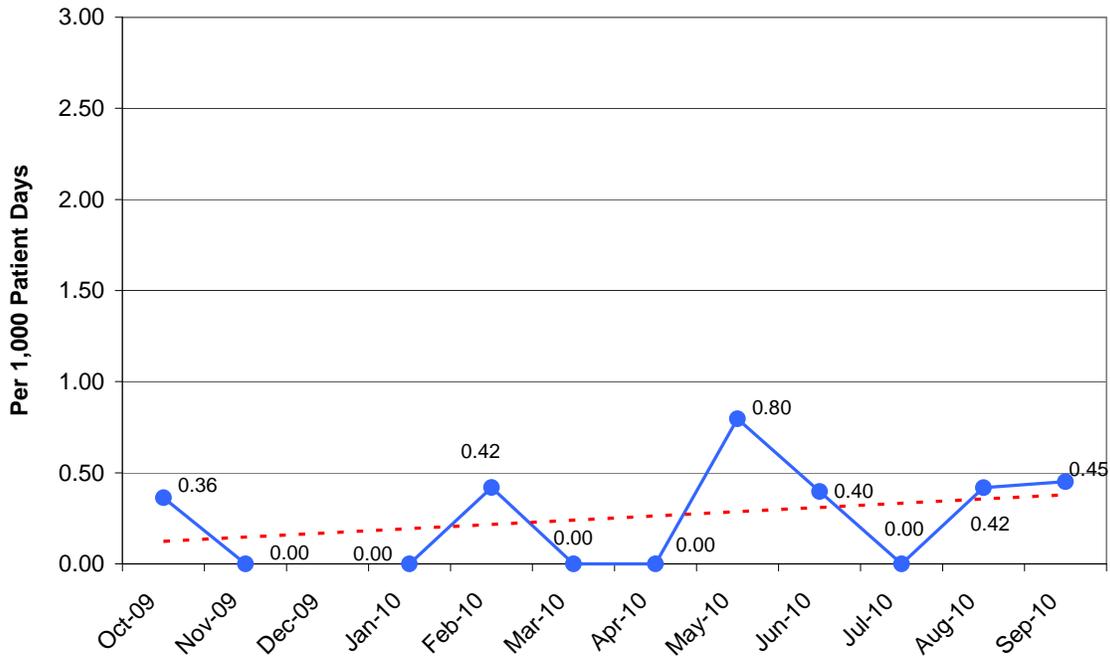
The trend line for reportable injuries sustained by direct care staff is beginning to show a slight increase in the number of injuries reported. Ongoing review and analysis of the number of direct care staff injured is being conducted to determine what correlation, if any, is apparent between the incidence of client events, the use of certain treatment modalities, and the frequency of coercive events.

To date, while there does appear to be some anecdotal relationship between certain events and the incidence of staff injuries, correlation studies have not revealed any statistically significant correlation.

# HUMAN RESOURCES

## ASPECT: NON-DIRECT CARE STAFF INJURIES

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



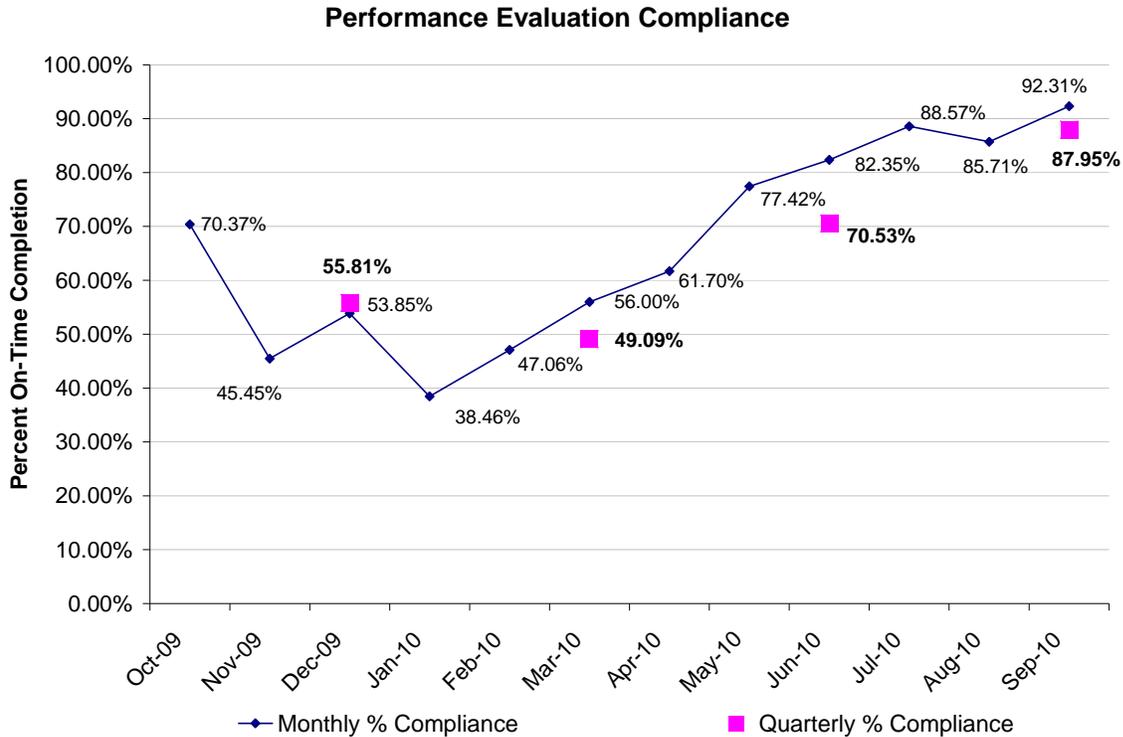
### Summary

The average percent of non-direct care staff who sought medical attention or lost time from work remains low. The annual trend line shows an overall slight increase in the rate of injury; however, this change is insignificant considering the total number of non-direct care staff injuries. As with the incidence of direct care staff injuries, close monitoring of surrounding events and activities is being conducted to determine correlations between injury rates and work activities.

# HUMAN RESOURCES

## ASPECT: PERFORMANCE EVALUATIONS COMPLETION

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



### Summary

This quarter has shown significant improvement in the completion of performance evaluations.

Cumulative results from this quarter (87.95%) have returned a level that exceeds the performance threshold of 85%. Ongoing efforts to insure on time completion of performance evaluations will continue in order to achieve the highest possible rate of on-time performance and to maintain a sustainable level of performance above the 85% level.

## ASPECT: PERSONNEL MANAGEMENT

Overtime hours and mandated shift coverage

Reporting Period	Overtime Hours	Mandated Shift Coverage
July 2010	2859.75	11
August 2010	1884.75	7
September 2010	1410.75	14

Staffing levels have achieved a high degree of stability with only a few positions open each much due to normalized attrition. Significant decreases in the level of overtime staffing should be able to be sustained moving forward.

# INFECTION CONTROL

## ASPECT: HOSPITAL ACQUIRED INFECTION

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the fourth quarter of the fiscal year, per 1000 patient days	18/2.5	100 % within standard	1 SD within the mean
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	2/0.27	100% within standard	1 SD within the mean

### Data

- 11 community acquired skin infections
- 2 community acquired dental infections
- 2 community acquired infections of the reproductive system
- 1 community acquired eye infection
- 1 hospital acquired skin infection
- 1 hospital acquired ear infection
- No MDRO infections

### Summary

Riverview psychiatric Center maintains a total house surveillance program. The overall infection rate for the last quarter of 2009-2010 was 3.8 (31 infections) compared to a total infection rate of 2.5 (18 infections) for the first quarter of fiscal year 2010-2011. There had been a spike in the total infection rate in April 2010 as well as a spike in hospital acquired skin infections. This spike most likely contributed to an overall increase in the total infection rate in the last quarter of 2009-2010.

There were 13 skin infections in the last quarter of 2009-2010 and 12 skin infections this quarter. Skin infections are the most common infection we see at Riverview. Seventeen of the skin infections (of various types) were on the Kennebec units. This is not unusual as Kennebec Lower is an admission unit and many are secondary to an underlying medical condition and/or poor hygiene practices.

### Action

- Continue total house surveillance.
- Encourage staff and clients to maintain good hand hygiene.
- Hand hygiene observation.

# LIFE SAFETY

## ASPECT: LIFE SAFETY

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. means.	285/285	100%	95%
3. Total number of staff who knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	285/285	100%	95%
4. Total number of staff who knows the emergency number.	285/285	100%	95%
5. During unannounced safety audits conducted by the Safety Officer, this represents the total number of staff who displays identification tags.	285/285	100%	95%
6. During unannounced safety audits conducted by the Safety Officer, this represents the total number of direct care staff who carries a personal duress transmitter.	92/92	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.

During drills, the following was discovered:

1. One unit was unable to start a census due to the heavy radio traffic during the first (2) minutes of the fire event.
2. Clients in the Dining Hall were taken to the Center Courtyard.
3. When deployed, one unit discovered a two-way did not function properly due to a damaged radio that had not been reported.
4. There was a combination of missing fire report forms and old forms during one event.

Numbers reflected in #'s 2-4 above included a recent fall training fair at which many facets of Life Safety were drilled with staff. These included R.A.C.E., evacuation routes, use of fire extinguishers, use of annunciator panels, and emergency communications.

### Actions

1. The 1<sup>st</sup> minute or two are extremely busy during an event. Will investigate ways to accomplish tasks at hand during the 1<sup>st</sup> few minutes of an event yet still perform a census.
2. An email has been sent to all staff reminding them that the Center Courtyard can not be used as an area of refuge and that the Gym or other alternate area may be used.
3. The two-way radio was repaired and an email sent to all staff with regard to the importance of reporting damaged equipment and having communications equipment in top working condition.
4. Blank fire reports have been distributed to all inside front covers of the Safety Manuals.

We continue with environmental tours and safety audits to assure that staff is in possession of required safety equipment and facility ID's. This area of monitoring has shown improvement. We continue to monitor these indicators during safety fairs, along with those during the tours and audits.

# LIFE SAFETY

## ASPECT: FIRE DRILLS REMOTE SITES

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

### Summary

There was an unannounced drill conducted by the Safety Officer during the fourth quarter. Unfortunately, due to dental services being performed on a client, we made the decision to not interrupt those services for the purpose of conducting the drill utilizing the alarms throughout the building. We will make an attempt to accomplish that during the next drill, which is planned for the 2<sup>nd</sup> quarter. We continue to perform environmental tours during which time we ask them questions as it relates to what actions they must take in the event of a fire and/or smoke emergency.

### Actions

No actions are required at this time other than coordinate the next planned drill with other participants sometime during the next quarter.

# LIFE SAFETY

## ASPECT: SECURITAS/RPC SECURITY TEAM

Indicators	Findings	Compliance	Threshold Percentile
Security Officer "foot patrols" during Open Hospital times. (Total # of "foot patrols" done vs. total # of "foot patrols" to be done.)	1797/2002	89%	95%

### Summary

Foot patrols continue to be done despite those rare times that the officers are on other details which take priority over the "foot patrol". We continue our work to putting together the "tour system". We anticipate having something in place for the next quarter.

### Actions

We continue our attempt to accomplish all foot patrols. Other tasks which are placed at a greater priority get assigned first. We have also reassigned duties to a "Float Officer" who will assume more of the foot patrols. We continue our work on the tour system.

# MEDICAL STAFF

## ASPECT: COMPLETION OF AIMS

Indicators	Findings	Compliance	Threshold Percentile
Charts of clients at Riverview for six or more months are reviewed. Each client should have an AIMS exam done upon admission and every six months thereafter.	For July and August 2010, 79 of 85 were in compliance	92%	90%

### Summary

AIMS testing is being done upon admission, and follow-up tests need to be done every six months thereafter. The compliance rate has increased from 29% in the 3<sup>rd</sup> quarter of FY09 to 92% for the 1st quarter of FY11.

### Actions

AIMS testing schedule will be changed from this point forward to take place upon admission then every January and July from there on. This practice will eliminate testing a few clients every month, and allow the psychiatrists to do all their clients twice a year.

## ASPECT: JUSTIFICATION FOR DISCHARGE ON MULTIPLE ANTIPSYCHOTICS

Indicators	Findings	Compliance	Threshold Percentile
Patients discharged on multi-antipsychotic medications will have clinical justification documented in the discharge summary.	Over a 2-mo period (June-July) 43 discharges had 9 patients on 2 or more antipsychotics; 1 was justified.	11%	80%

### Summary

The number of clients discharged on multiple antipsychotics increased in July, with only one justified.

### Actions

We will continue to monitor justification documentation on patients discharged. Psychiatrists will be provided with a monthly list. Feedback to individual psychiatrists is given at the Peer Review Committee.

# NURSING

## ASPECT: SECLUSION/RESTRAINT RELATED TO STAFFING EFFECTIVENESS

Indicators	Findings	Compliance
1. Staff mix appropriate	127 of 127	100%
2. Staffing numbers within appropriate acuity level for unit	127 of 127	100%
3. Debriefing completed	122 of 127	96%
4. Dr. Orders	127 of 127	100%

### SUMMARY

The indicators of “Seclusion/Restraint Related To Staffing Effectiveness” has remained consistent with only a minor negative deviation from 98% to 96% in completing debriefing after incident.

### ACTION

We believe that this 2% decline in documentation of debriefing may be related to increased acuity during this measurement period. However, it is the intent of nursing to continue to pursue maximum compliance as expected and achievable in the upcoming quarter.

## ASPECT: INJURIES RELATED TO STAFFING EFFECTIVENESS

Indicators	Findings	Compliance
1. Staff mix appropriate	40 of 40	100%
2. Staffing numbers within appropriate acuity level for unit	40 of 40	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. The staffing numbers are within the appropriate level for the current staffing plan and the acuity level.

### ACTIONS

This is an important issue that is of concern to all. The Director of Nursing is working in concert with the Superintendent and Risk management to monitor and measure trends and variables that contribute to staff injury. The focus is on appropriate use of stat calls for support to heighten awareness of safety and the obvious support in numbers for lifting and other manual activities.

# NURSING

## ASPECT MEDICATION ERRORS AS IT RELATES TO STAFFING EFFECTIVENESS

NURSING: Staffing levels during medication errors – July.-September 2010 NASMHPD reportable variances

Date	Omit	Co-mission	Float	New	O/T	Unit Acuity	Staff Mix
6/13-8/10/10 Report	N	Topical cream discontinued	N	N	N	UK	2 RN,1 LPN, 5 MHW
7/8/10	Y		N	Y	N	LS-SCU	2 RN,1 LPN, 6 MHW
7/15/10	N/A	Prescribing (medical)	N/A	N/A	N/A	US	N/A
8/2/10	Y		N	N	N	UK	3 RN,1LPN., 5 MHW
8/4/10	N	Discontinued med.	N	N	N	LS	1 RN,0 LPN, 5 MHW
8/5/10	N/A	Pharmacy Error	N/A	N/A	N/A	LK	N/A
8/5/10	Y		N	N	N	LK	4 RN,0 LPN, 7 MHW
8/5/10	N	Wrong Time	Y	N	N	US	3 RN, 0 LPN, 4 MHW
8/12/10	N	Discontinued med	N	N	N	UK	2 RN,0 LPN, 4 MHW
8/17/10	Y	Out of sequence med	N	N	N	LK	4 RN,0 LPN, 7 MHW
8/19/10	Y		N	Y	N	UK	2 RN,0 LPN, 4 MHW
8/21/10	N	Wrong Client	N	N	N	UK	2 RN,0 LPN, 5 MHW
8/21/10	Y		N	N	N	LS	2RN, 1 LPN.,6 MHW
8/24/10	N/A	:Pharmacy Error	N/A	N/A	N/A	LSSCU	N/A
8/25/10	Y		N	N	N	LS	3 RN, 1 LPN,6 MHW
8/26/10	Y		y	N	N	LSSCU	2 RN, 1 Orientee RN, 0 LPN, 6 MHW
9/06/10	N	Med given early	N	N	N	LS	1 RN,0 LPN, 5 MHW
9/10/10	Y		Y	N	N	LK	2 RN,0 LPN, 4 MHW
9/12/10	Y		N	N	N	LK	3RN, 0 LPN, 7 MHW
9/14/10	Y		N	N	N	US	2 RN, 0 LPN,5 MHW
9/16/10	N	Wrong dose given	N	N	N	LKSCU	3 RN, 1 LPN,7 MHW
9/18/10	Y		N	N	N	US	1 RN,0 LPN, 3 MHW
9/24/10	N	Med given early	N	N	N	LSSCU	2 RN,1 LPN, 5 MHW
9/30/10	Y		Y	N	N	LSSCU	4 RN,1 LPN, 7 MHW

## SUMMARY

There were a total of twenty-five (25) reportable errors. Two (2) involved pharmacy and did not involve staffing effectiveness evaluation. One (1) involved medical staff and did not involve staffing effectiveness evaluation. Fourteen (14) were omissions. Two (2) involved pharmacy stocking error. Three (3) involved administering a discontinued medication. Four (4) involved a medication being given at the wrong time. One (1) involved administration of medications to the wrong client, requiring monitoring for potential side effects, with no resulting consequences. One (1) involved an incorrect dose. One nurse with multiple medication errors was counseled and arrangements for remedial education were made. All nursing related medication variances were noted to have appropriate staffing levels at the time they occurred, and on the given shift that they occurred.

# NURSING

## ASPECT: PAIN MANAGEMENT

Indicator		Findings	Compliance
Pre-administration	Assessed using pain scale	2015/2025	99.51%
Post-administration	Assessed using pain scale	1860/2025	91.90%

### SUMMARY

The “Pre-administration assessment” indicator met the maximum compliance of 99.51% this quarter and there is a continued improvement from 88% to 92% in “Post-administration” assessment using the pain scale. The modest improvement in “Post-administration” assessment is expected to increase with the advent of implementation of the pharmacy module of our Electronic Medical Record.

### ACTION

We believe that the increase in compliance for “Post-administration” assessment is a result of strategy implemented in the past quarter. Nursing will continue to place a great deal of attention and effort on post administration assessment and management of the related documentation. Nursing will continue to track this indicator and strive for increase in post assessment in the next quarter. The two ADONs will continue to work with unit nursing staff to assure that this is done consistently.

# NURSING

## ASPECT: INITIAL CHART COMPLIANCE

Indicators	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours.	57 of 58	98%
2. All sections completed or deferred within document.	57 of 58	98%
3. Initial Safety Treatment Plan initiated.	34 of 58	59%
4. All sheets required signature authenticated by assessing RN.	56 of 58	97%
5. Medical Care Plan initiated if Medical problems identified.	14 of 48	29%
6. Informed Consent sheet signed.	51 of 56	91%
7. Potential for violence assessment upon admission.	58 of 58	100%
8. Suicide potential assessed upon admission.	58 of 58	100%
9. Fall Risk assessment completed upon admission.	53 of 58	91%
10. Score of 5 or above incorporated into problem need list.	11 of 32	34%

## SUMMARY

This area is monitored upon admission. Initial Safety Treatment Plan initiation decreased from 100% to 59% results of the previous Quarter; Fall Risk Assessment improved by 10% in collection and improved on percent of Fall Risk Score of 5 or above being incorporated into the problem need list. 34% from 18%. Medical Care Plan initiated decreased from 55% to 29%.

## ACTION

Continue to work with the Professional staff to increase awareness of the interdependence of each subsection in this category. Review sample size to seek a constant statistically significant numerical representation for analysis.

## ASPECT: CHART REVIEW EFFECTIVENESS

Indicators	Findings	Compliance	Threshold Percentile
1. GAP note written in appropriate manner at least every 24 hours.	60 of 60	100%	85%
2. STGs/Interventions relate directly to content of GAP note.	49 of 60	82%	85%
3. Weekly Summary note completed.	39 of 59	66%	85%
4. BMI on every treatment plan review.	43 of 59	73%	85%
5. Diabetes Education Teaching Checklist shows documentation of client teaching (diabetic clients).	31 of 43	72%	85%
6. Multidisciplinary Teaching checklist active being completed.	25 of 40	63%	85%
6. Dental Education Teaching Checklist active/being completed.	23 of 40	58%	85%

# NURSING

## ASPECT: CHART REVIEW EFFECTIVENESS (cont'd)

### UNIT SPECIFIC Lower Kennebec

Indicators	Findings	Compliance	Threshold Percentile
1. SRC monitor sheets completed	9 of 10	90%	85%
2. Client debriefings completed within 24 hours after coercive episode	5 of 10	50%	65%
3. Safety meetings within 72 hours after coercive episode	1 of 10	10%	

### UNIT SPECIFIC Upper Kennebec

Indicators	Findings	Compliance	Threshold Percentile
1. Comprehensive Service Plan (CSP) updated every 2 weeks (consistent with review)	8 of 9	89%	65%
2. Client Signature on CSP within 2 weeks	3 of 10	30%	85%

### UNIT SPECIFIC Lower Saco

Indicators	Findings	Compliance	Threshold Percentile
1. STG Interventions are clear, simple behavioral actions for nurses	1 of 10	10%	85%
2. STG's are updated/modified every 2 weeks (concurrent with Treatment Plan Reviews).	6 of 10	60%	85%
3. STG for client is a behavioral and measurable statement	4 of 10	40%	85%

### UNIT SPECIFIC Upper Saco

Indicators	Findings	Compliance	Threshold Percentile
1. Client Signature on CSP monthly	6 of 9	67%	85%
2. STG's are updated/modified monthly	1 of 9	11%	85%

## SUMMARY

This was a major format change for this quarter. Some indicators are shared by all four units and other indicators are done specifically by the individual units. We saw a major improvement in 2 areas: Weekly summary notes and BMI on every treatment plan. There were decreases in two areas

Reliability continues to be enhanced by the utilization of a single reviewer.

## ACTION

As in the current measurement period, unit RNs will audit 1 chart per RN and discuss during supervision. The Nurse Educator responsible for chart audit will continue to meet with individual nurses following each chart audit. The PSD/ Nurse IV will continue to discuss and review chart audit results at staff meetings. The increase in compliance appreciated during this measurement period has continued vigilance in proceeding with the template designed for weekly notes and expectations of maintaining current levels while striving for measurable achievable results for the next quarter activities

# PEER SUPPORT

## ASPECT: INTEGRATION OF PEER SPECIALISTS INTO CLIENT CARE

Indicators	Findings	Compliance	Threshold Percentile
a. Attendance at Comprehensive Treatment Team meetings.	322 of 390	83%	80%
b. Level II grievances responded to by RPC on time.	3 of 3	100%	100%
c. Attendance at Service Integration meetings.	54 of 55	98%	100%
d. Contact during admission.	58 of 59	98%	100%
e. Level I grievances responded to by RPC on time.	48 of 64	75%	100%
f. Client satisfaction surveys completed.	15 of 23	65%	50%

### Summary

Overall compliance is 84%, down 3% from last quarter. The majority of indicators dropped in compliance.

Level II grievances responded to on time remained at 100% and completion of client satisfaction surveys increased slightly, although the number of surveys offered has decreased.

Attendance at treatment team meetings dropped 7% primarily due to a prolonged shortage of staff through July and August. The service integration meeting that was missed was due to lack of staffing and miscommunication of priorities. One client did not have contact with peer support during admission because the admission was less than 24 hours.

The most significant drop in compliance was with level I grievances being responded to on time, 21%.

# PHARMACY & THERAPEUTICS

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

## ASPECT: ORDER WRITING POLICY

Indicators	Findings	Compliance	Threshold Percentile
All order sheets are required to have that patient's allergies listed at the top of the sheet	<b>July</b> <b>Nine</b> orders received by pharmacy without allergies listed and an estimated 1325 orders total received by pharmacy.	99.3%	98.0%
	<b>August</b> Eleven orders received by pharmacy without allergies listed and an estimated 1325 orders total received by pharmacy.	99.2%	98.0%
	<b>September</b> Seven orders received by pharmacy without allergies listed and an estimated 1200 orders total received by pharmacy	99.4%	98.0%

## Summary

There were a total of 26 orders sent to the pharmacy during Q1 without allergy information written at the top of the page. An estimated 3850 total orders were received during that time period. Total compliance during this time period is 99.3%. All orders received without allergies listed were faxed back to their respective units for clarification.

# PHARMACY & THERAPEUTICS

## ASPECT: DIVERSION OF CONTROLLED SUBSTANCES

Controlled substances are potentially habit forming medications that are useful in the treatment of specific disease states. Under proper supervision these medications are used to treat a wide variety of disease states effectively, easing the suffering of millions of Americans. If used improperly they can become addictive and destroy lives.

Due to their addictive side effects controlled substances have a high potential for being diverted for a number of different uses. For this reason Riverview has many safeguards to prevent the diversion of controlled substances.

Riverview utilizes Automatic Dispensing Cabinets (produced by McKesson called AcuDose machines) as the primary medication delivery system. This technology provides excellent documentation for all medications which are stored in the ADCs, including controlled substances. All medication transactions are tracked. All controlled substance transactions require 2 users and a count of the medication in the pocket to be entered into the machine. If the quantity entered differs from the quantity in the computer's database that ADC will register the error and will notify the user. Until the discrepancy is resolved by a Riverview employee credentialed to do so the word discrepancy will appear on that ADC alerting all users of the problem.

Pharmacists, NODs, and members of nursing leadership privileged by the Director of Nursing are allowed to correct discrepancies. Another user of the ADC must also sign off with the above described staff to resolve the discrepancy electronically. If the pharmacy is open, the discrepancies will be corrected by the pharmacy. If the pharmacy is closed the discrepancies will be corrected by the NOD.

The ADC software creates a report daily at 0730 alerting the pharmacy of any open discrepancies called the "AcuDose-Rx Discrepancy by Station Report." A pharmacist reviews these reports daily (or the next day the pharmacy is open for weekends and holidays).

The goal of this report is to review all ADC discrepancies from July 1, 2010 through September 30, 2010 and ensure that controlled substances are not being diverted from unit stock and discrepancies are being addressed in a timely manner.

Discrepancies Recorded	Incidences	Pharmacy Corrected	NOD Correction	Suspected Diversion	Actual Diversion
34	22	13	9	0	0

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

All of the 34 discrepancies recorded were all accounted for by user error and correction of previously created error. (A discrepancy will sometimes be purposely created to correct a previous mistake. For example, if there was 1 tablet in the ADC and the nurses finger slips and presses both the "1" and "2" key at the same time thus accidentally entering a quantity of 12. The computer will then believe that 12 is the correct quantity. A second discrepancy will have to be created to correct the computer quantity to 1.)

The above data shows strong evidence that controlled substances are not being diverted from the ADCs and that any discrepancies created are being addressed in a timely manner.

# PROGRAM SERVICES

## ASPECT: ACTIVE TREATMENT IN ALL FOUR UNITS

Indicator	Findings	Compliance
1. Documentation reveals that the client attended 50% of assigned psycho-social-educational interventions within the last 24 hours.	85 of 100	85%
2. A minimum of three psychosocial educational interventions are assigned daily.	90 of 100	90%
3. A minimum of four groups is prescribed for the weekend.	85 of 100	85%
4. The client is able to state what his assigned psycho-social-educational interventions are and why they have been assigned.	83 of 99	84%
5. The client can correctly identify assigned RN and MHW. (Or where the information is available to him / her)	95 of 99	96%
6. The medical record documents the client's active participation in Morning Meeting within the last 24 hours.	62 of 100	62%
7. The client can identify personally effective distress tolerance mechanisms available within the milieu.	97 of 99	98%
8. Level and quality of client's use of leisure within the milieu are documented in the medical record over the last 7 days.	97 of 100	97%
9. Level and quality of social interactions within the milieu are documented in the medical record over the last 7 days.	94 of 100	94%
10. Suicide potential moderate or above incorporated into CSP	42 of 42	100%
11. Allergies displayed on order sheets and on spine of medical record.	100 of 100	100%
12. By the 7 <sup>th</sup> day if Fall Risk prioritized as active-was it incorporated into CSP	43 of 57	61%

## SUMMARY

Overall compliance for all indicators is 89% which is an increase from 80%. Client attending psychosocial education is at 85%, which is up from 81% last quarter. The indicator that the client is able to state what his assigned psychosocial education interventions is at 81%, which is down from 84% last quarter. The indicator suicide potential moderate or above is incorporated into the CSP is at 100% which is an increase from 87% last quarter. Nine indicator numbers 1, 3, 4, 5, 6, 7, 9, 10, and 12 have improved since last quarter. Two indicators have decreased slightly.

## ACTION

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

# PROGRAM SERVICES

## ASPECT: MILIEU TREATMENT

Indicator	Compliance
1. Percentage of clients participating in Morning Meeting	46 of 65
2. Percentage of clients who establish a daily goal.	46 of 65
3. Percentage of clients who attend Wrap Up group in the evening or address with primary staff, the status of their daily goal.	34 of 60
4. Percentage of clients attending community meeting.	50 of 60

## SUMMARY

Overall compliance in this area is 63% which is down from 73%. Client's plans for establishing a daily goal is at 71%, which is up from last quarter. Percentage of clients attending community meeting is at 95% up from 71%. Percentage of clients who attended wrap up has decreased from 59% to 53%.

## ACTION

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

# REHABILITATION SERVICES

## ASPECT: READINESS ASSESSMENTS, COMPREHENSIVE SERVICE PLANS & PROGRESS NOTES

Indicators	Findings	Compliance
1. Readiness assessment and treatment plan completed within 7 days of admission.	30 of 30	100%
2. Rehabilitation short term goals on Comprehensive Service Plan are measurable and time limited.	28 of 30	93%
3. 3. Rehabilitation progress notes indicate treatment being offered as prescribed on Comprehensive Service Plan.	28 of 30	93%
4. Rehabilitation progress notes indicate progress towards addressing identified goals on the Comprehensive Service Plan.	29 of 30	97%

### Summary

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

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

**Indicator #2 & 3-** Two charts on one unit had Rehabilitation treatment goals written by another discipline in the plan in addition to the treatment goals established by the RT. This had an impact on the HA documenting on this clients progress towards achieving the Rehabilitation goals in that they were not aware that these goals existed elsewhere in the treatment plan. Director will speak to Clinical Leaders to ensure that no other discipline is developing goals for another discipline.

**Indicator #4-** Acting capacity employee in the department this quarter who is new to the Rehab method of documentation and did not include all the information in the documentation. Unit RT will address this in the training process.

With regard to all indicators, the Director will continue to audit charts and provide individual supervision for all RT's to ensure expectations of indicators are achieved. The treatment planning process still continues to need review as it applies to client's participation in groups at the Harbor Mall.

# REHABILITATION SERVICES

## ASPECT: HARBOR MALL HAND-OFF COMMUNICATIONS

Indicators	Findings	Compliance	Threshold Percentile
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	10 of 28	35%	100%
2. RN signature/Harbor Mall staff signatures present.	28 of 28	100%	100%
3. SBAR information completed from the units to the Harbor Mall.	24 of 28	86%	100%
4. SBAR information completed from the Harbor Mall to the receiving unit.	27 of 28	96%	100%

### SUMMARY

This is the first quarter review as well as the first time this area is being monitored. All units were made aware of the criteria that would be monitored in order to ensure that the hand-off communication process for the Harbor Mall is being done properly. This data only reflects two months of this quarter as the procedure/process was not presented to the units until the end of July this quarter.

**Indicator #1-** 18 of the hand-off communication sheets did not arrive to the Harbor Mall within the allotted time frame. The sheet is to be brought to the mall no later than 5 minutes before the start of groups and this did not happen on 18 of the sheets that were reviewed in the past two months. Director of Rehabilitation Services will remind each of the units what the protocol is for the hand-off sheet to ensure that the information reaches the mall in time to be relayed to group leaders.

**Indicator #2-** All hand-off communication sheets were received with RN signatures and signed off as received by the Harbor Mall. No issues at this time.

**Indicator #3-** On four of the 28 sheets reviewed, the information from the unit was either incomplete or inaccurate. The clients were checked off as attending the mall and they did not attend on that day or nothing was checked as attended, refused or excused. Director of Rehabilitation Services will review the need for accuracy in completing the Hand-off sheet with each of the units.

**Indicator #4-** One of the 28 sheets reviewed did not have information from the treatment mall back to a unit. All the others had no issues to report documented.

With regard to all indicators, the Director of Rehabilitation Services will continue to randomly audit all the hand-off communication sheets received from the units. Any patterns from one particular unit will be reported to that unit's PSD in order to ensure accurate and timely communication between the two areas.

# SOCIAL WORK

## ASPECT: PRELIMINARY CONTINUITY OF CARE MEETING AND COMPREHENSIVE PSYCHOSOCIAL ASSESSMENTS

Indicators	Findings	Compliance	Threshold Percentile
1. Preliminary Continuity of Care meeting completed by end of 3 <sup>rd</sup> day	29/30	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.	1/1	100%	100%
3a. Client Participation in Preliminary Continuity of Care meeting.	29/30	96%	90%
3b. CCM Participation in Preliminary Continuity of Care meeting.	30/30	100%	100%
3c. Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation in Preliminary Continuity of Care meeting.	29/30	96%	100%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	12/15	66%	90%
3e. Correctional Personnel Participation in Preliminary Continuity of Care Meeting.	2/15	7%	90%
4a. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	27/30	90%	100%
4b. Annual Psychosocial Assessment completed and current in chart	28/30	93%	100%

### SUMMARY

Aspect areas 3d and 3e remain low but have shown improvement in the two preceding quarters. We continue to foster positive communication and collaboration with the community and corrections.

# SOCIAL WORK

## ASPECT: INSTITUTIONAL AND ANNUAL REPORTS

Indicators	Findings	Compliance	Threshold Percentile
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	8/8	100%	95%
2. The assigned <b>CCM</b> will review the new court order with the client and document the meeting in a progress note or treatment team note.	N/A	N/A	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 has been at 100% compliance for the last two reporting quarters.

## ASPECT: CLIENT DISCHARGE PLAN REPORT/REFERRALS

Indicators	Findings	Compliance	Threshold Percentile
1. The Client Discharge Plan Report will be updated/reviewed by each <b>Social Worker minimally one time per week.</b>	12/13	92%	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

Report was sent or distributed each week except the first week in August when Director was on vacation.

# 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 <b>CCM</b> 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 <b>CCM</b> 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.	56/60	93%	95%

### SUMMARY

Area 1 and 3 are being addressed in the Social Work Team Meeting and individually through supervision.

# STAFF DEVELOPMENT

## ASPECT: NEW EMPLOYEE AND MANDATORY TRAINING

<i>Indicators</i>	<i>Findings</i>	<i>Compliance</i>	<i>Threshold Percentile</i>
1. New employees will complete new employee orientation within 60 days of hire.	16 of 16 completed orientation	100%	100 %
2. New employees will complete CPR training within 30 days of hire.	16 of 16 completed CPR training	100%	100 %
3. New employees will complete NAPPI training within 60 days of hire.	16 of 16 completed Nappi training	100%	100 %
4. Riverview and Contract staff will attend CPR training bi-annually.	327 of 327 are current in CPR certifications	100%	100 %
5. Riverview and Contract staff will attend NAPPI training annually. Goal to be at 100% by end of fiscal training year 2011 on June 30 <sup>th</sup> .  <b>Fiscal year 10 at 100%</b>	111 of 392 have completed annual training	28%	100 %
6. Riverview and Contract staff will attend Annual training. Goal is to be at 100% by end of fiscal training year 2011 on June 30 <sup>th</sup> .  <b>Fiscal year 10 at 100%</b>	234 of 392 have completed annual training	60%	100 %

### Findings

The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. **16 out of 16 of** (100%) new Riverview/Contracted employees completed these trainings. **327 of 327** (100%) Riverview/Contracted employees are current with CPR certification. **111 of 392** (28%) Riverview/Contracted employees are current in Nappi training. **232 of 392** (60%) employees are current in Annual training. All indicators remained at 100% compliance for quarter 1-FY 2011.

### Problem

No identified problems at this time.

### Status

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

### Actions

No actions needed at this time.