

# Riverview

PSYCHIATRIC CENTER



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PERFORMANCE IMPROVEMENT REPORT

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FIRST STATE FISCAL QUARTER 2012  
July, August, September 2011

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October 21, 2011



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## Glossary of Terms, Acronyms & Abbreviations

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



## Glossary of Terms, Acronyms & Abbreviations

R.A.C.E.	Rescue/Alarm/Confine/Extinguish
RN	Registered Nurse
RT	Recreation Therapist
SA	Substance Abuse
SBAR	Acronym for a model of concise communications first developed by the US Navy Submarine Command. S = Situation, B = Background, A = Assessment, R = Recommendation
SD	Standard Deviation – a measure of data variability.
Seclusion, Open	Client is placed in a secured room with the door locked.
Seclusion, Locked	Client is placed in a room and instructed not to leave the room.
SRC	Single Room Care (seclusion)
URI	Upper respiratory infection
UTI	Urinary tract infection
VOL	Voluntary – Self
VOL-OTHER	Voluntary – Others (Guardian)
MHW	Mental Health Worker



## INTRODUCTION

To accommodate the needs of the readers of this report, recognizing the wide span of knowledge regarding medical, social, and legal abbreviations, a glossary of terms has been added as a regular feature of the quarterly report. This section will continually evolve as new abbreviations, terms, or acronyms are identified.

The use of seclusion and restraint as a safety mechanism for clients and staff in the clinical setting remains a focus of risk and process improvement activities. Both the number and duration of client incidents managed with restraint and seclusion techniques is variable and often dependent upon client acuity and concerns for maintaining client safety. The duration of both seclusion and restraint remain the national mean as determined by the National Association of State Mental Health Program Directors Research Institute (NRI). For the same period, the average number of restraint and seclusion incidents over the past several quarters has been within one standard deviation of the national mean as determined by NRI. Efforts continue to further reduce the incidence of both restraint and seclusion while maintaining the safety of the client, the milieu and our staffs.

Medication variance is becoming an issue requiring urgent intervention. While few, if any, incidents impact the care of the clients, the number of events has grown to the point where an in depth analysis of systems and processes is required. The Clinical Risk Manager, Director of Nursing, Clinical Director, and Director of Pharmacy meet regularly to review the incidence of medication variance and plans are being formulated to identify common variables and address the most frequently occur root causes for these events.

Ongoing efforts to ensure consistent documentation of standards are being addressed in the section on Consent Decree Compliance. This section continues to be developed. The elements of substantial compliance abstracted from this document are listed with an explanation of how current operations fulfill the standards described. Several of the compliance standards require specific evidence or documentation of compliance that in various stages of development. One of these evaluation methods includes an ongoing process for evaluating the appropriate application and management of seclusion and mechanical restraints. This tool has been implemented and ongoing reports regarding this measure have been included in this report. As this reporting mechanism is developed, it is expected that subsequent reports will address all of the standards of substantial compliance in a manner that demonstrates a good faith effort to maintain continual compliance with all of the elements of the Consent Decree and to maintain an environment and treatment methods that are both safe and therapeutic and focused on the recovery of the client.

# ADMISSIONS

Figure CD-06

## Client Admission Diagnoses

	2011				2012	Total
	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	
ADJUSTMENT DIS W MIXED DISTURBANCE OF EMOTIONS & CONDUCT		1	1		1	3
ADJUSTMENT DISORDER WITH DEPRESSED MOOD	1		1	2	2	6
ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD	1				1	2
ADJUSTMENT REACTION NOS	1			1		2
ALCOH DEP NEC/NOS-REMISS			2			2
ANXIETY STATE NOS					1	1
ATTN DEFICIT W HYPERACT					1	1
BIPOL I DIS, MOST RECENT EPIS (OR CURRENT) MANIC, UNSPEC				1		1
BIPOL I, MOST RECENT EPISODE (OR CURRENT) MIXED, UNSPECIFIED			1			1
BIPOL I, REC EPIS OR CURRENT MANIC, SEVERE, SPEC W PSYCH BEH			1	1		2
BIPOLAR DISORDER, UNSPECIFIED	11	11	10	11	17	60
CANNABIS ABUSE-IN REMISS				1		1
CONDUCT DISTURBANCE NOS				1		1
DELUSIONAL DISORDER	2	2	2	2		8
DEPRESS DISORDER-UNSPEC				1		1
DEPRESSIVE DISORDER NEC	4	5	5	7	4	25
DRUG ABUSE NEC-IN REMISS					2	2
DRUG ABUSE NEC-UNSPEC				1		1
DYSTHYMIC DISORDER			1	2		3
HALLUCINOG ABUSE-REMISS					1	1
HEBEPHRENIA-CHRONIC		1		1		2
IMPULSE CONTROL DIS NOS					1	1
INTERMITT EXPLOSIVE DIS			1		3	4
NONPSYCHOT BRAIN SYN NOS			1			1
OPPOSITIONAL DEFIANT DISORDER			1			1
PARANOID SCHIZO-CHRONIC	7	6	4	5	10	32
PARANOID SCHIZO-UNSPEC	2	4	5	2	1	14
PARANOID STATE NOS			1			1
POSTTRAUMATIC STRESS DISORDER	4	4	2	3	4	17
PSYCHOSIS NOS	4	7	13	14	6	44
REC DEPR DISOR-PSYCHOTIC	2	2				4
RECUR DEPR DISOR-SEVERE					1	1
RECURR DEPR DISORD-UNSP		1	1			2
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	13	20	14	13	11	71
SCHIZOPHRENIA NOS-CHR	1	6	4	2	3	16
SCHIZOPHRENIA NOS-UNSPEC	2	1	1		1	5
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED			1		1	2
UNSPECIFIED EPISODIC MOOD DISORDER	3	3	3	5	12	26
Total Admissions	58	74	76	76	84	368
% Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	0%	0%	2.7%	2.7%	3.6%	1.9%

# ADMISSIONS

Figure CD-04 Client Legal Status on Admission	2011				2012	Total
	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	
ICDCC	3	17	26	23	39	108
ICDCC-M					1	1
ICDCC-PTP				1		1
IC-PTP+M			1			1
ICRDCC		1		2		2
INVOL CRIM	19	20	29	30	32	130
INVOL-CIV	1	2	7	2	1	13
PCHDCC		1		2		3
PCHDCC+M			1	1	1	3
VOL	35	34	11	10	13	103
VOL-OTHER	1	1	1	2		5
ICDCC-M				3		3

# COMMUNITY FORENSIC ACT TEAM

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

Indicators	Findings	Compliance	Threshold Percentile
1. The ACT Team Director will review all client cases of re-hospitalization from the community for patterns and trends of the contributing factors leading to re-hospitalization each quarter. The following elements are considered during the review:  a. Length of stay in community b. Type of residence (i.e.: group home, apartment, etc) c. Geographic location of residence d. Community support network e. Client demographics (age, gender, financial) f. Behavior pattern/mental status g. Medication adherence h. Level of communication with ACT Team	2 clients were re-admitted for exacerbation of symptoms, both well established in the community (over one year for both). Both stays were under 30 days and extensive transition plans back to community placements were attended by both inpatient and outpatient treatment teams.	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.	100%	100%	100%

### Summary

1. The 2 male clients resided in group home and independent apartment, respectively. In the former case, it appears that a prescribed reduction in medication may have caused the return of symptoms, which was what was addressed in the hospital. In the second case, it appears that decompensation was due in large part to a reluctance to take medications as prescribed, as well as taking on many responsibilities very quickly. These issues were the focus of his hospitalization.
2. The ACT Team continues to place strong emphasis on collaborative in treatment team meeting participation while clients are in the hospital, particularly regarding recommendations for goals of re-hospitalization and transition back to the community.

# COMMUNITY FORENSIC ACT TEAM

## ASPECT: INSTITUTIONAL AND ANNUAL REPORTS

Indicators	Findings	Compliance	Threshold Percentile
3. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of notification of submitted petition.	4 of 7 on time	60%	95%
4. 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.	4 new court orders, all reviewed.	100%	100%
5. Annual Reports (due Nov) to the commissioner for all out-patient Riverview ACT NCR clients are submitted annually	N/A	N/A	100%

### Summary

1. Eight clients petitioned to have their cases heard on the 5/13/11 court date; one withdrew his petition so seven went to court. Four of seven had Institutional reports completed on time. The major factor influencing this poor outcome was the continued revision of the internal process for writing/filing reports. The process has been further improved to include essential reviewers and continued emphasis on deadlines triggered with the receipt of petitions.
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.
3. Annual Reports were not due within this quarter.

## ASPECT: SUBSTANCE ABUSE AND ADDICTIVE BEHAVIOR HISTORY

Indicators	Findings	Compliance	Threshold Percentile
1. age of onset documented in Comprehensive Assessment	39/42	90%	95%
2. duration of behavior documented in C.A. and progress notes	39/42	90%	95%
3. pattern of behavior documented in C.A. and progress notes	39/42	90%	95%

### Summary

The Co-Occurring Specialist has reviewed all urinalyses for illicit drug/alcohol us, as well as appropriateness of substances screened for. This has streamlined the process of responding to the client with the information and will identify one point-person for the Maine General Lab for drug screens (Co-Occurring Specialist) and one for all other lab work (Nurse). Our randomization of urinalyses for drug/alcohol detection implemented by the Co-Occurring Specialist has been adapted to meet the MaineCare standards in order for lab work to be funded (no more than one time in 7 days).

# COMMUNITY FORENSIC ACT 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.	41/42	95%	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.	42/42	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.	10/10	100%	95%

### Summary

1. Clients in transition from ACT to other community resources have had less than weekly direct contact but are discussed weekly in clinical meeting and are seen face to face at least 4 times per month (averaging weekly contacts).
2. ISPs also contain group attendance goals, especially with clients who are petitioning for increased court ordered privileges. Case managers are focused on including group attendance in ISP goals.
3. One client in an outlying status is now seeing the ACT Team Psychiatrist as his State Provider, but is petitioning the court for the privilege of utilizing a community-based psychiatrist nearer his home.

## ASPECT: PEER SUPPORT

Indicators	Findings	Compliance	Threshold Percentile
1. Engagement attempt with client within 7 days of admission.	1/1	100%	95%
2. Documented offer of peer support services.	1/1	100%	95%
3. Attendance at treatment team meetings as appropriate.	25/30	80%	95%

### Summary

The Peer Support Specialist makes every effort to attend treatment team meetings at ACT offices and in hospital; this quarter the Peer Support Specialist has returned to work full time within the reporting period, and as expected, we saw excellent results. The number and quality of contacts with clients by Peer Support continues to contribute 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.	<b>July</b> Twenty surveys were done by in-house clients as well as outpatient, all were positive.	100%	90%
	<b>August</b> Twenty surveys were done by in-house clients as well as outpatient, all were positive.	100%	90%
	<b>September</b> Twenty-five surveys were done by in-house clients as well as outpatient, all were positive.	100 %	90%

### Summary

Sixty five surveys were returned and all showed positive results for the 1<sup>st</sup> quarter 2012.

### 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
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"> <li>• Bleeding</li> <li>• Swelling</li> <li>• Pain</li> <li>• Muscle soreness</li> <li>• Mouth care</li> <li>• Diet</li> <li>• Signs/symptoms of infection</li> </ul> b. The client, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist.	<b>July</b> Six extractions were performed. Post extraction instructions verbalized to each client. Client repeated back to Dental Assistant that they understood the instructions without difficulty.	100%	100%
	<b>August</b> Four extractions were performed. Post extraction instructions verbalized to each client. Client repeated back to Dental Assistant that they understood the instructions without difficulty.	100%	100%
	<b>September</b> Four extractions were performed. Post extraction instructions verbalized to each client. Client repeated back to Dental Assistant that they understood the instructions without difficulty.	100%	100%

### Summary

There were fourteen extractions in the first quarter 2012. 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 the client’s progress. Of the fourteen calls made, there were no issues or complications post procedure. Reports were reviewed at monthly staff meetings and forwarded quarterly to RPC.

### 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
<p>National Patient Safety Goals</p> <p>Goal 1: Improve the accuracy of Client Identification.</p> <p>Capital Community Dental Clinic assures accurate client identification by asking the client to state his/her name and date of birth.</p> <p>Goal 2: Verify the correct procedure and site for each procedure.</p> <p>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.</p>	<p><b>July</b> There were six extractions for the month, The client was given a time out to identify extraction site, and asked to state their name and dob.</p>	100 %	100%
	<p><b>August</b> There were four extractions done for the month. The each client was given a time out to identify extraction site, and asked to state their name and dob.</p>	100%	100%
	<p><b>September</b> There were four extractions done for the month. The each client was given a time out to identify extraction site, and asked to state their name and dob.</p>	100%	100%

### Summary:

In the 1st quarter 2012, fourteen clients had extractions. In all fourteen cases there is appropriate documentation of a time-out procedure prior to the extraction. The client was asked to identify the extraction site and was also asked to identify themselves by providing their full name and date of birth.

### Actions

The dental clinic staff will continue to report and monitor performance of key safety strategies.

# 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.	<b>July</b> Thirty-six clients that had scheduled appointments had their vitals signs taken before their clinic appointment.	100%	100%
	<b>August</b> There were thirty-six clients scheduled for appointments during the month of February. All clients had vital signs taken before their appointment.	100%	100%
	<b>September</b> There were thirty-two clients scheduled for appointments. All clients had their vital signs taken before their clinic appointment.	100%	100%

### Summary

For the 1<sup>st</sup> quarter 2012 there were 104 clients. All clients had their vitals taken before their scheduled appointment. This information was reviewed at monthly staff meetings and reports forwarded quarterly to RPC Quality Council.

### Actions

Staff will continue to strive for 100% of the goal. Staff will monitor and report monthly, as well as quarterly to RPC.

# CLIENT SATISFACTION

## ASPECT: CLIENT SATISFACTION WITH CARE

#	Indicators	Findings	
		Results	% Change
1	I am better able to deal with crisis.	52%	+13%
2	My symptoms are not bothering me as much.	65%	+36%
3	The medications I am taking help me control symptoms that used to bother me.	54%	+20%
4	I do better in social situations.	37%	0%
5	I deal more effectively with daily problems.	50%	+29%
6	I was treated with dignity and respect.	33%	+7%
7	Staff here believed that I could grow, change and recover.	50%	+24%
8	I felt comfortable asking questions about my treatment and medications.	48%	+30%
9	I was encouraged to use self-help/support groups.	43%	-2%
10	I was given information about how to manage my medication side effects.	33%	+7%
11	My other medical conditions were treated.	20%	+4%
12	I felt this hospital stay was necessary.	20%	+12%
13	I felt free to complain without fear of retaliation.	17%	+9%
14	I felt safe to refuse medication or treatment during my hospital stay.	-7%	+4%
15	My complaints and grievances were addressed.	30%	+6%
16	I participated in planning my discharge.	35%	-2%
17	Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.	4%	-12%
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	11%	-23%
19	The surroundings and atmosphere at the hospital helped me get better.	37%	+11%
20	I felt I had enough privacy in the hospital.	24%	-10%

# CLIENT SATISFACTION

#	Indicators	Findings	
		Results	% Change
21	I felt safe while I was in the hospital.	43%	+9%
22	The hospital environment was clean and comfortable.	52%	+7%
23	Staff were sensitive to my cultural background.	13%	-5%
24	My family and/or friends were able to visit me.	63%	+18%
25	I had a choice of treatment options.	17%	-7%
26	My contact with my doctor was helpful.	33%	+1%
27	My contact with nurses and therapists was helpful.	54%	+17%
28	If I had a choice of hospitals, I would still choose this one.	30%	+9%
29	Did anyone tell you about your rights?	33%	+1%
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	11%	-5%
31	Do you know someone who can help you get what you want or stand up for your rights?	41%	+12%
32	My pain was managed.	15%	+10%

ND = no data

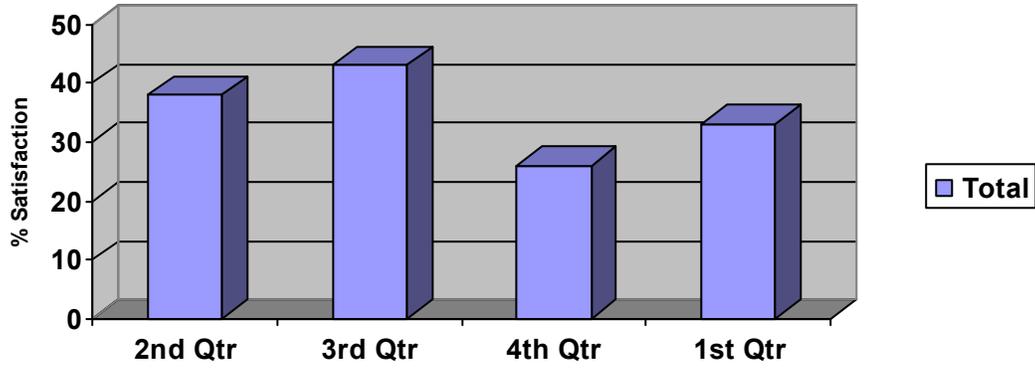
## Summary

Positive scores indicate satisfaction, while negative scores indicate dissatisfaction. Percentages are calculated using actual weighted scores and highest possible score for each indicator. The total number of respondents was 23. The first column indicates the score for 1<sup>st</sup> quarter and the second column shows increases/decreases from 4<sup>th</sup> quarter. Overall satisfaction for 1<sup>st</sup> quarter increased 7%.

All but 8 indicators went up, with the most significant increases relating to illness/symptom management. There were 7 indicators that continue to drop, primarily related to treatment/ discharge planning and involvement.

# CLIENT SATISFACTION

**Total Satisfaction**



# 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](#)
- [Confinement Events Analysis](#)
- [Confinement Events Management](#)
- [Medication Administration during Behavioral Events](#)

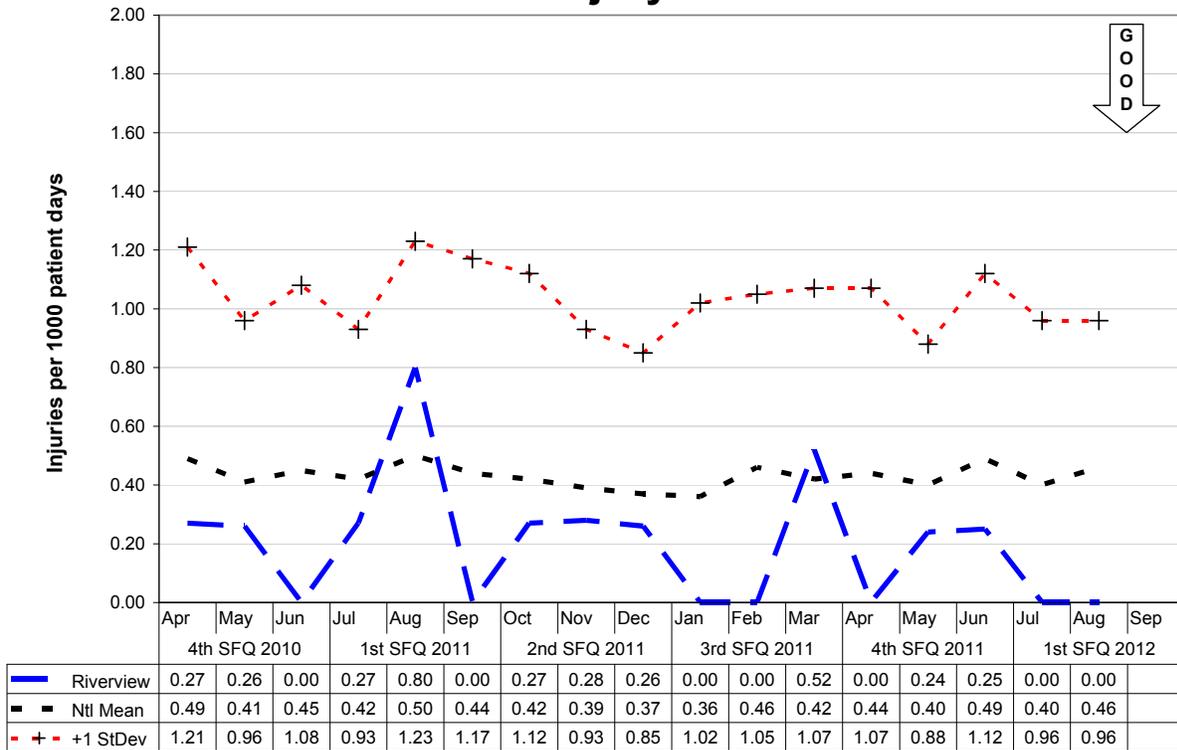
In addition to the areas of performance listed above, each of the comparative statistics areas includes a graph that depicts the stratification of forensic and non-forensic (civil) services provided to clients. This is new information that is being provided by the National Association of State Mental 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

Figure CD-29

## 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, 2) Minor First Aid, or 3) Medical Intervention

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

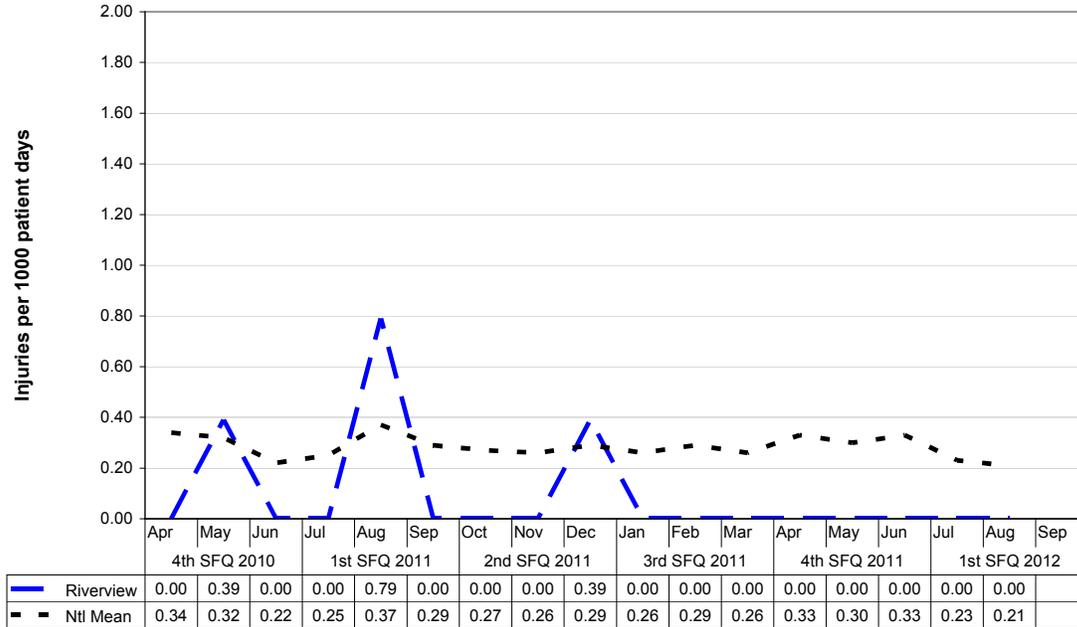
- No Treatment – The injury received by a client may be examined by a clinician but no treatment is applied to the injury.
- Minor First Aid – The injury received is of minor severity and requires the administration of minor first aid.
- Medical Intervention Needed – The injury received is severe enough 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

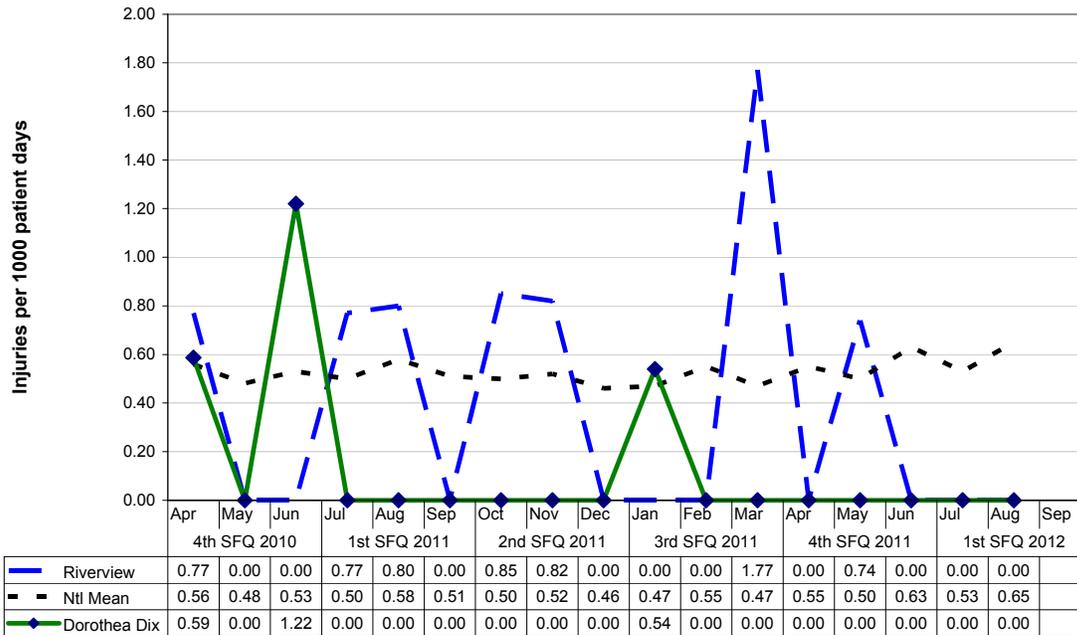
## Client Injury Rate

Forensic Stratification



## Client Injury Rate

Civil Stratification



These graphs depict the number of client injury events stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days. The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

# COMPARATIVE STATISTICS

## ASPECT: SEVERITY OF INJURY BY MONTH

<b>Severity</b>	<b>Jul</b>	<b>Aug</b>	<b>Sep</b>	<b>1<sup>st</sup> FQ 2012</b>
No Treatment	1	2	2	5
Minor First Aid	4		1	5
Medical Intervention Required	2		2	4
Hospitalization Required				
Death Occurred				
<b>Total</b>	<b>7</b>	<b>2</b>	<b>5</b>	<b>14</b>

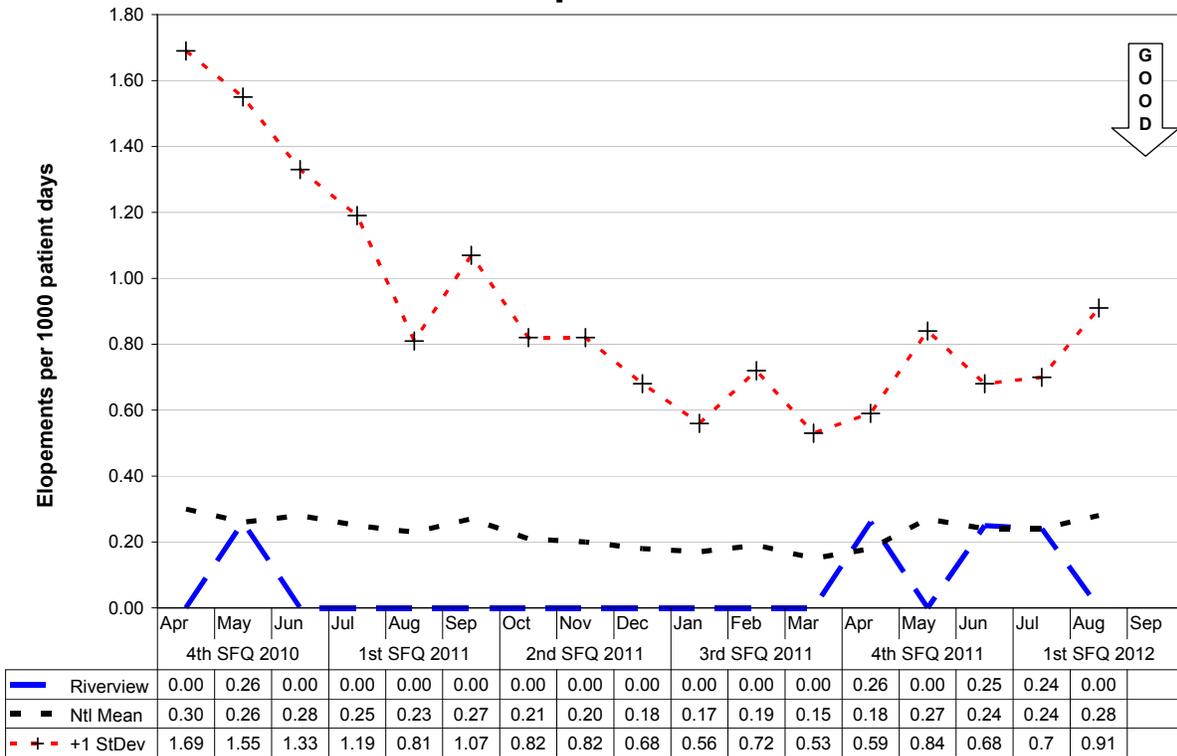
## ASPECT: TYPE AND CAUSE OF INJURY BY MONTH

<b>Type - Cause</b>	<b>Jul</b>	<b>Aug</b>	<b>Sep</b>	<b>1<sup>st</sup> FQ 2012</b>
Accident - Environmental	1			1
Accident – Equipment Use	2			2
Accident – Fall Unwitnessed	1			1
Accident – Fall Witnessed	1			1
Accident – Other	2	2	3	7
Accident – Unknown			1	1
Self-Injurious Behavior			1	1

# COMPARATIVE STATISTICS

Figure CD-28

## Elopement

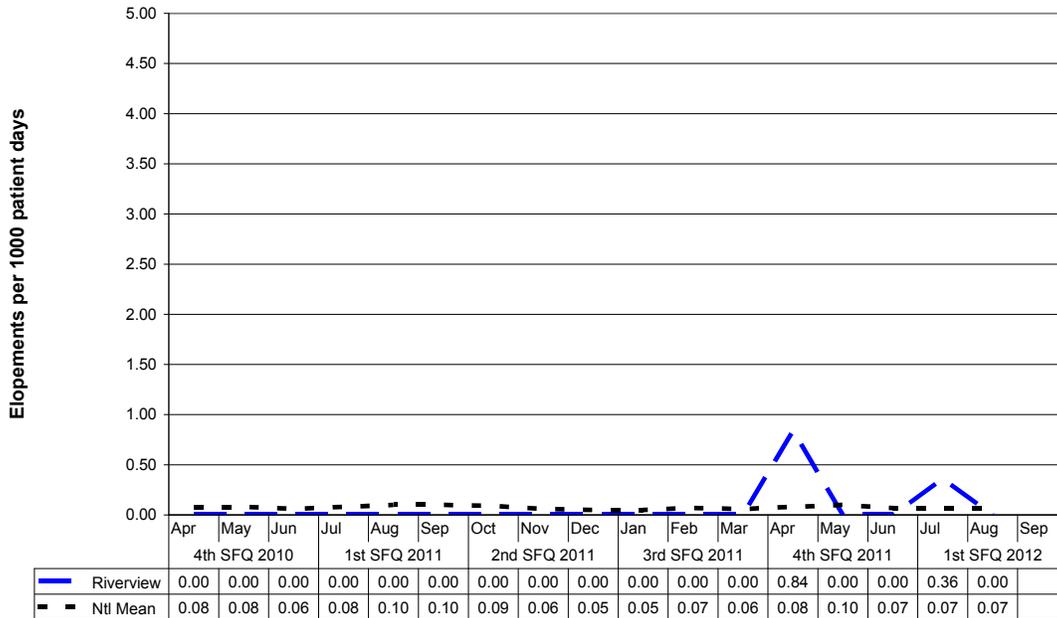


This graph depicts the number of elopements that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

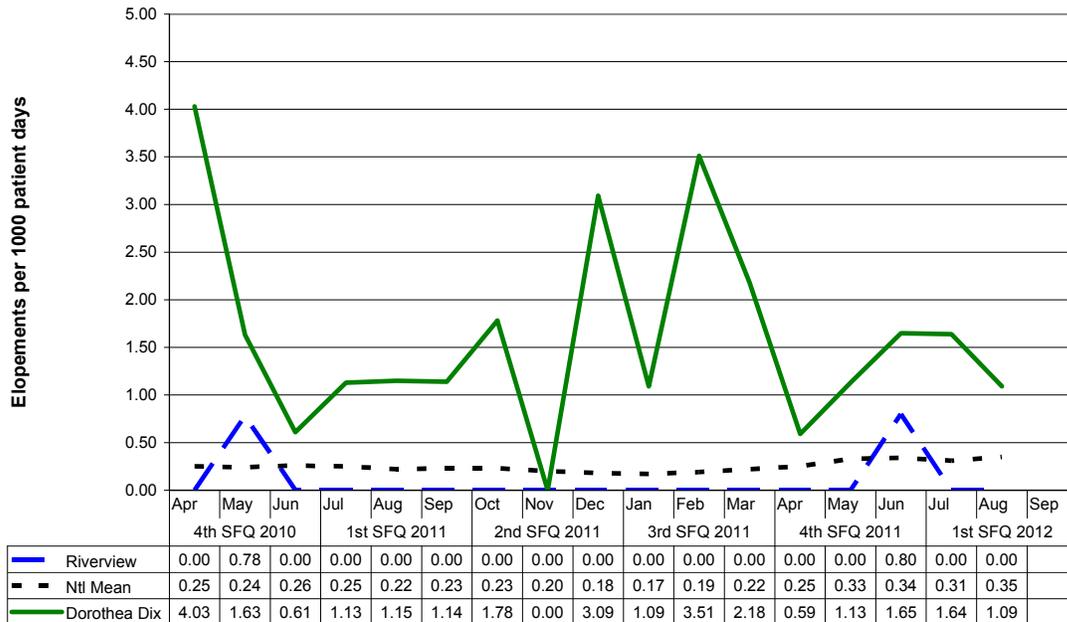
An elopement is defined as any time a client is “absent from a location defined by the client’s privilege status regardless of the client’s leave or legal status.”

# COMPARATIVE STATISTICS

## Elopement Forensic Stratification



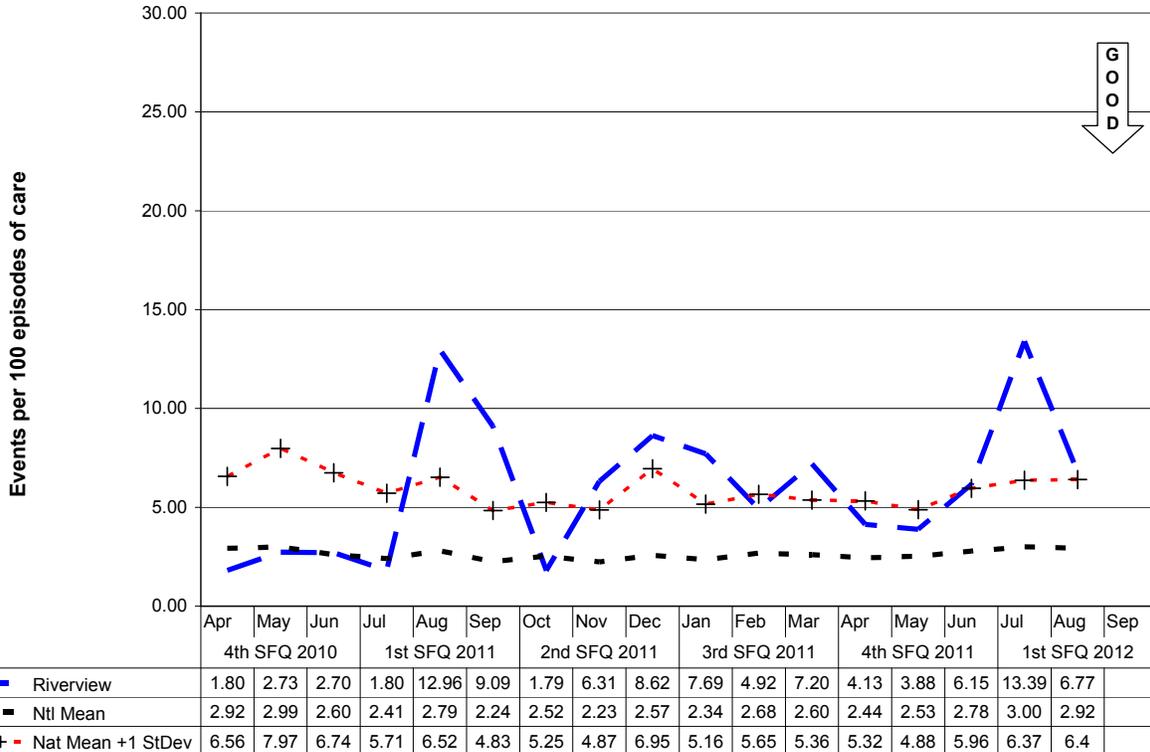
## Elopement Civil Stratification



This graph depicts the number of elopements stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days. The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

# COMPARATIVE STATISTICS

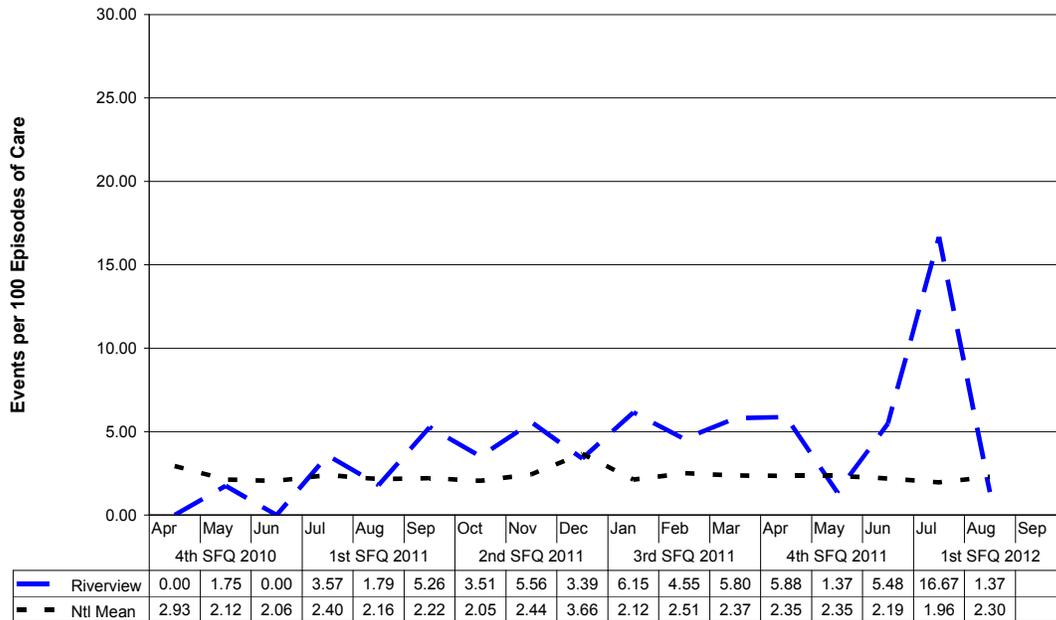
## Medication Errors



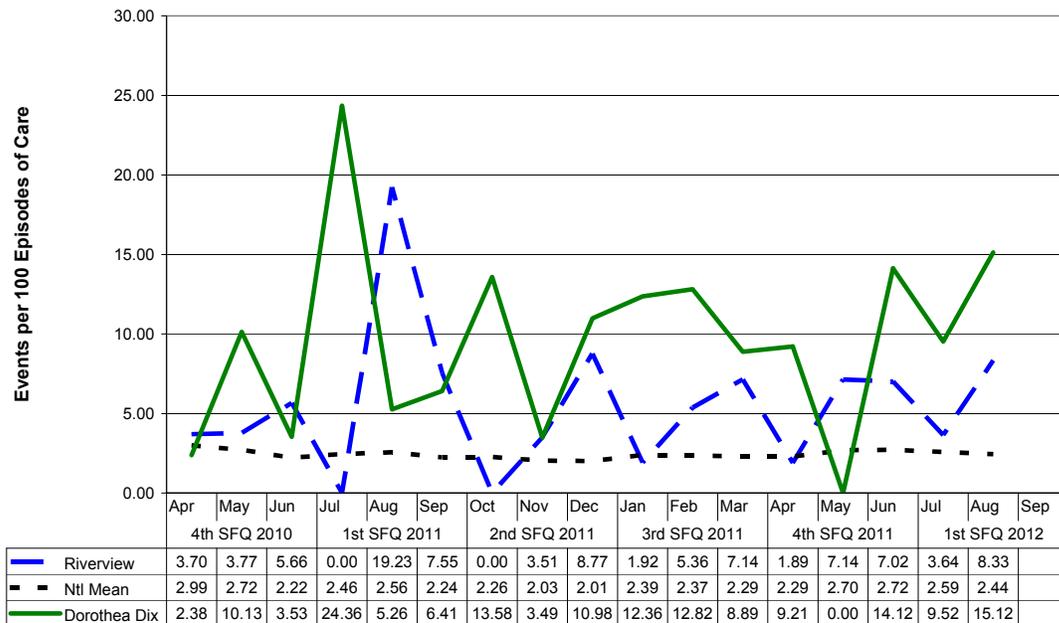
This graph depicts the number of medication error events that occurred for every 100 episodes of care (duplicated client count). For example, a rate of 1.6 means that 2 medication error events occurred for each 125 episodes of care.

# COMPARATIVE STATISTICS

## Medication Errors Forensic Stratification



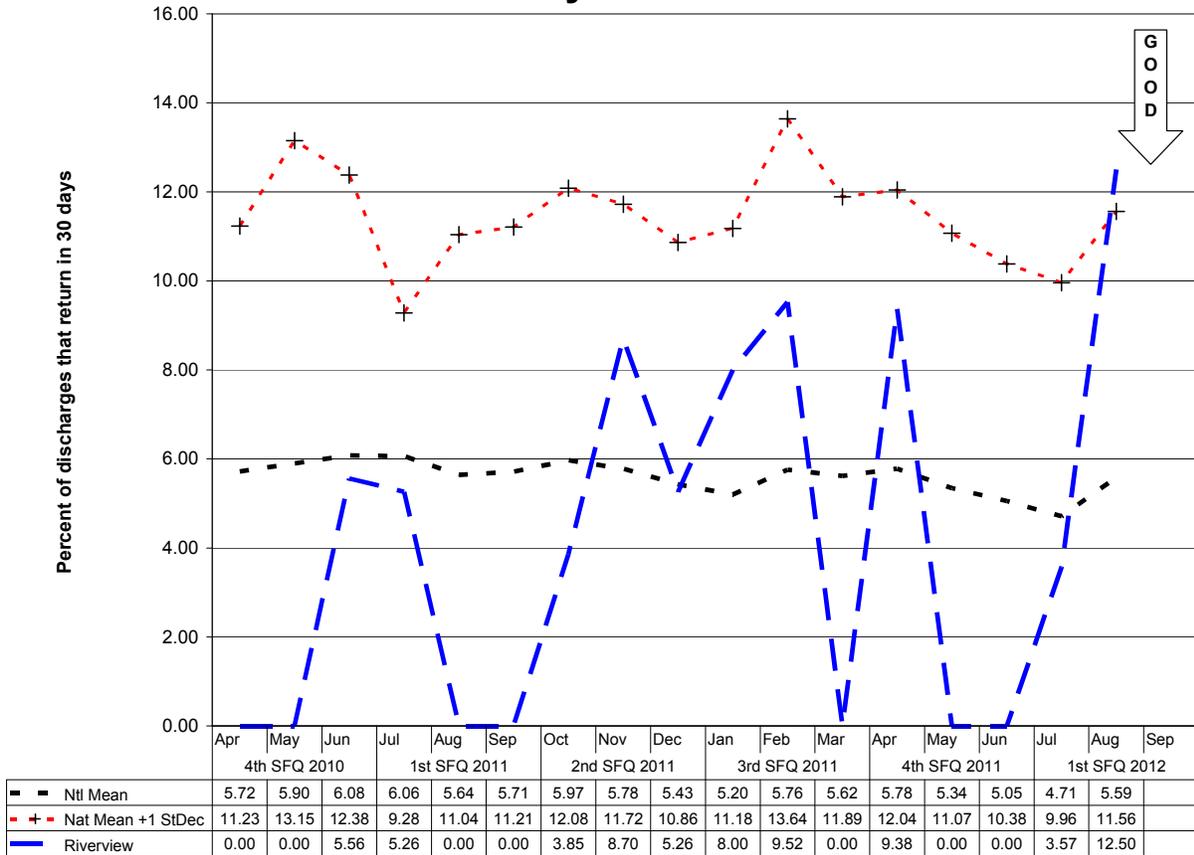
## Medication Errors Civil Stratification



This graph depicts the number of medication error events stratified by forensic or civil classifications 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. The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

# COMPARATIVE STATISTICS

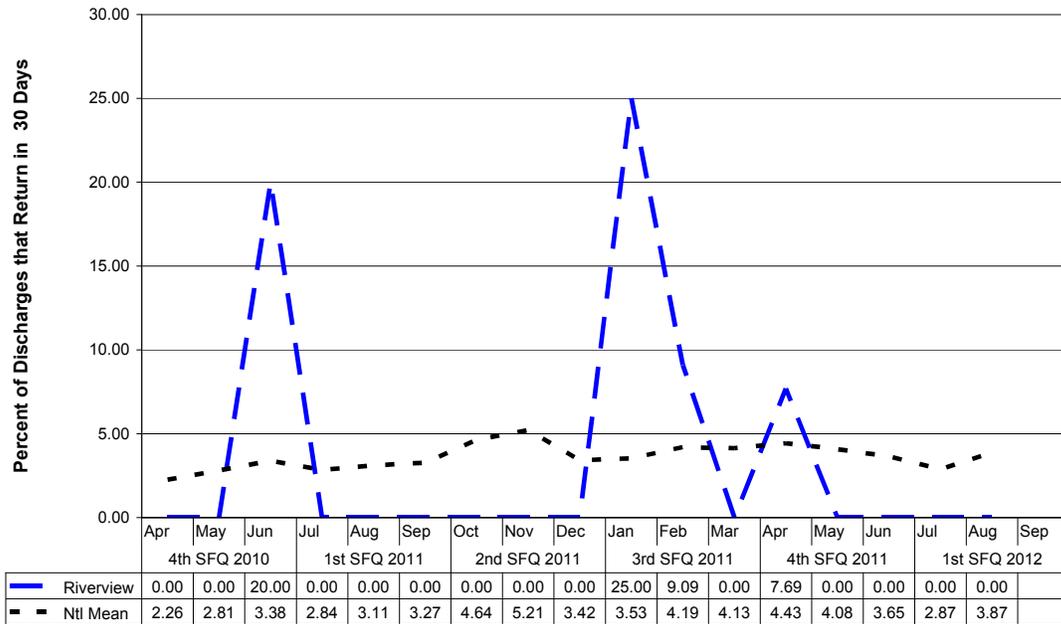
## 30 Day Readmit



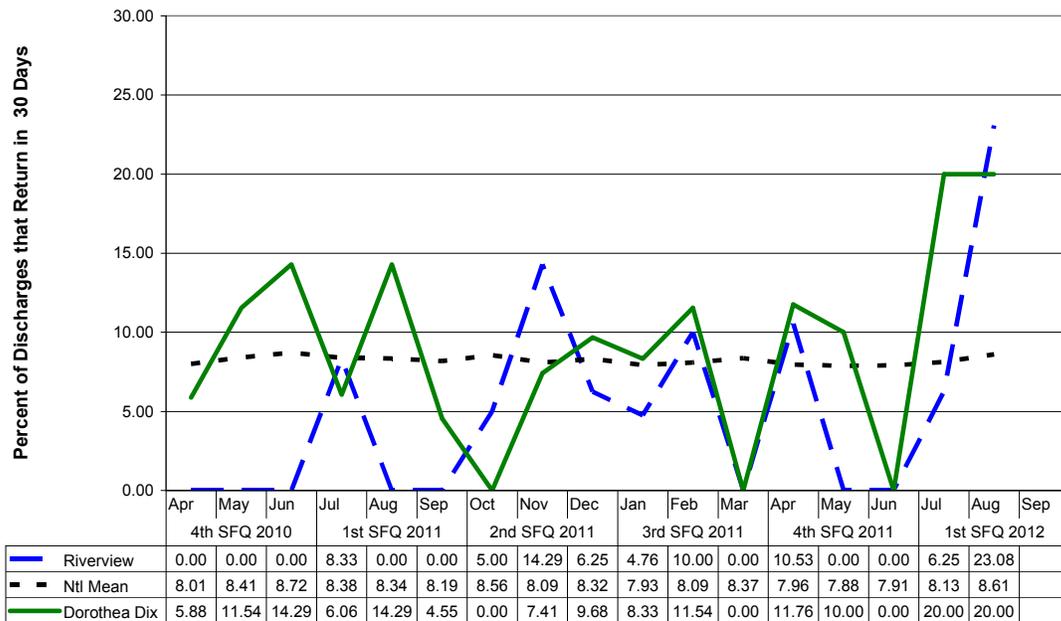
This graph depicts the percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility. For example, a rate of 10.0 means that 10% of all discharges were readmitted within 30 days.

# COMPARATIVE STATISTICS

## 30 Day Readmit Forensic Stratification



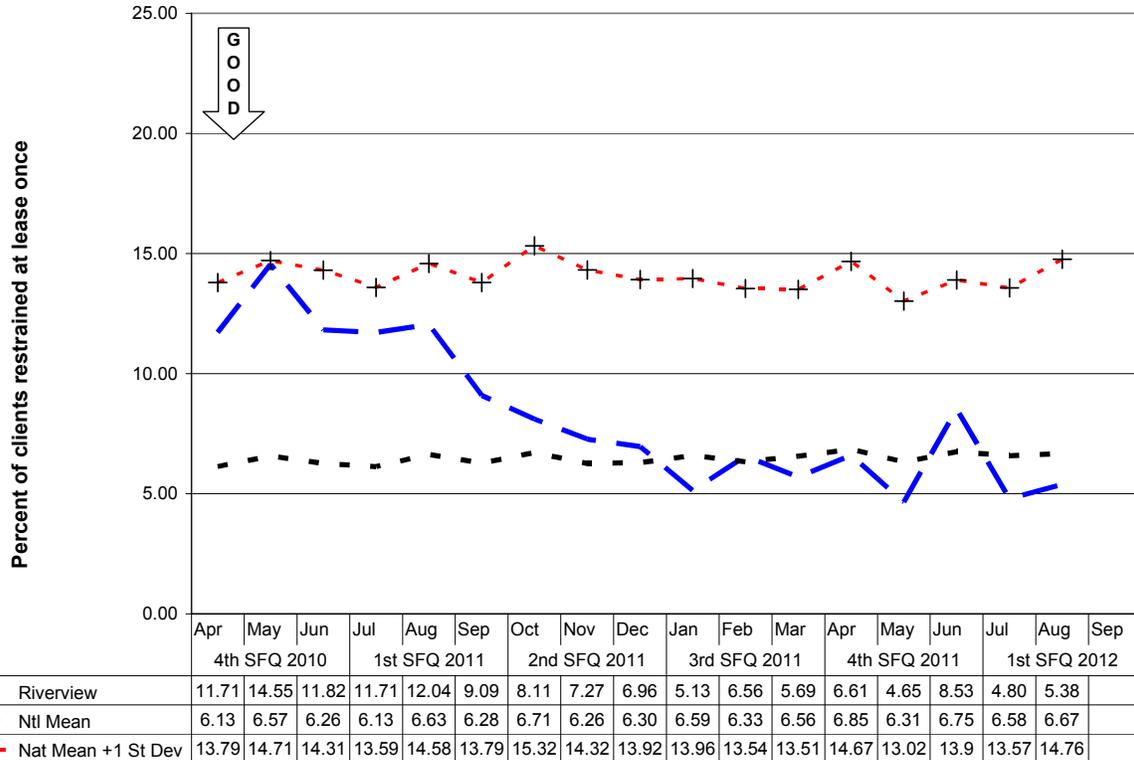
## 30 Day Readmit Civil Stratification



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

# COMPARATIVE STATISTICS

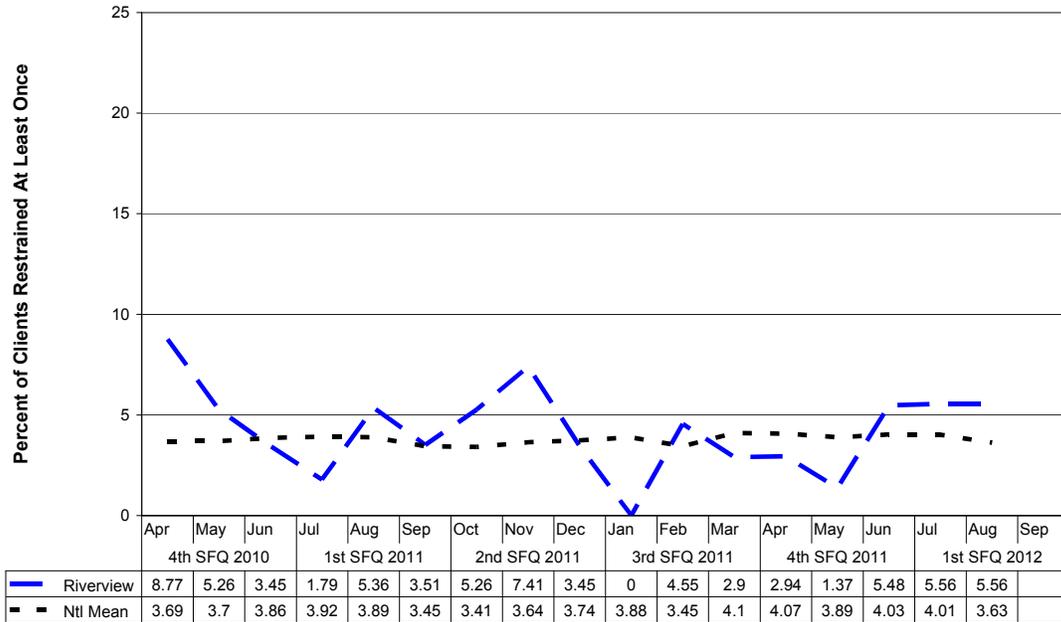
## Percent of Clients Restrained



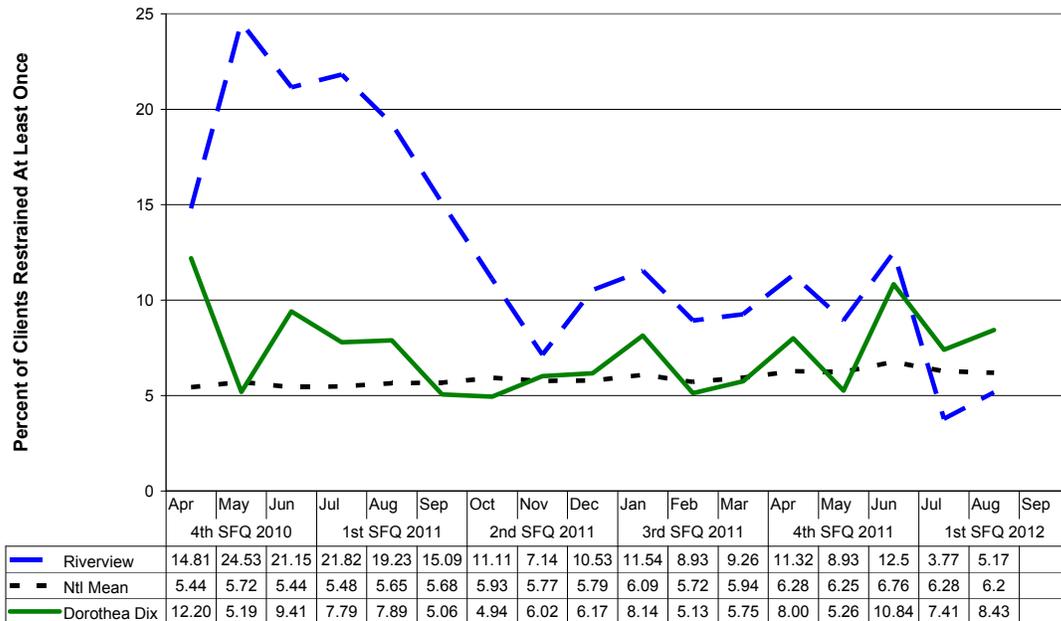
This graph depicts the percent of unique clients who were restrained at least once – includes all forms of restraint of any duration. For example, a rate of 4.0 means that 4% of the unique clients served were restrained at least once.

# COMPARATIVE STATISTICS

## Percent of Clients Restrained Forensic Stratification



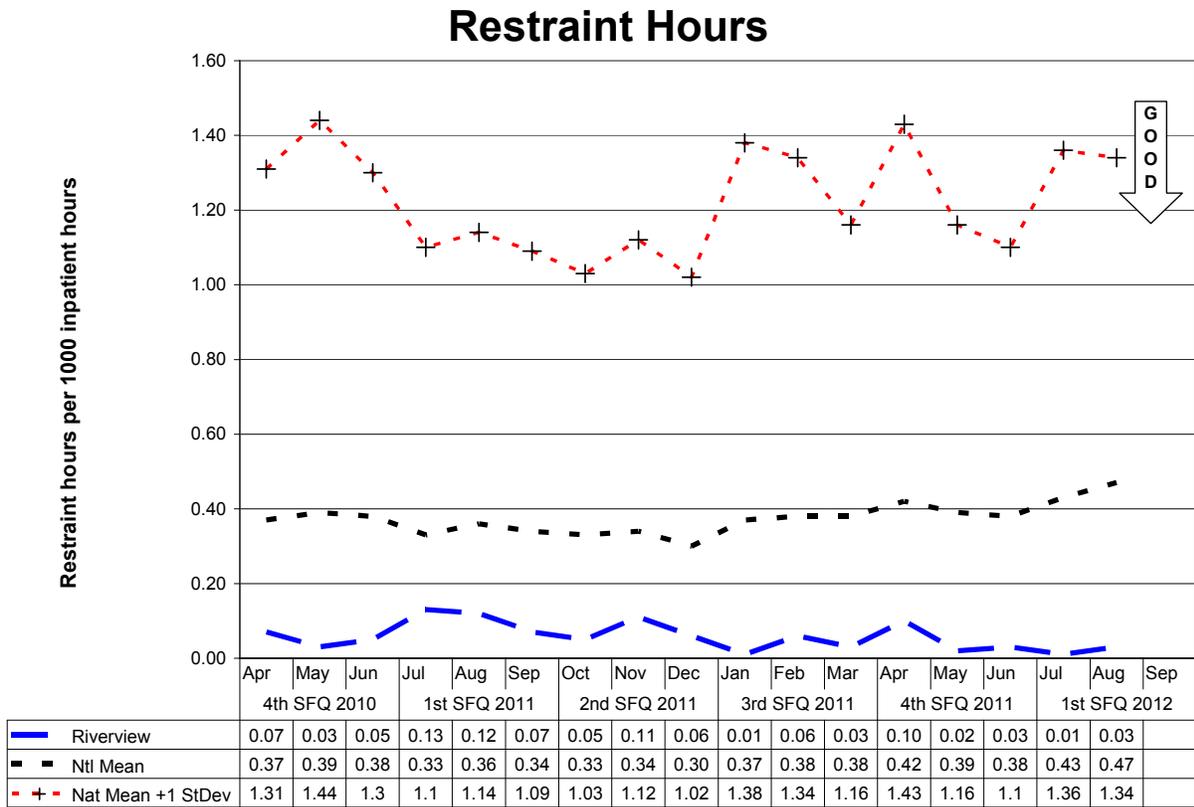
## Percent of Clients Restrained Civil Stratification



This graph depicts the percent of unique clients who were restrained at least once stratified by forensic or civil classifications – includes all forms of restraint of any duration. For example, a rate of 4.0 means that 4% of the unique clients served were restrained at least once. The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

# COMPARATIVE STATISTICS

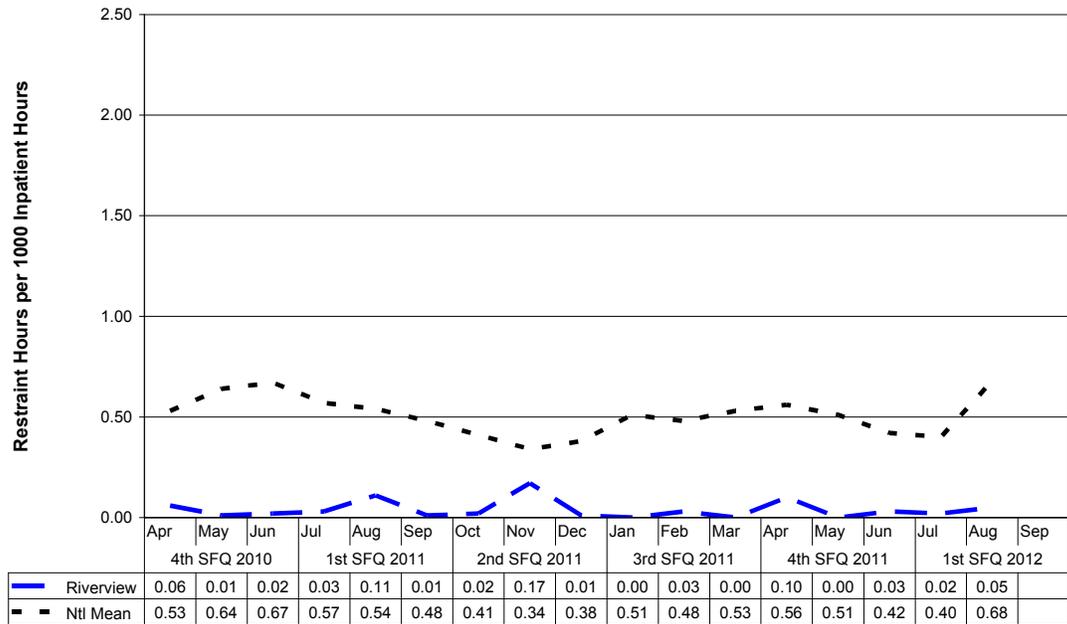
Figure CD-24



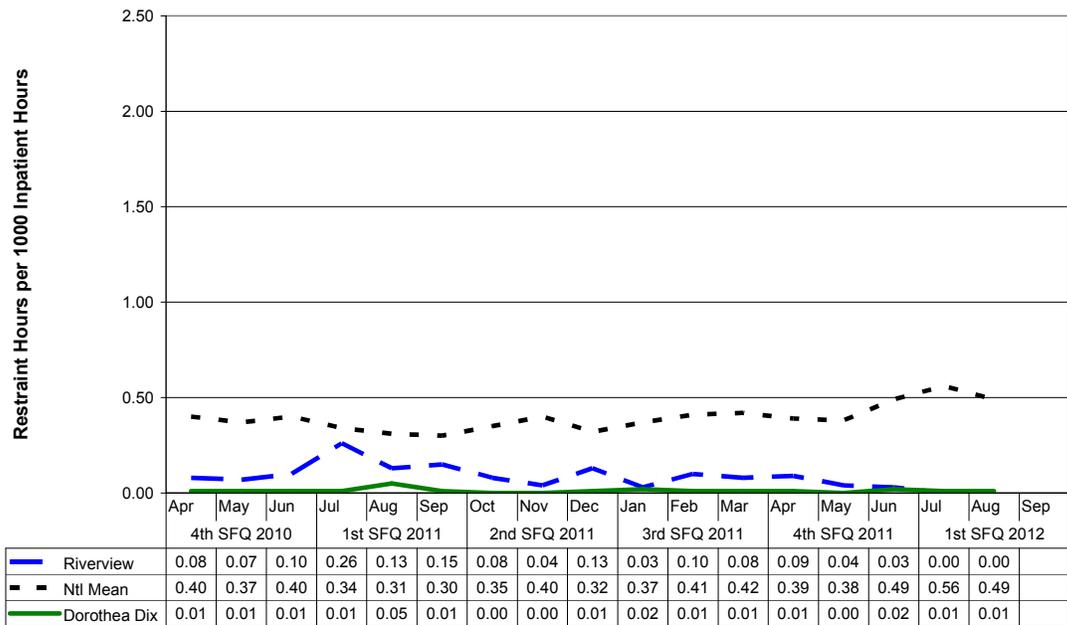
This graph depicts the number of hours clients spent in restraint for every 1000 inpatient hours - includes all forms of restraint of any duration. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours.

# COMPARATIVE STATISTICS

## Restraint Hours Forensic Stratification



## Restraint Hours Civil Stratification

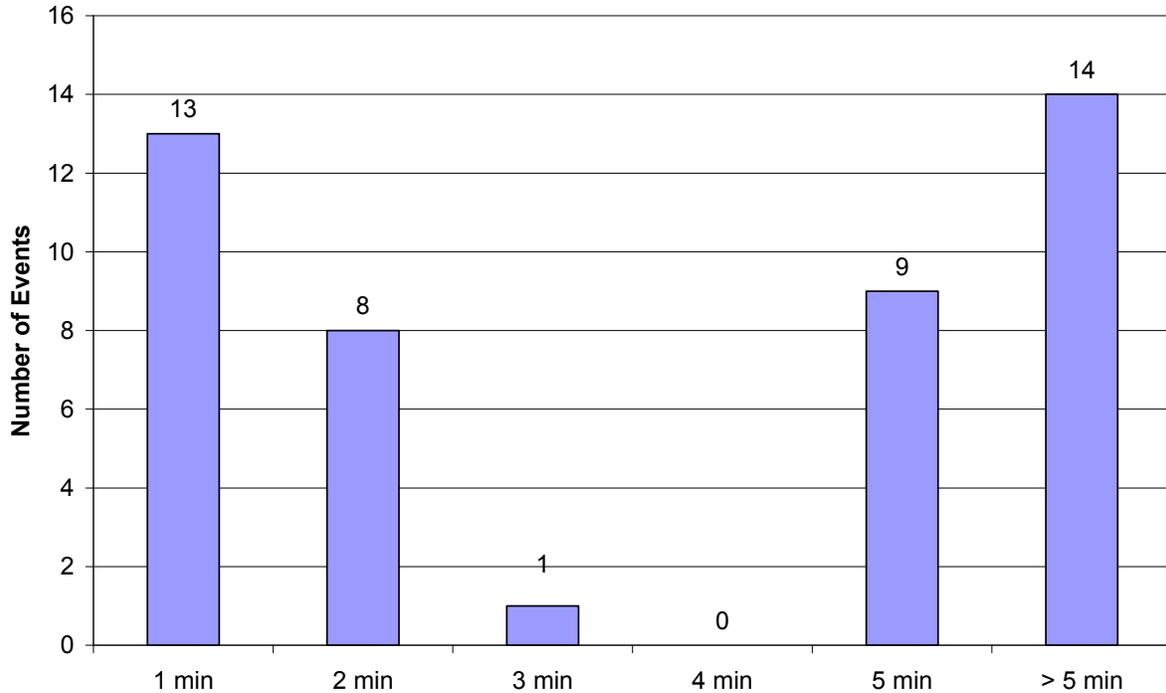


This graph depicts the number of hours clients spent in restraint for every 1000 inpatient hours stratified by forensic or civil classifications - includes all forms of restraint of any duration. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours. The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

# COMPARATIVE STATISTICS

## Duration of Manual Hold (Restraint) Events

July - September 2011



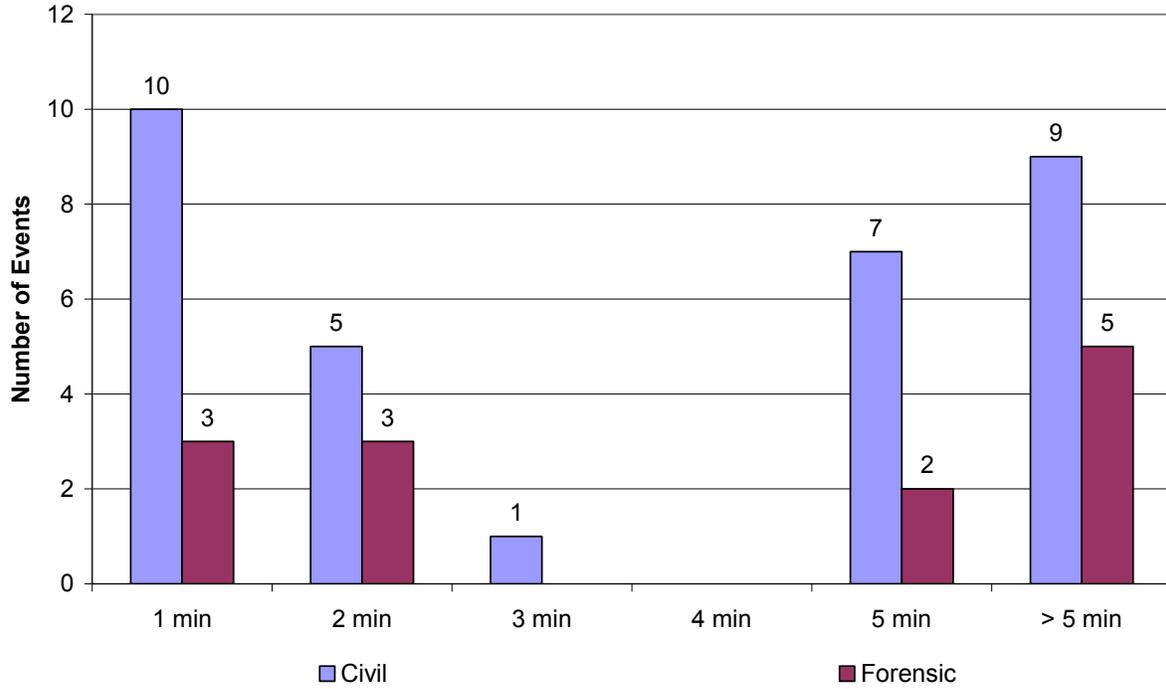
The overall number of manual hold events as well as the number of clients restrained for greater than 5 minutes decreased during the 1<sup>st</sup> quarter 2012. The overall decrease in the number of manual holds was 22% during the period (from 58 to 45) and the decrease in manual holds greater than 5 minutes was 36% (from 22 to 14).

Manual holds greater than 5 minutes most often result from a clinical assessment of the clients acuity and the potential for injury should the patient be left alone and without the control afforded by the manual hold. Those clients with the greatest number of manual holds over five minutes are usually suicidal, exhibit self injurious behaviors, or are highly psychotic and require one on one control that other methods of containment (e.g. seclusion) do not offer.

The decision on how each incident is managed is made on an individualized basis depending on the presentation and needs of the client. Each event is reviewed during the debriefing process and changes in methods of managing the events related to each client are evaluated to determine opportunities for improvement.

# COMPARATIVE STATISTICS

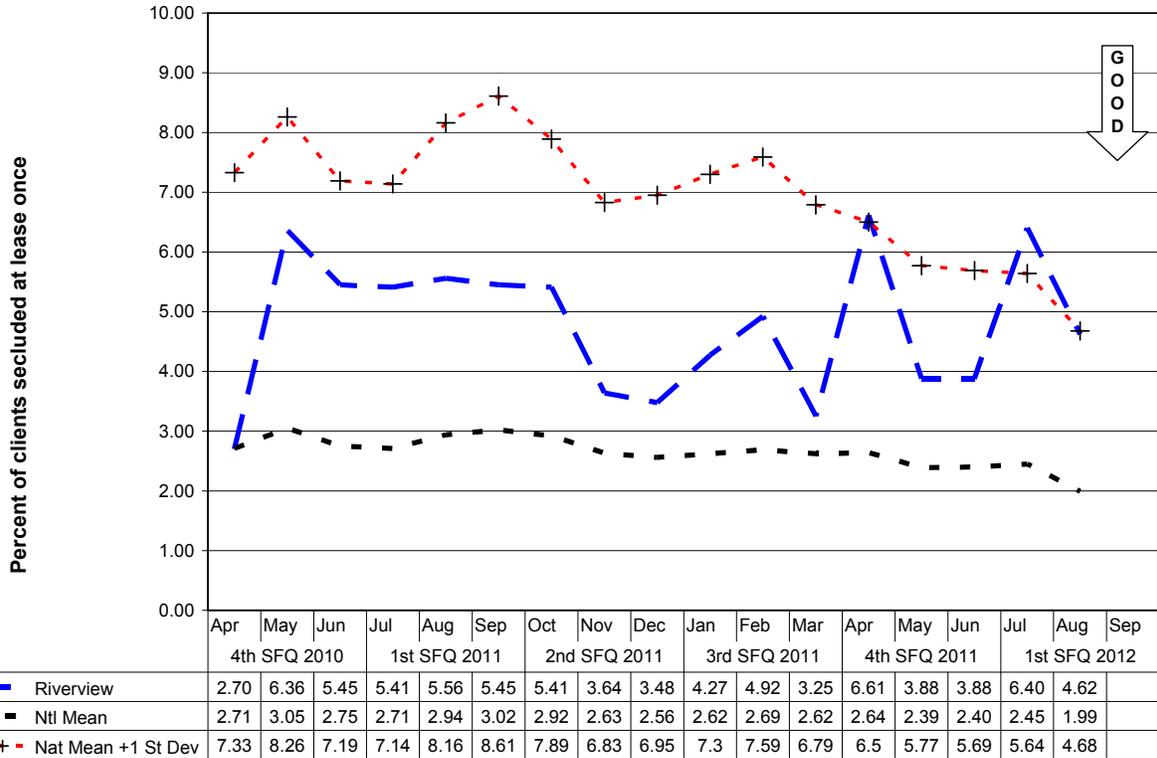
**Duration of Manual Hold (Restraint) Events**  
Forensic and Civil Stratification  
July - September 2011



The mix of manual hold incidents in this chart depicts the differentiation between the civil and forensic units.

# COMPARATIVE STATISTICS

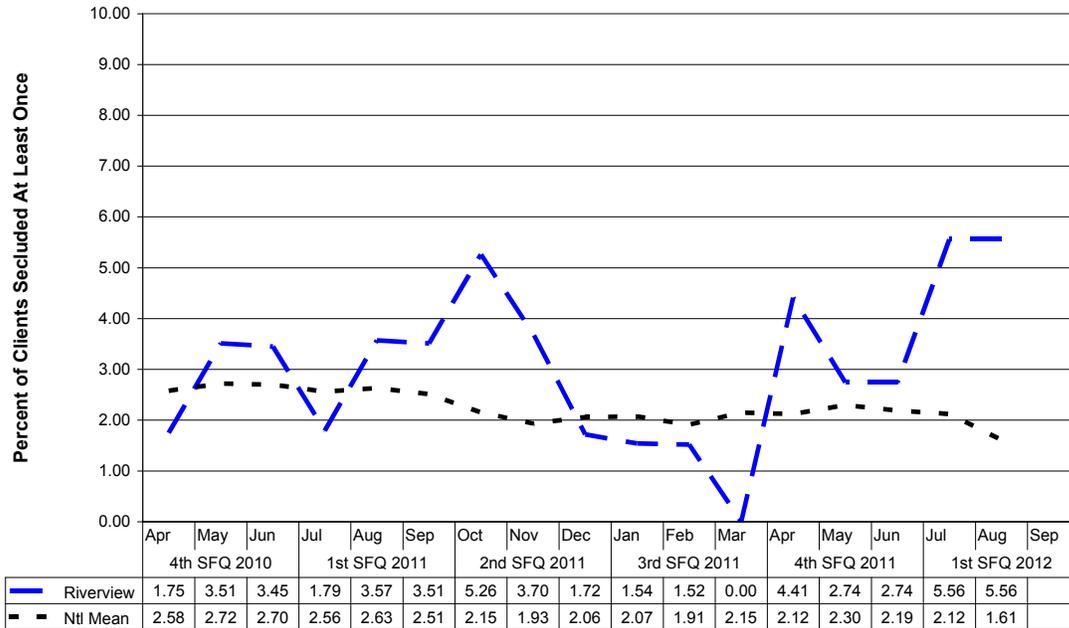
## Percent of Clients Secluded



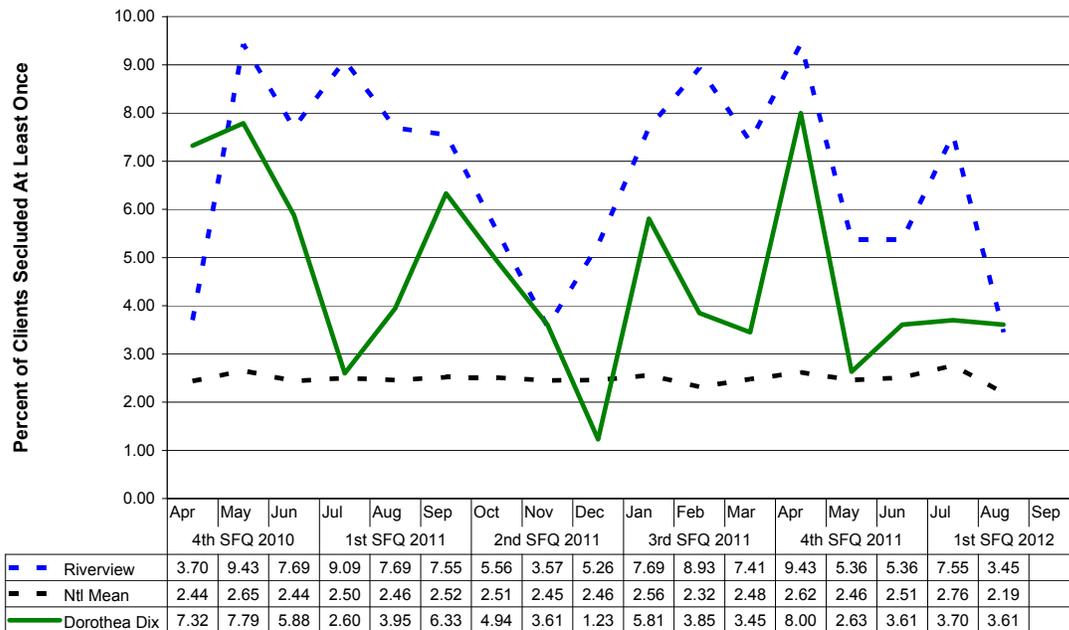
This graph depicts the percent of unique clients who were secluded at least once. For example, a rate of 3.0 means that 3% of the unique clients served were secluded at least once.

# COMPARATIVE STATISTICS

## Percent of Clients Secluded Forensic Stratification



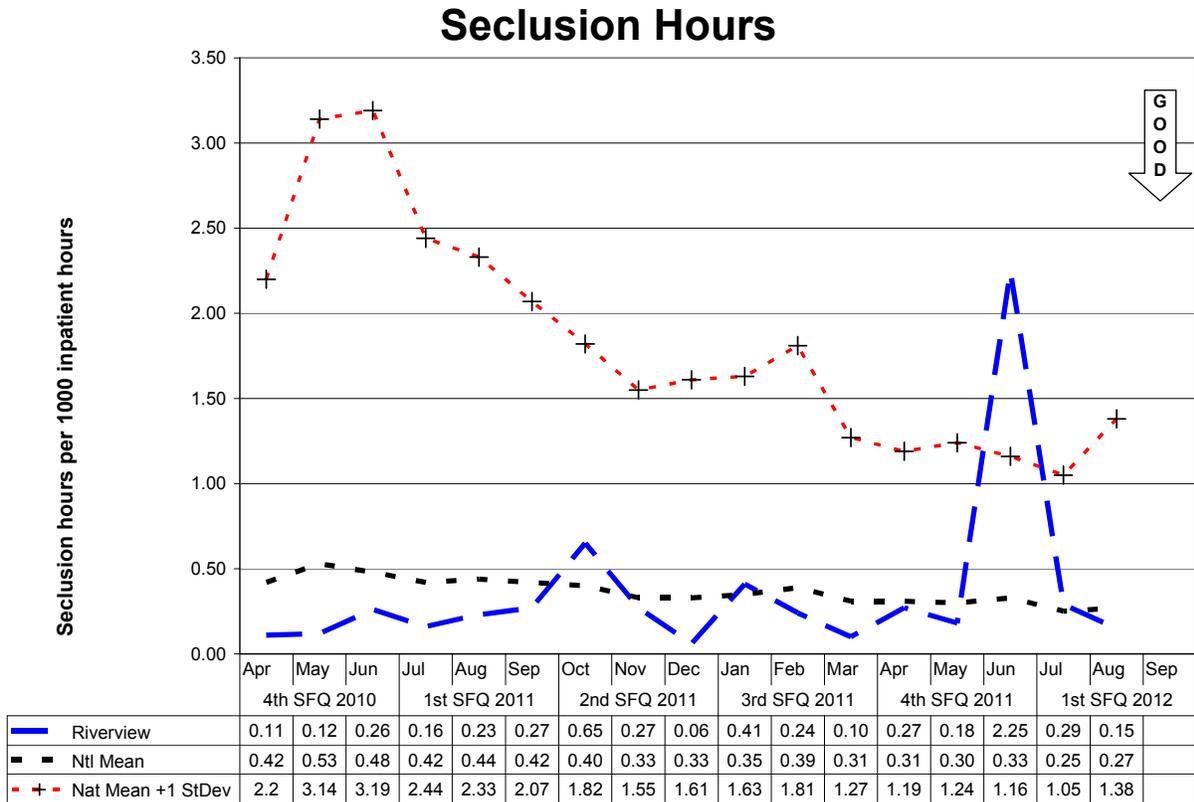
## Percent of Clients Secluded Civil Stratification



This graph depicts the percent of unique clients who were secluded at least once stratified by forensic or civil classifications. For example, a rate of 3.0 means that 3% of the unique clients served were secluded at least once. The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

# COMPARATIVE STATISTICS

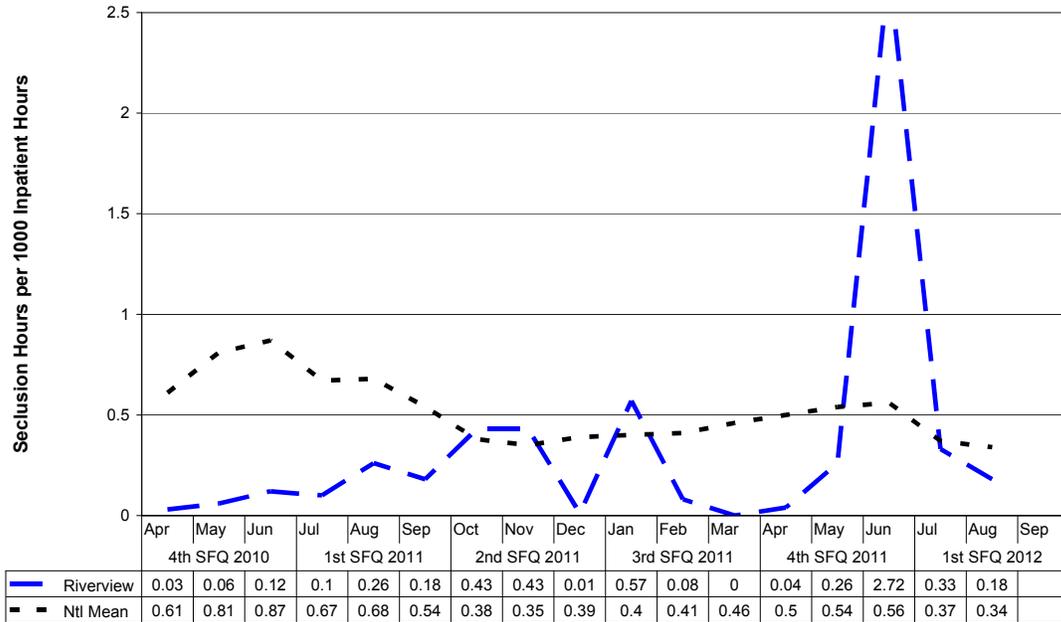
Figure CD-23



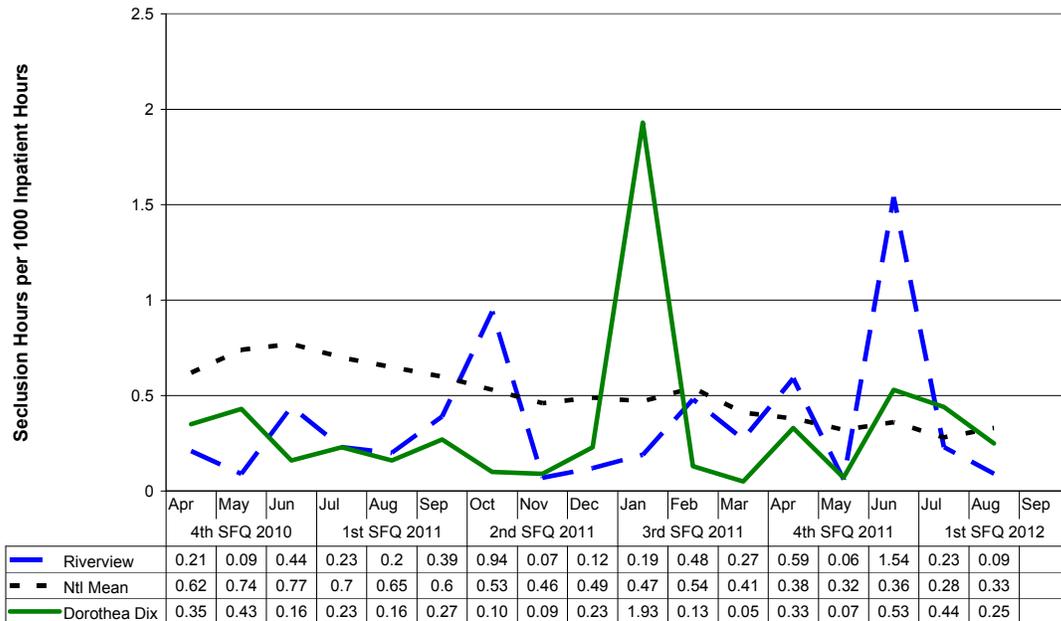
This graph depicts the number of hours clients spent in seclusion for every 1000 inpatient hours. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

# COMPARATIVE STATISTICS

## Seclusion Hours Forensic Stratification



## Seclusion Hours Forensic Stratification



This graph depicts the number of hours clients spent in seclusion for every 1000 inpatient hours stratified by forensic or civil classifications. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours. The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

# COMPARATIVE STATISTICS

## Confinement Event Breakdown

	Manual Hold	Mechanical Restraint	Locked Seclusion	Open Seclusion	Grand Total	% of Total	Cumulative %
MR00000763	5		8		13	15%	15%
MR00000045	10		1		11	13%	28%
MR00003766	4		5		9	11%	39%
MR00000477	5		3		8	9%	48%
MR00006495	2		5		7	8%	56%
MR00006509	5		2		7	8%	65%
MR00003726	1		5		6	7%	72%
MR00000091	2	1	1		4	5%	76%
MR00000092	2				2	2%	79%
MR00004271	1		1		2	2%	81%
MR00005620	1		1		2	2%	84%
MR00006391	1		1		2	2%	86%
MR00006487	1		1		2	2%	88%
MR00000273	1				1	1%	89%
MR00001106	1				1	1%	91%
MR00001416			1		1	1%	92%
MR00003374			1		1	1%	93%
MR00005334	1				1	1%	94%
MR00006330			1		1	1%	95%
MR00006402			1		1	1%	96%
MR00006437	1				1	1%	98%
MR00006456			1		1	1%	99%
MR00006491	1				1	1%	100%
Total	45	1	39		85		

28% (23/82) of average hospital population experienced some form of confinement event during the 1<sup>st</sup> fiscal quarter 2012. Twelve of these clients (15% of the average hospital population) accounted for 86% of the containment events.

## Confinement Events by Time of Day

	0000-0359	0400-0759	0800-1159	1200-1559	1600-1959	2000-2359
MR00000763			4	7		2
MR00000045		2	8	1		
MR00003766		1	4	3		1
MR00000477		1	2	2	3	
MR00006495		2	1	2	2	
MR00006509		2	1		1	3
MR00003726			4	2		
MR00000091			1	2	1	
MR00000092					2	
MR00004271			2			
MR00005620				2		
MR00006391				2		
MR00006487					2	
MR00000273				1		
MR00001106			1			
MR00001416			1			
MR00003374				1		
MR00005334				1		
MR00006330			1			
MR00006402			1			
MR00006437			1			
MR00006456				1		
MR00006491				1		
Total		8	32	28	11	6

# COMPARATIVE STATISTICS

Figure CD-25, CD-26

## Factors of Causation Related to All Confinement Events

(Manual Hold, Mechanical Restraint, Seclusion)

Year Ending Sep 2012	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Danger to Others/Self	5	2	1	15	33	27	27	17	57	24	19	42
Danger to Others	3	5	6	4	1		5	1	7			
Danger to Self	4	1	2		1		1					
% Dangerous Precipitation	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Events	12	8	9	19	35	27	33	18	64	24	19	42

# COMPARATIVE STATISTICS

Figure CD-42

## Confinement Events Management Seclusion Events (39) Events

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

# COMPARATIVE STATISTICS

Figure CD-43

## Confinement Events Management Mechanical Restraint Events (1) Events

<u>Standard</u>	<u>Threshold</u>	<u>Compliance</u>	<u>Standard</u>	<u>Threshold</u>	<u>Compliance</u>
The record reflects that restraint was absolutely necessary to protect the patient from causing serious physical injury to self or others.	95%	100%	The record reflects that the need for restraint was re-evaluated every 2 hours by a nurse.	90%	100%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective.	90%	100%	The record reflects that re-evaluation was conducted while the patient was free of restraints unless clinically contraindicated.	70%	100%
The record reflects that the decision to place the patient in restraint was made by a physician or physician extender	90%	100%	The record includes a special check sheet that has been filled out to document the reason for the restraint, description of behavior and the lesser restrictive alternatives considered.	85%	100%
The decision to place the patient in restraint was entered in the patient's records as a medical order.	90%	100%	The record reflects that the patient was released as necessary for eating, drinking, bathing, toileting or special medical orders.	90%	100%
The record reflects that, if a physician or physician extended was not immediately available to examine the patient, the patient was placed in restraint following an examination by a nurse.	90%	100%	The record reflects that the patient's extremities were released sequentially, with one released at least every fifteen minutes.	90%	100%
The record reflects that the physician or physician extender personally evaluated the patient within 30 minutes after the patient has been placed in restraint, or, if there was a delay, the reasons for the delay.	90%	100%	Copies of events were forwarded to medical director and advocate.	90%	100%
The record reflects that the patient was kept under constant observation during restraint.	95%	100%	For persons with mental retardation, the applicable regulations were met.	85%	100%
Individuals implementing restraint have been trained in techniques and alternatives.	90%	100%	The record reflects that the order was not entered as a PRN order.	90%	100%
The record reflects that reasonable efforts taken to notify guardian or designated representative as soon as possible that patient was placed in restraint.	75%	100%	Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A
The medical order states time of entry of order and that number of hours shall not exceed four.	90%	100%	A restraint event that exceeds 24 hours will be reviewed against the following requirement: If total consecutive hours in restraint, with renewals, exceeded 24 hours, the record reflects that the patient was medically assessed and treated for any injuries; that the order extending restraint beyond 24 hours was entered by Medical Director (or if the Medical Director is out of the hospital, by the individual acting in the Medical Director's stead) following examination of the patient; and that the patient's guardian or representative has been notified.	90%	100%
The medical order shall state the conditions under which the patient may be sooner released.	85%	100%			

# COMPARATIVE STATISTICS

## Medication Administration during Behavioral Events

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
COURTN		3		1		2	1						7
COURTY					1		1						2
GUARDN	2	6	9	12	2	1							32
GUARDY		7	11	7	4	1		1	1				32
PEMEDSN	1	4	1	3	1	8		1	8				27
PEMEDSY	1	2	5	6	5	13	2	1	3				39
PRNY	10	14	11	11	12	31	7	6	15				117
Total Meds Admin	14	36	37	40	25	56	11	9	27				255
Percent Unwilling	21.4	35.2	27.0	40.0	12.0	19.6	9.1	11.1	29.6				26.9

1 <sup>st</sup> FQ 2012	Manual Hold	Mechanical Restraint	Locked Seclusion
COURTN			1
COURTY			1
GUARDN			
GUARDY	1		1
PEMEDSN	2	1	6
PEMEDSY			6
PRNY	15		13
Total		1	

A manual hold is often required to temporarily secure the client and protect their safety during the administration of an intramuscular injection of ordered medication.

1 <sup>st</sup> FQ 2012	COURTN	GUARDN	PEMEDSN	TOTAL
MR00000763			2	2
MR00003766	1			1
MR00006495			2	2
MR00006509			4	4
MR00000091			1	1
	1	0	9	10

All unwilling administrations of medications were supported by a court order, a guardian order, or the declaration of a psychiatric emergency.

COURTN = Court ordered medication administration, client unwilling  
 COURTY = Court ordered medication administration, client willing  
 GUARDN = Guardian permission for medication administration, client unwilling  
 GUARDY = Guarding permission for medication administration, client willing  
 PEMEDSN = Psychiatric Emergency declared, client unwilling  
 PEMEDSY = Psychiatric Emergency declared, client willing  
 PRNY = PRN medications offered, client willing

# DIETARY

## ASPECT: CLEANLINESS OF MAIN KITCHEN

Indicators	Quarterly % Compliance						Threshold Percentile
	Jul. '11- Sep. '11	April 2011- June 2011	Jan. '11- Mar. '11	Oct. '10- Dec. '10	Jul. '10- Sep. '10	Apr. '10- Jun. '10	
1. All convection ovens (4) were thoroughly cleaned monthly.	75% (9 of 12)	100% (12 of 12)	100% (12 of 12)	75% (9 of 12)	92% (11 of 12)	83% (10 of 12)	100%
2. Dish machine was de-limed monthly	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100%
3. Shelves (6) used for storage of clean pots and pans were cleaned monthly	100% (18 of 18)	100% (9 of 9)	100% (18 of 18)	100% (18 of 18)	100% (18 of 18)	100% (18 of 18)	100%
4. Knife cabinet was thoroughly cleaned monthly	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)	100%
5. Walk in coolers were cleaned thoroughly monthly.	100% (6 of 6)	100% (6 of 6)	100% (6 of 6)	100% (6 of 6)	100% (6 of 6)	100% (6 of 6)	100%
6. Steam kettles (2) were cleaned thoroughly on a weekly basis	54% (14 of 26)	100% (26 of 26)	100% (26 of 26)	69% (18 of 26)	93% (26 of 28)	93% (26 of 28)	95%
7. All trash cans (4) and bins (1) were cleaned daily	99% (548 of 552)	97% (530 of 546)	89% (401 of 450)	98.9% (455 of 460)	97% (445 of 460)	85% (462 of 546)	95%
8. All carts(9) used for food transport (tiered) were cleaned daily	100% (828 of 828)	99.4% (814 of 819)	97.7% (792 of 810)	98% (812 of 828)	98% (811 of 828)	97% (794 of 819)	100%
9. All hand sinks (4) were cleaned daily	100% (368 of 368)	100% (364 of 364)	100% (360 of 360)	95.6% (352 of 368)	98% (360 of 368)	92% (794 of 819)	95%
10. Racks(3) used for drying dishes were cleaned daily	98% (270 of 276)	98.9% (270 of 273)	98.8% (267 of 270)	99% (273 of 276)	99% (273 of 276)	81% 222 of 273	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.

# DIETARY

- The improvement seen with cleaning of the carts used for food transport is due to a reassignment of the task.
- There was a significant decrease seen within two areas of the cleaning tasks. Convection ovens: There has been no reported reason for lack of completion of two of them. The third oven was not cleaned due to employee long term illness. Steam kettles: Employee assigned to this task had a long term illness.
- The improvement seen in the cleaning of the trash cans and bins is due to employee compliance

Overall Compliance: 98.8%

**Actions:**

- FSM reviews all daily cleaning schedules on a daily basis to assure staff completion.
- FSM will review the status of the all weekly and monthly cleaning tasks and assure completion.
- Cleaning schedules will be modified to reflect changes in staff availability.
- The weekly staff meeting includes review of the past weeks completion rates.
- Results of this CPI indicator will be discussed with staff.

## ASPECT: TIMELINESS OF NUTRITIONAL ASSESSMENT

Indicator	Quarterly % Compliance						Threshold Percentile
	Jul. '11- Sep. '11	April 2011- June 2011	Jan. '11- Mar. '11	Oct. '10- Dec. '10	Jul. '10- Sep. '10		
A nutrition assessment is completed within 5 days of admission when risk is identified via the nutrition	100% (87 of 87)	100% (76 of 76)	100% (75 of 75)	97.4% (74 of 76)	100% (59 of 59) (New Indicator)	100%	

### Summary

All assessments completed within 5 days of admission.

Overall Compliance: 100%

### 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.

# HARBOR TREATMENT MALL

## Aspect: Harbor Mall Hand-off Communication

Indicators	Findings	Compliance	Threshold Percentile
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	26 of 42	62%	100%
2. RN signature/Harbor Mall staff signatures present.	41 of 42	98%	100%
3. SBAR information completed from the units to the Harbor Mall.	18 of 42	43%	100%
4. SBAR information completed from the Harbor Mall to the receiving unit.	32 of 42	76%	100%

### Summary

This is the third quarterly report for this year. 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. Indicator number one is the same as the first and second quarter. Indicator number two dropped to 98% for the first time. Indicator number three increased from 52% to 55% and has now dropped to 43%. Indicator number four increased from 55% to 71% to 76% for this quarter.

Sixteen of the hand-off communication sheets did not arrive AT the Harbor Mall within the allotted time frame. This sheet is to be brought to the mall no later than 5 minutes before the start of groups and this did not happen on sixteen of the sheets that were reviewed for this quarter. September showed improvement for lateness was only one or two minutes which is a big improvement over July and August.

One of the hand-off communication sheets was not brought to the mall so we are missing one RN signature for the first time. Indicator#2 was 100% for both prior quarters.

Twenty-four of the 42 sheets reviewed did not have any client concerns or comments from the unit(s) written for the Harbor Mall and/or did not state no issues to report on the HOC.

Ten of the 42 sheets reviewed did not have any client concerns or comments from the Harbor Mall back to the units and/or did not state know issues to report on the HOC sheet.

### Actions

The PSD 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.

The PSD for the mall 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.

# HEALTH INFORMATION MANAGEMENT

## ASPECT: DOCUMENTATION & TIMELINESS

Indicators	Findings	1 <sup>st</sup> Qtr 2012	4 <sup>th</sup> Qtr 2011	3 <sup>rd</sup> Qtr 2011	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 89 discharges in quarter 1 2012. Of those, 86 were completed by 30 days.	97 %	79 %	49 %	80%
Discharge summaries will be completed within 15 days of discharge.	88 out of 89 discharge summaries were completed within 15 days of discharge during quarter 1 2012.	99 %	100 %	100 %	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	6 forms were approved/ revised in quarter 1 2012 (see minutes).	100%	100%	100%	100%
Medical transcription will be timely and accurate.	Out of 1386 dictated reports, 1292 were completed within 24 hours.	93%	86%	84%	90%

### Summary

The indicators are based on the review of all discharged records. There was 97% compliance with record completion. There was 99% 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 96% compliance with timely & accurate medical transcription services.

### Actions

Continue to monitor the compliance rate of each measure and work closely with the Medical Director to identify barriers to on-time completion of medical records according to the prescribed timeline.

# 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.	2819 requests for information (181 requests for client information and 2638 police checks) were released for quarter 1 2012. (It should be noted that 600 police checks from this quarter are outstanding due to staff shortage)	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	22 new employees/contract staff in quarter 1 2012.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	0 privacy-related incident reports during quarter 1 2012.	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 related to release of information from the Health Information department and training of new employees/contract staff, however compliance with current law and HIPAA regulations need to be strictly adhered to requiring training, education and policy development at all levels.

### Actions

The above indicators will continue to be monitored.

# HOUSEKEEPING

## ASPECT: LINEN CLEANLINESS AND QUALITY

Indicators	Quarterly % Compliance						Threshold Percentile
	Jul. '11- Sep. '11	Apr. '11- Jun. '11	Jan. '11- Mar. '11	Oct. '10- Dec. '10	Jul. '10- Sep. '10	Apr. '10- Jun. '10	
1. Was linen clean coming back from vendor?	80% (24 of 30)	98% (45 of 46)	100% (34 of 34)	100% (53 of 53)	96% (23 of 24)	100% (37 of 37)	100%
2. Was linen free of any holes or rips coming back from vendor?	97% (29 of 30)	98% (45 of 46)	92% (31 of 34)	100% (53 of 53)	92% (22 of 24)	81% (30 of 37)	95%
3. Did we have enough linen on units via complaints from unit staff?	100% (30 of 30)	98% (45 of 46)	88% (30 of 34)	96% (51 of 53)	92% (22 of 24)	97% (36 of 37)	90%
4. Was linen covered on units?	100% (30 of 30)	100% (46 of 46)	97% (33 of 34)	100% (53 of 53)	100% (24 of 24)	100% (37 of 37)	95%
5. Did vendor provide a 24 hr. turn around service as specified in the contract?	100% (30 of 30)	96% (44 of 46)	97% (33 of 34)	96% (51 of 53)	79% (19 of 24)	95% (35 of 37)	100%
6. Did we receive an adequate supply of mops and rags from vendor?	100% (30 of 30)	98% (45 of 46)	97% (33 of 34)	100% (53 of 53)	100% (24 of 24)	100% (37 of 37)	95%
7. Was linen bins clean returning from vendor?	93% (28 of 30)	87% (40 of 46)	100% (34 of 34)	100% (53 of 53)	100% (24 of 24)	97% (36 of 37)	100%
8. Was the linen manifest accurate from the vendor	77% (23 of 30)	89% (41 of 46)	88% (30 of 34)	96% (51 of 53)	31% (5 of 16) (New)		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 indicators #1, & #8.

The overall compliance for this quarter was 93%. This shows a 2.5% decrease from last quarters' report.

1. (Indicator #1) inadequate supply of linen (blankets) were not coming back from vendor
2. Linen manifests were not accurate from vendor (Indicator #8)

# HOUSEKEEPING

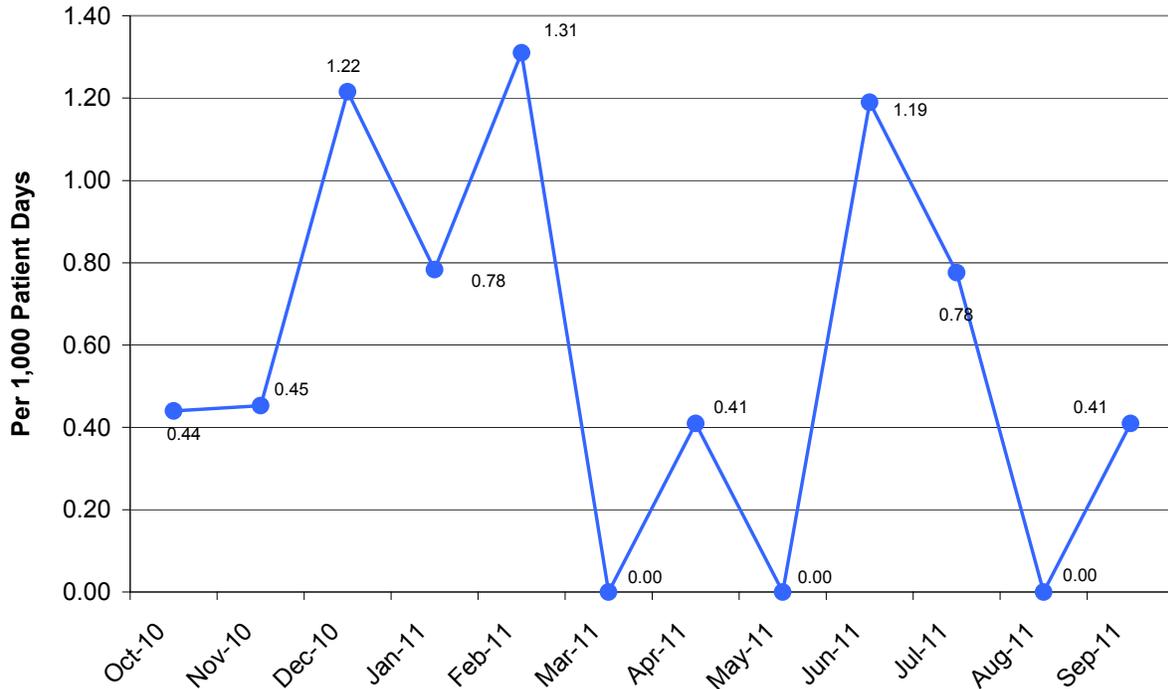
## **Actions**

- The Housekeeping Department has done the following actions to remedy the above problem indicators:
- Housekeeping Supervisor will monitor how many blankets are being sent out to be cleaned and how many return from vendor.
- Housekeeping Supervisor contacted the linen vendor and advised them of the problems with inaccuracies of linen returning from their facility.
- Communicate to all Housekeeping staff to be aware of the status of this indicator.
- Housekeeping staff member will continue to document all information regarding to inventory and manifest statistics from the vendor.
- Housekeeping Supervisor and Director of Support Services did schedule a visit to the linen cleaning facility (Alpine) to see how the linen processing was done. Riverview representatives both gave recommendations to manager to meet infection control standards and the Joint Commission standards.
- Contract with current linen company was extended for the rest of the year only and Riverview will request for proposals from other companies to begin January of 2012.

# HUMAN RESOURCES

## ASPECT: DIRECT CARE STAFF INJURIES

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



### Summary

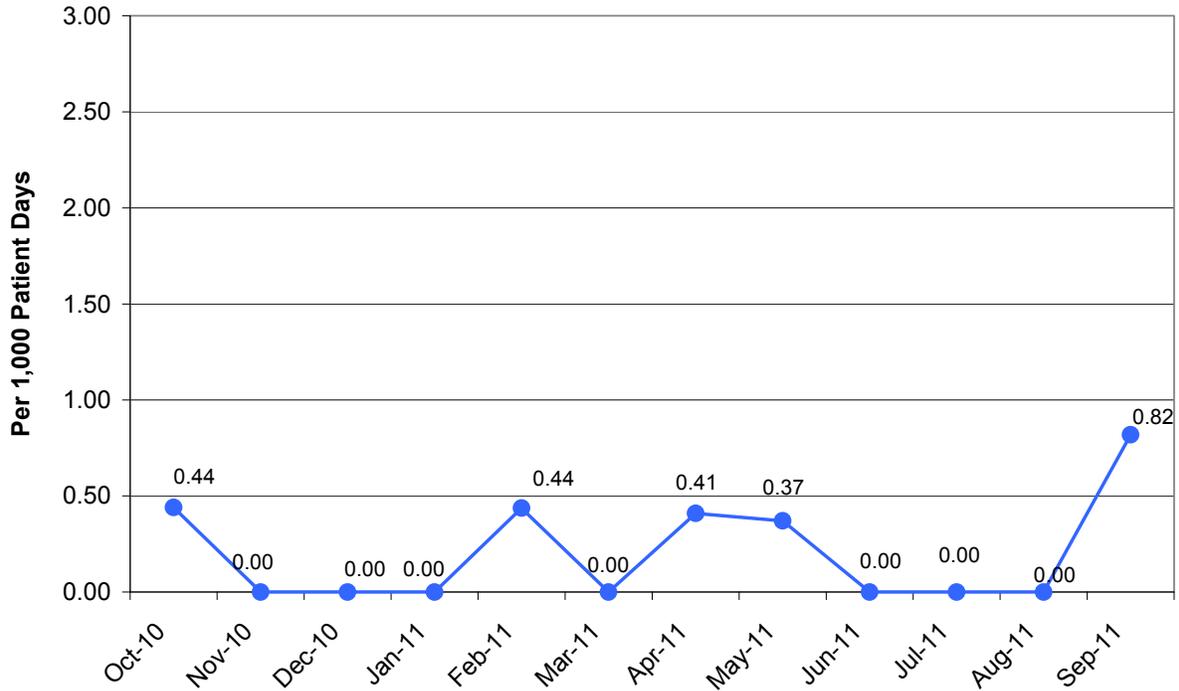
The trend for reportable injuries sustained by direct care staff increased during the month of June and showed a precipitous drop in July and August. This directly corresponds to the incidence of increased client aggressive behaviors attributable to one unstable client.

The greatest percentage of injuries with direct care staff tend to be related to client to staff interactions. Current work on developing tools to reduce the incidence of physical interaction between clients and staff through heightened awareness of client's triggers and coping mechanisms appear to be having an impact on the frequency of client to staff physical interactions. Any reduction in the number of these interactions may also impact the number of both client and staff injuries that may result from these interactions.

# HUMAN RESOURCES

## ASPECT: NON-DIRECT CARE STAFF INJURIES

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



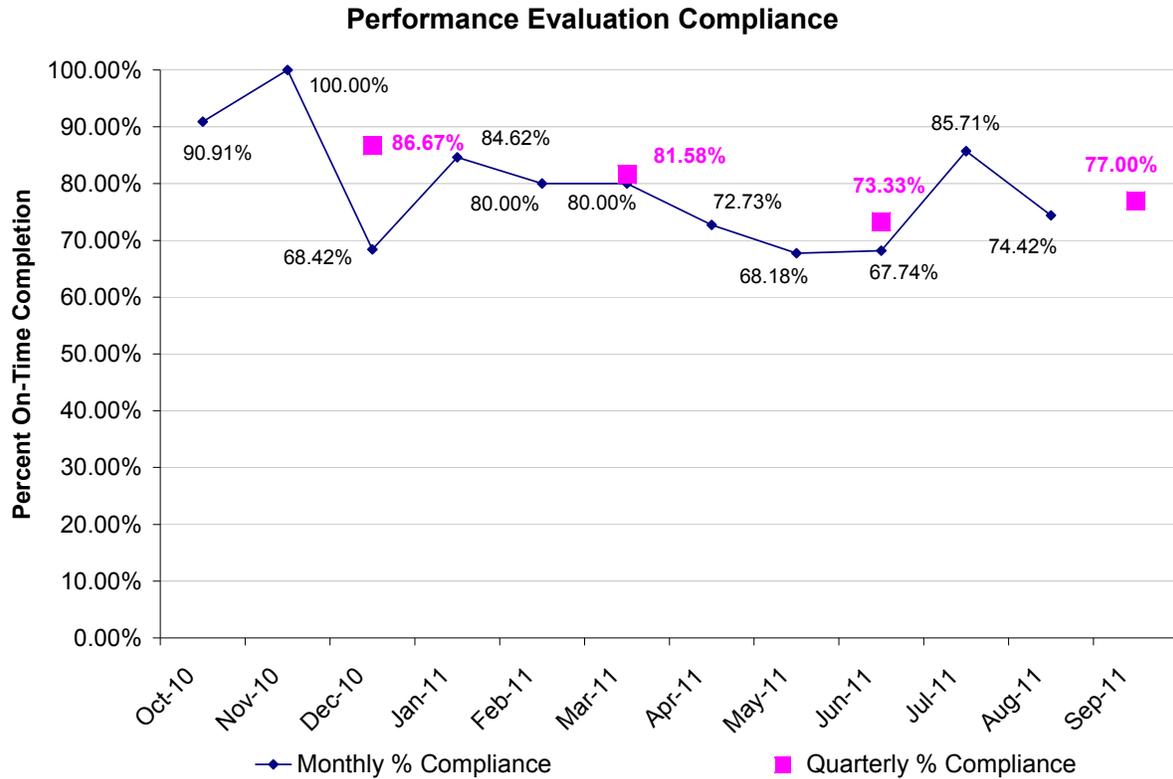
### Summary

The average percent of non-direct care staff who sought medical attention or lost time from work remains low. The annual trend shows a steady yet low rate of injury. 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 some difficulties in maintaining a high degree of completion of performance evaluations.

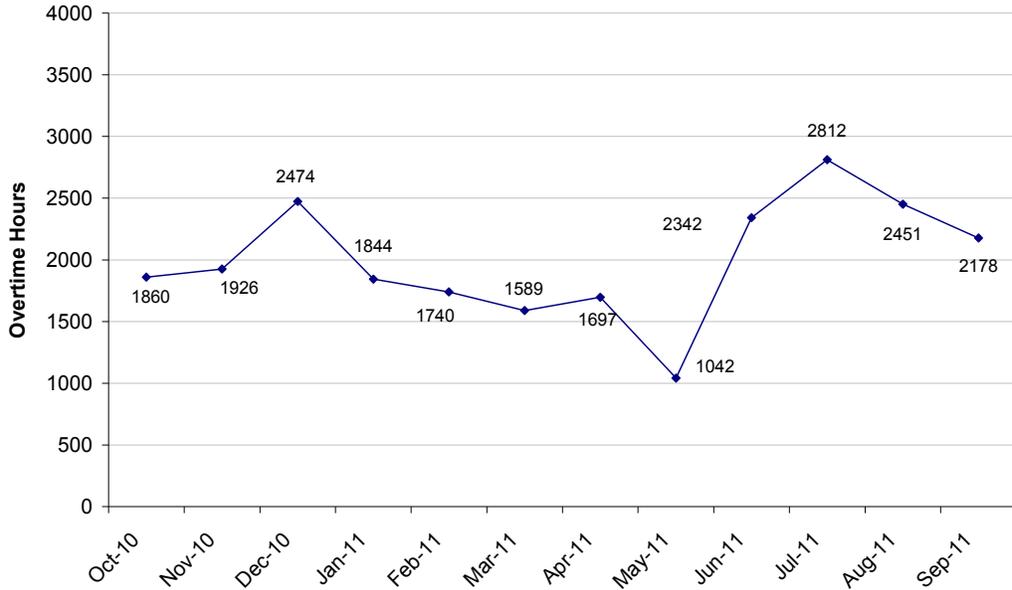
Cumulative results from this quarter (77.00%) are below the planned performance threshold of 85%. The monthly results for compliance are also all below the planned performance threshold. These results are beginning to show a trend lower than planned performance as six data points are below the threshold level. Ongoing measurement of performance is indicated for the remainder of the calendar year. Ongoing efforts to insure on time completion of performance evaluations by unit managers 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.

# HUMAN RESOURCES

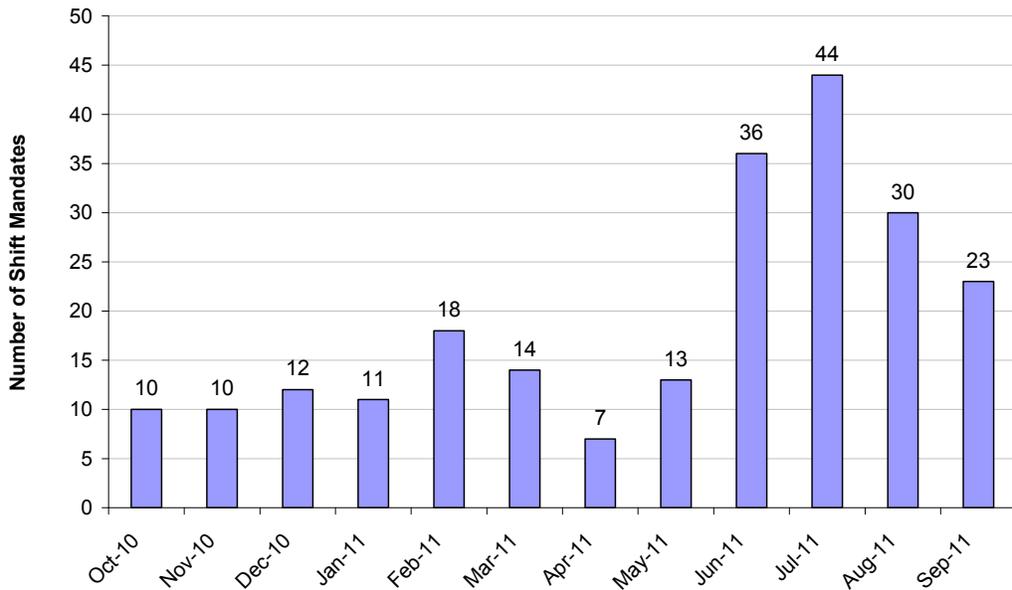
## ASPECT: PERSONNEL MANAGEMENT

Overtime hours and mandated shift coverage

### Monthly Overtime



### Monthly Mandated Shifts



The level of overtime hours and number of mandates for the month of June and the last quarter showed significant spikes while the preceding months remained stable and low. Current staffing patterns are being adjusted to take advantage of the shift from contract staff to regular staff and adjustments are being made to address the issue of lost personnel due to changes related to the retirement incentive.

# 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	5.1	100 % within standard	1 SD within the mean
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	0.5	100% within standard	1 SD within the mean

### Data

Upper Respiratory Infections – 2  
 Lower Respiratory Infections – 1  
 Gastrointestinal Infections – 0  
 Reproductive Infections – 1.  
 Dental Infections – 15  
 Skin Infections – 16  
 Ear Infections – 1  
 Urinary Tract Infections – 2  
 Eye Infections – 4  
 Wound Infections – 1

**July 2011-** One client was found to have a positive TB skin test (TST). This gentleman was given a complete medical work up with a community referral, and in consultation with the Maine CDC. Prophylactic treatment was recommended; but because of history of substance abuse and noncompliance the Maine CDC did not want to initiate treatment.

In response to an outbreak of Tinea Pedis (Athletes' Foot) in May 2011 a nursing protocol was put in place to ensure client showers are cleaned and disinfected after each use. The Infection Control Nurse met with clients during their community meetings to advise them of this protocol and to educate on Athletes' Foot.

### Summary

The most common infections seen within the hospital client population are upper respiratory (URI), skin and dental. The infection rates were consistent with previous months.

### Action Plan

- Continue total house surveillance.
- Encourage all clients and employees to receive the influenza vaccine and to engage in good hand and respiratory hygiene.
- Initiate a procedure to ensure client education on hand hygiene, respiratory hygiene and Athletes Foot within 10 days of admission.

# LIFE SAFETY

## ASPECT: LIFE SAFETY

Indicators	Quarterly % Compliance						Threshold Percentile
	Jul. '11- Sep. '11	Apr. '11- Jun. '11	Jan. '11- Mar. '11	Oct. '10- Dec. '10	Jul. '10- Sep. '10	Apr. '10- Jun. '10	
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.	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	100%
2. Total number of staff who knows what R.A.C.E. stands for.	100% (124/124)	100% (159/159)	100% (202/202)	100% (221/221)	100% (285/285)	100% (160/160)	95%
3. Total number of staff who knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	97% (121/124)	96% (153/159)	100% (202/202)	100% (221/221)	100% (285/285)	100% (160/160)	95%
4. Total number of staff who knows the emergency number.	100% (124/124)	100% (159/159)	100% (202/202)	100% (221/221)	100% (285/285)	100% (160/160)	95%
5. During unannounced safety audits conducted by the Safety Officer, this represents the total number of staff who displays identification tags.	98% (124/126)	98% (163/165)	98% (204/208)	97% (224/230)	100% (285/285)	96% (164/170)	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.	99% 125/126	98% 162/165	97% 206/208	97% 225/230	100% (92/92)	98% (167/170)	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.

# LIFE SAFETY

During drills, the following was discovered and noted:

1. Three staff people were unsure how to acknowledge the annunciator panel and get the required information
2. One 2-way radio did not operate. Staff did use the adjacent unit’s radio.
3. Security did have trouble accessing a Maintenance area to check the surrounding area. Safety will get them the appropriate access.
4. After verification that there was not an actual fire, one staff person requested that the horns be turned off. Communications has been sent out that that there is a new code requirement that horns and strobes must be turned off together.

Drills and environmental tours addressed areas such as R.A.C.E., evacuation routes, use of fire extinguishers, use of annunciator panels, census taking, and emergency communications.

## Actions

Actions taken after drills were the following:

1. Two separate mini training sessions were conducted with those staff with regard to the use of the annunciator panel.
2. The unit staff immediately utilized one of the 2-way radios on an adjacent unit. The radio was immediately brought to the Safety Office who changed the battery, tested the radio, and returned the radio to the unit. The Safety Officer will be conducting regular tests on the 2-way radios.
3. A new fire key was issued.
4. No action required.
5. During the after-drill critique, the unit was reminded of the importance of immediately utilizing the 2-way radios.

We continue to conduct 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.

## ASPECT: FIRE DRILLS REMOTE SITES

Indicators	Quarterly % Compliance						Threshold Percentile
	Jul. '11- Sep. '11	Apr. '11- Jun. '11	Jan. '11- Mar. '11	Oct. '10- Dec. '10	Jul. '10- Sep. '10	Apr. '10- Jun. '10	
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.	100% (1 drill)	100% (1 drill)	100% (1 drill)	100% (1 drill)	100% (1 drill)	100% (1 drill)	100%

# LIFE SAFETY

## Summary

On 9/15/11, the Safety Officer conducted an unannounced drill. The results of that drill are as follows:

1. The drill was orderly.
2. The receptionist was reminded that the records cabinets need to be closed if time permits.
3. Some staff was unsure of all the locations of the fire alarm pull stations.

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. Questions are later posed to staff that are not caring for clients when the decision is made to not conduct a drill.

## Actions

No actions are required at this time. The required drills have been performed.

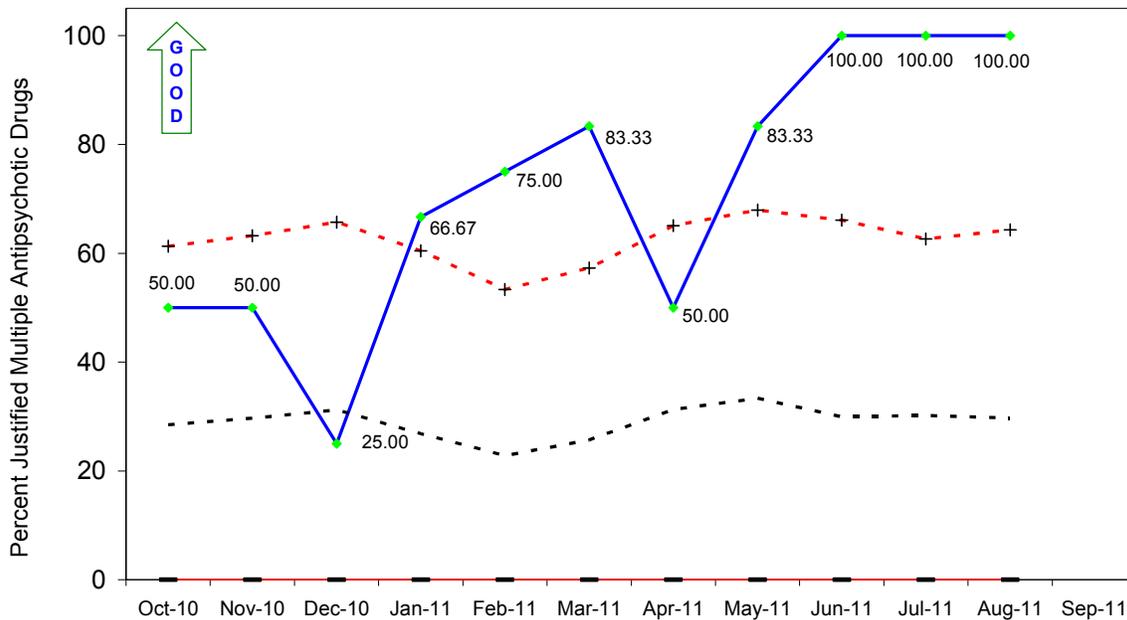
# MEDICAL STAFF

## 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 3-mo period (June-August) 85 discharges had 20 patients on 2 or more antipsychotics; all were justified.	100%	80%

### Multiple Antipsychotics Justified

Percent of Clients Discharged on Multiple Antipsychotic Drugs With Appropriate Justification



	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
● RPC%	50.00	50.00	25.00	66.67	75.00	83.33	50.00	83.33	100.00	100.00	100.00	
- - - Ntl Mean	28.48	29.67	31.20	26.82	22.82	25.66	31.26	33.35	29.93	30.19	29.71	
+ - +1 St Dev	61.28	63.20	65.71	60.44	53.34	57.27	65.07	67.92	66.09	62.61	64.28	
- - -1 St Dev	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	

### Summary

For the past three months, all 20 clients discharged on two or more antipsychotics were clinically justified according to the criteria. This represents a marked improvement in Medical Staff performance over the past 18 months.

### Actions

We will discontinue this monitor because of demonstration of meeting compliance for a reasonable time frame.

# NURSING

## **ASPECT: SECLUSION/RESTRAINT RELATED TO STAFFING EFFECTIVENESS**

Figure CD-27

Indicators	Findings	Compliance
1. Staff mix appropriate	93 of 93	100%
2. Staffing numbers within appropriate acuity level for unit	93 of 93	100%
3. Debriefing completed	67 of 69	97.9%
4. Dr. Orders	69 of 69	100%

### **SUMMARY**

The indicators of “Seclusion/Restraint Related to Staffing Effectiveness” has remained above 95% for 2 quarters.

### **ACTION**

Good Progress. We will continue to monitor.

## **ASPECT: INJURIES RELATED TO STAFFING EFFECTIVENESS**

Indicators	Findings	Compliance
1. Staff mix appropriate	43 of 43	100%
2. Staffing numbers within appropriate acuity level for unit	43 of 43	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. We will continue 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 RELATED TO STAFFING EFFECTIVENESS

NURSING: Staffing levels during medication errors – July - Sept 2011 NASMHPD reportable variances

Date	Omit	Co-mission	Float	New	O/T	Unit Acuity	Staff Mix
6/23/11	Y	First pg of orders not noted/ processed – Missed scheduled med.	No	No	No	LK	1 RN, 1 LPN, 5 MHW
6/27/11	Y	No written IM back-up for PO refusal – Transcription error	Yes	No	No	LS	3 RN, 1 LPN, 9 MHW
6/29/11	N	Unable to find that half-tab was wasted	No	No	No	UK	2 RN, 1 LPN, 3 MHW
7/3/11	N	Gave double dose of scheduled med – misread MAR	No	No	No	US	3 RN, 3 MHW
7/7/11	N	Incorrect med obtained from night closet	No	No	No	US	3 RN, 4 MHW
7/7/11	N	Signed on wrong date, did not notice meds already given	No	No	No	LS	3 RN, 1 LPN, 9 MHW
7/8/11	N	Med given at the wrong time	No	No	No	US	2 RN, 1 LPN, 4 MHW
7/8/11	Y	Dose not given	No	No	No	US	2 RN, 1 LPN, 4 MHW
7/9/11	Y	Med not available, did not attempt to notify NOD	No	No	No	LS	2 RN, 1 LPN, 10 MHW
7/11/11	Y	Gave half dose of scheduled med – transcription error	No	No	No	LS	3 RN, 0 LPN, 9 MHW
7/12/11	Y	Wrote med not available – did not notice med was on the unit	No	No	No	LS	3 RN, 1 LPN, 9 MHW
7/13/11	Y	Y-substituted one med for another, omitted one med.	Yes	No	No	LS	3 RN, 9 MHW, 1 LPN
7/17/11	Y	RN missed order – color coding not done.	Yes Contract	No	No	LS	1 RN, 7 MHW
7/18/11	N	Transcription error – original order not discontinued – extra dose	No	No	No	LS	3 RN, 1 LPN, 8 MHW
7/20/11	Y	Accudose error – machine not working – dose missed.	Yes	No	No	LS	2 RN, 2 LPN, 7 MHW
7/20/11	Y	Accudose failure – missed dose	Yes	No	No	LS	2 RN, 2 LPN, 7 MHW
7/20/11	N	Transcription error, med above max dose	No	No	No	LS	2 RN, 2 LPN, 7 MHW
7/24/11	Y	Med found in client's box not administered	No	No	No	UK	2 RN, 1 LPN, 3 MHW
7/28/11	Y	Did not see order change to increase dose – transcription error	Yes	No	No	US	1 RN, 3 MHW
8/2/11	No	Dose over amount specified	No	No	No	LK	2 RN, 1 LPN, 7 MHW
8/9/11	No	Gave med a day early	No	No	No	LS	3 RN, 1 LPN, 8 MHW
8/10/11	Yes	Transcription error – missed second page	No	No	No	LK	3 RN, 1 LPN, 7 MHW
8/10/11	No	Gave med one day early	No	No	No	LS	1 RN, 6 MHW
8/10/11	No	Transcription error – missed second page	No	No	No	LK	3 RN, 1 LPN, 7 MHW
8/23/11	Yes	New admission order missed	No	No	No	LK	3 RN, 1 LPN, 7 MHW
8/23/11	Yes	New admission order missed	No	No	No	LK	3 RN, 1 LPN, 7 MHW
8/25/11	Yes	Faxed order not received or in Accudose.	No	No	No	LS	3 RN, 1 LPN, 7 MHW

# NURSING

## SUMMARY

There were a total of 28 reportable errors. 17 omissions, 11 commissions in July, August, and September. 21 involved admissions units (LK and LS) Med variances involved the following:

- Inappropriate administration of med (no wasting noted); wrong dose
- Not following procedure
- Early administration of medication
- Not checking the MAR
- Not completing order transcription
- Incomplete redlining
- Incorrect or incomplete color coding of MAR
- Meds left in client’s med box
- Accudose failure x2
- Fax machine failure/incomplete
- Haste: trying to assist med nurse on an acute unit
- Incorrect substituting one med for another from night closet x2
- Failure to obtain medication from night closet x2
- Signed for meds on wrong date, causing extra dosing
- Misread MAR

Involved floating to another unit: 6 incidents, 4 actual staff involved, one variance involved a contract nurse. Corrective action was completed in regard to one nurse with multiple errors.

## Actions

- Reduction in medication procedure to all nurses
- Careful checking of med administration times and dates
- Utilization of accurate transcription and redlining procedures
- Continue to follow the “3 R’s” of medication administration
- Double-check meds taken from the night closet for correctness
- Notify NOD or pharmacy if a medication appears to be unavailable

## ASPECT: PAIN MANAGEMENT

Indicator		Findings	Compliance
Pre-administration	Assessed using pain scale	938 of 989	94.8%
Post-administration	Assessed using pain scale	741of 989	74.9%

## SUMMARY

The “Pre-administration assessment” indicator did not meet the compliance of 100% this quarter and there is a significant drop in the Post-administration assessment percentile, from 92% to 74.9% using the pain scale. “Post-administration” assessment is expected to increase with the advent of implementation of the pharmacy module of our Electronic Medical Record.

## ACTION

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

# NURSING

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. Frequent checks by Nurse Educator will be instituted.

## ASPECT: CHART REVIEW EFFECTIVENESS

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	40 of 60	67%%
2. STGs/ Interventions relate directly to content of GAP note.	57 of 60	95%
3. Weekly Summary note completed.	43 of 60	72%
4. BMI on every Treatment Plan.	50 of 60 1 N/A	83%
5. Diabetes education Teaching checklist shows documentation of client teaching (diabetic clients)	2 of 2	100%
6. Multidisciplinary Teaching checklist active being completed.	21 of 60	35%
7. Dental education Teaching checklist	24 of 60	37%

## SUMMARY

Indicators 1, 2, 3, 6, 7 are down from last quarter. Indicator 5 has increased.

## ACTION

Education on GAP notes, weekly notes. Education on multi-disciplinary teaching checklist.

# NURSING

## ASPECT: INITIAL CHART COMPLIANCE

<b>Indicator</b>	<b>Findings</b>	<b>Compliance</b>
1. Universal Assessment completed by RN within 24 hours	87 of 87	100%
2. All sections completed or deferred within document	87 of 87	100%
3. Initial Safety Treatment Plan initiated	87 of 87	100%
4. All sheets required signature authenticated by assessing RN	87 of 87	100%
5. Medical Care Plan initiated if Medical problems identified	32 of 32	100%
6. Informed Consent sheet signed	69 of 76 1 N/A 2 ref.	100%
7. Potential for violence assessment upon admission	72 of 76	100%
8. Suicide potential assessed upon admission	75 of 76	100%
9. Fall Risk assessment completed upon admission	70 of 76	100%
10. Score of 5 or above incorporated into problem need list	25 of 31	80.6%

## SUMMARY

All aspects of initial chart review have increased in compliance with most at 100% this quarter.

## ACTION

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

# PEER SUPPORT

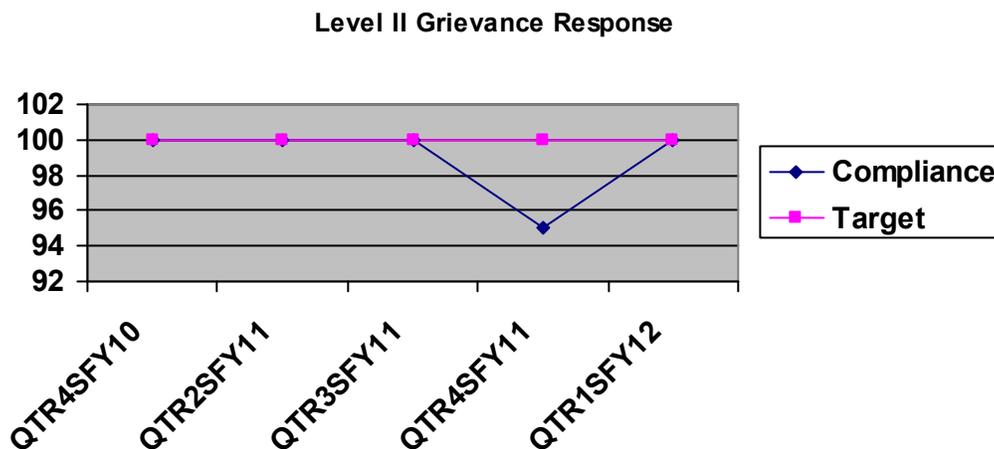
## ASPECT: INTEGRATION OF PEER SPECIALISTS INTO CLIENT CARE

Indicators	Findings	Compliance	Threshold Percentile
1. Attendance at Comprehensive Treatment Team meetings.	419 of 468	90%	80%
2. Urgent grievances responded to by RPC on time. No urgent grievances were determined to be Level II. All were referred for Level 1 response.	31 of 31	100%	100%
3. Attendance at Service Integration meetings.	67 of 74	90%	100%
4. Contact during admission.	87 of 87	100%	100%
5. Level I grievances responded to by RPC on time.	61 of 67	91%	100%
6. Client satisfaction surveys completed.	20 of 25	80%	50%

### Summary

Overall compliance is 91%, up 6% from last quarter. Peer support attendance at treatment team meetings increased by 7%. Return rate of client satisfaction surveys went up significantly, 21%. Hospital response time to grievances went up, 5% for level II to meet compliance and 10% for level I. The majority of late grievances were on the civil units, ranging from 1 to 8 days late. Documented contact between clients and peer support remains at 100%. Peer support attendance at Service Integration Meetings dropped 7%. Missed meetings were due to not being notified of meeting time by social workers and peer support not being available at the scheduled times.

Figure CD-03



# PEER SUPPORT

Figure CD-07

## Documented Contact During Admission

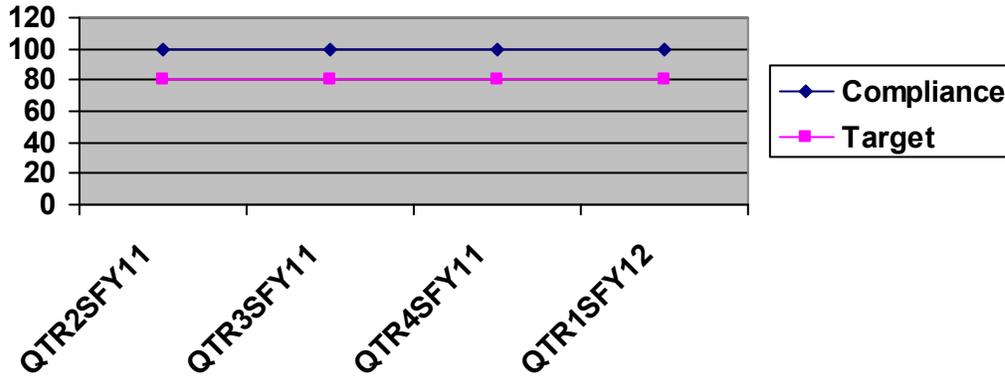
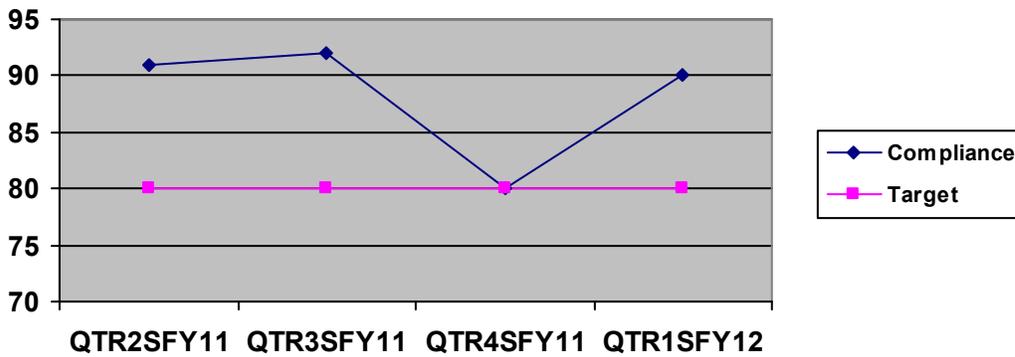


Figure CD-08

## Treatment Team Attendance



# 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> Forty-two orders were received by the pharmacy without allergies listed and an estimated 1325 total orders were received by pharmacy.	96.8%	98.0%
	<b>August</b> Thirty-two orders were received by the pharmacy without allergies listed and an estimated 1325 total orders were received by pharmacy.	97.6%	98.0%
	<b>September</b> Twenty-five orders were received by the pharmacy without allergies listed and an estimated 1200 total orders were received by pharmacy	97.9%	98.0%

### Summary

There were a total of 99 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 97.4%. 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 January 1, 2011 through March 31, 2011 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
51	36	10	26	0	0

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

All of the 25 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

Figure CD-11

Indicator	Findings	Compliance
1. Documentation reveals that the client attended 50% of assigned psycho-social-educational interventions within the last 24 hours.	87 of 120	70.8%
2. A minimum of three psychosocial educational interventions are assigned daily.	100 of 120	89%
3. A minimum of four groups is prescribed for the weekend.	84 of 120	70%
4. The client is able to state what his assigned psycho-social-educational interventions are and why they have been assigned.	92 of 120	75.9%
5. The client can correctly identify assigned RN and MHW. (Or where the information is available to him / her)	117 of 120	97.5%
6. The medical record documents the client's active participation in Morning Meeting within the last 24 hours.	77 of 120	63%
7. The client can identify personally effective distress tolerance mechanisms available within the milieu.	116 of 120	100%
8. Level and quality of client's use of leisure within the milieu are documented in the medical record over the last 7 days.	113 of 120	92.5%
9. Level and quality of social interactions within the milieu are documented in the medical record over the last 7 days.	115 of 120	95.8%
10. Suicide potential moderate or above incorporated into CSP	32 of 32	100%
11. Allergies displayed on order sheets and on spine of medical record.	120 of 120	100%
12. By the 7 <sup>th</sup> day if Fall Risk prioritized as active-was it incorporated into CSP	23 of 25	94%

### SUMMARY

Seven of the indicators have increased since last quarter; number 2, 3, 5, 7, 8, 9 and 11 have shown improvement. Three have decreased slightly; numbers 1, 6, and 12. Two have remained the same.

### ACTION

Continue to monitor focusing on the indicators that have decreased slightly.

# PROGRAM SERVICES

## Aspect-Milieu Treatment

Indicator	Findings-%
1. Percentage of clients participating in Morning Meeting	63.3%
2. Percentage of clients who establish a daily goal.	67.8%
3. Percentage of clients who attend Wrap Up group in the evening or address with primary staff, the status of their daily goal.	57%
4. Percentage of clients attending Community Meeting	65%

### Summary

Indicators 1 & 4 have increased from last quarter. Indicators 2 & 3 have decreased.

### Actions

Our effort toward improving our attendance with weekend groups is long standing and will continue to encourage all clients to attend all meetings. We also continue to encourage clients to establish goals and attend wrap up groups.

# 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.	29 of 30	97%
2. Rehabilitation short term goals on Comprehensive Service Plan are measurable and time limited.	30 of 30	100%
3. Rehabilitation progress notes indicate treatment being offered as prescribed on Comprehensive Service Plan.	30 of 30	100%
4. Rehabilitation progress notes indicate progress towards addressing identified goals on the Comprehensive Service Plan.	30 of 30	100%

### Summary

This is the first quarter review of the above indicators and this will be the last quarter for review as the compliance percentage has been consistently above the 95% mark for the past 4 quarters. A new indicator will be developed as it relates to Rehab. Services, the Comprehensive Service plan and the Harbor Mall groups identified in the plan.

**Indicator #1-** All assessments but one was completed in the allotted time frame and all annual updates reviewed were completed in the allotted time frame. No issues at this time with the completion of the assessment and treatment plan. The assessment not completed in time was due to client unresponsiveness to CTRS requests to complete for the first two weeks of admission.

**Indicator #2-**The short term Rehabilitation goals on all treatment plans reviewed were measurable and time limited. No issues at this time but it should be noted that there will be changes in the treatment plans in the near future that will make this indicator easier to maintain at 100% with the new structure.

**Indicator #3 & 4-**Rehabilitation progress notes were reflective of the treatment being offered and the progress towards the identified goals in all charts reviewed. No issues at this time.

The treatment planning process still continues to need review as it applies to client’s participation in groups at the Harbor Mall and development of measurable short term goals for all disciplines. This will be the focus for Rehabilitation Services for the next 3 quarters of this year.

# SECURITY & SAFETY

## ASPECT: SECURITAS/RPC SECURITY TEAM

Indicators	Quarterly % Compliance						Threshold Percentile
	Jul. '11 Sep. '11	Apr. '11- Jun. '11	Jan. '11- Mar. '11	Oct. '10- Dec. '10	Jul. '10- Sep. '10	Apr. '10- Jun. '10	
Security Officer "foot patrols" during Open Hospital times. (Total # of "foot patrols" done vs. total # of "foot patrols" to be done.)	99% (1981/2002)	98% (1975/2002)	99% (1980/2002)	98% (1964/2002)	89% (1797/2002)	98% (1973/2002)	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".

### Actions

In collaboration with Securitas, the contracted site-security services, the Safety Officer took tours of both St. Joseph's Hospital and Eastern Maine Medical Center, both located in Bangor for the purpose of assessing tour systems used at each facility. After much deliberation, Riverview has chosen the "Vision System" as its' new electronic tour system to be used by all officers and select Riverview staff. Plans are now underway to obtain the new equipment and to train the required users of the new system. It is hoped that this will be reported in the next report.

# SOCIAL WORK

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

Figure CD-05	Indicators	Findings	Compliance	Threshold Percentile
1.	Preliminary Continuity of Care meeting completed by end of 3 <sup>rd</sup> day	30/30	96%	100%
2.	Service Integration form completed by the end of the 3rd day	30/30	96%	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.	7/7	100%	100%
3a.	Client Participation in Preliminary Continuity of Care meeting.	29/29	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.	28/30	93%	100%
3d.	Community Provider Participation in Preliminary Continuity of Care meeting.	6/15	40%	90%
3e.	Correctional Personnel Participation in Preliminary Continuity of Care Meeting.	2/15	13%	90%
4a.	Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	29/30	96%	100%
4b.	Annual Psychosocial Assessment completed and current in chart	30/30	100%	100%

### SUMMARY

Areas 3d and 3c are consistently low each quarter and we continue to have on going discussions with DHHS and Corrections.

# SOCIAL WORK

## ASPECT: INSTITUTIONAL AND ANNUAL REPORTS

Figure CD-18 Indicators	Findings	Compliance	Threshold Percentile
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	4 /4	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.	3/3	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 has been at 100% compliance for the last six 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>	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.	13/13	100%	100%
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	13/13	100%	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.	13/13	100%	100%

## ASPECT: TREATMENT PLANS AND PROGRESS NOTES

Figure CD-15, CD-16, CD-17 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.	43/45	95%	95%
2. On Upper Saco progress notes in GAP/Incidental format will indicate at minimum bi- weekly 1:1 meeting with all clients on assigned <b>CCM</b> caseload	30/30	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

Area 1, 2 and 3 are monitored in the Social Work Team Meeting and individually through supervision.

# SOCIAL WORK

## ASPECT: BARRIERS TO COMMUNITY PLACEMENT OF CIVIL CLIENTS

FY12 Q1 16 % of civil clients discharged faced a barrier

54 civil clients discharged in the quarter.  
9 faced identified barrier

Figures CD-12, CD-13, CD-14

### Clinical Readiness

24 discharged 7days  
20 discharged 8-30 days  
3 discharged 31-45days  
7 discharged post 45 days

### Residential Supports (0) 0%

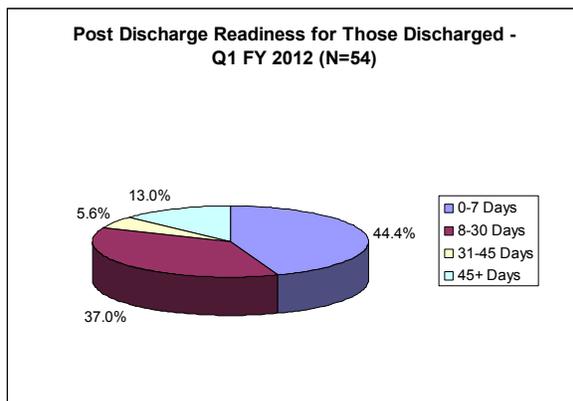
No Barriers in this area this quarter

### Treatment Services (1) 2%

1 client discharged 35 days post clinical readiness/treatment barrier

### Housing (8) 15 %

1 client discharged 6 days post clinical readiness  
1 client discharged 22 days post clinical readiness  
1 client discharged 26 days post clinical readiness  
1 client discharged 39 days post clinical readiness  
1 client discharged 50 days post clinical readiness  
1 client discharged 56 days post clinical readiness  
1 client discharged 59 days post clinical readiness  
1 client discharged 98 days post clinical readiness



This chart shows the percent of civil clients who were discharged within 7 days of their discharge readiness to be at 54.4% for this quarter. Cumulative percentages and targets are as follows:

**Within 7 days = 68.8% (target 75%)**  
**Within 30 days = 76.6% (target 90%)**  
**Within 45 days = 86.0% (target 100%)**  
**14.1% faced a barrier and were discharged post 45 days.**

**The previous five quarters are displayed in the table below**

Quarter	Within 7 days	Within 30days	Within 45 days	45 +days
Target	75%	90%	100%	0%
Q4 2011	68.8%	76.6%	86.0%	14.1%
Q3 2011	54.4%	77.9%	88.2%	11.0%
Q2 2011	67.6%	83.8%	89.2%	10.8%
Q1 2011	51.4%	64.9%	83.8%	16.2%
Q4 2010	47.4%	76.3%	84.2%	15.8%
Q3 2010	57.5%	62.5%	72.5%	27.5%

# STAFF DEVELOPMENT

## ASPECT: NEW EMPLOYEE AND MANDATORY TRAINING

Figure CD-19 and CD-20

<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.	19 of 19 completed orientation	100%	100 %
2. New employees will complete CPR training within 30 days of hire.	19 of 19 completed CPR training	100%	100 %
3. New employees will complete NAPPI training within 60 days of hire.	19 of 19 completed Nappi training	100%	100 %
4. Riverview and Contract staff will attend CPR training bi-annually.	318 of 319 are current in CPR certifications	99%	100 %
5. Riverview and Contract staff will attend NAPPI training annually. Goal is to be at 100% by end of fiscal training year 2012 on June 30 <sup>th</sup> . <b>Last Fiscal Year (2011) at 99.7%</b>	92 of 386 have completed annual training as of the 1 <sup>st</sup> quarter	24%	100 %
6. Riverview and Contract staff will attend Annual training. Goal is to be at 100% by end of fiscal training year 2012 on June 30 <sup>th</sup> . <b>Last Fiscal Year (2011) at 100%</b>	219 of 386 have completed annual training as of the 1 <sup>st</sup> quarter	56%	100 %
7. Riverview nursing and medical staff will complete 10 hours of training each year in the psychiatric aspects of their treatment responsibilities. Goal is to be at 100% by end of fiscal training year 2012 on June 30th.	24 of 175 have received a minimum of 10 hours annually as of the 1 <sup>st</sup> quarter	14%	100 %

### Findings

The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. **19 out of 19** (100%) new Riverview/Contracted employees completed these trainings. **318 of 319** (99%) Riverview/Contracted employees are current with CPR certification. **92 of 386** (24%) Riverview/Contracted employees are current in Nappi training. **219 of 386** (56%) employees are current in Annual training. All indicators remained at 100% compliance for quarter 1-FY 2012.

# CONSENT DECREE COMPLIANCE

<u>Subject Area</u>	<u>Standard of Substantial Compliance</u>	<u>Efforts to Comply &amp; Evidence of Compliance</u>
Client Rights	<p>Riverview produces documentation that clients are routinely informed of their rights upon admission in accordance with ¶ 150 of the Settlement Agreement</p> <p>Grievance tracking data shows that the hospital responds to 90% of Level II grievances within five working days of the date of receipt or within a five-day extension.</p>	<p>CD-02: <i>An abstraction process is being developed that will illustrate the degree to which clients are informed of their rights on admission.</i></p> <p>CD-03: Report compiled by Peer Support. Information extracted from Grievance tracking database.</p>
Admissions	<p>Quarterly performance data shows that in 4 consecutive quarters, 95% of admissions to Riverview meet legal criteria.</p> <p>Director of Social Work reviews all readmissions occurring within 60 days of the last discharge; and for each client who spent fewer than 30 days in the community, evaluated the circumstances to determine whether the readmission indicated a need for resources or a change in treatment and discharge planning or a need for different resources and, where such a need or change was indicated, that corrective action was taken.</p> <p>No more than 5% of patients admitted in any year have a primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.</p>	<p>CD-04: Report compiled for Admissions. Information extracted from the Meditech report entitled, "Admission Legal Report."</p> <p>CD-05: This items in reported in the Social Work section under the report entitled, "Preliminary Continuity of Care Meeting and Comprehensive Psychosocial Assessments" under section 2a of that report.</p> <p>CD-06: Report compiled for Admissions. Information extracted from the Meditech report entitled, "Admission Diagnosis Report by Date."</p>
Peer Support	<p>In 3 out of 4 consecutive quarters:</p> <ul style="list-style-type: none"> <li>• 80% of all clients have documented contact with a peer specialist during hospitalization</li> <li>• 80% of all treatment meetings involve a peer specialist.</li> </ul>	<p>CD-07: Report compiled by Peer Support.</p> <p>CD-08: Report compiled by Peer Support.</p>
Treatment Planning	<p>In 3 out of 4 consecutive quarters</p> <ul style="list-style-type: none"> <li>• 95% of clients have a preliminary treatment and transition plan developed within 3 working days of admission</li> <li>• 95% of clients also have individualized treatment plans in their records within 7 days thereafter</li> <li>• Riverview certifies that all treatment modalities required by ¶155 are available.</li> </ul>	<p>CD-09: <i>A method for the reporting of this compliance standard is currently under development.</i></p> <p>CD-10: <i>A method for the reporting of this compliance standard is currently under development.</i></p> <p>CD-11: Records of client participation in active treatment are maintained by the unit PSD. All required, unit and Harbor Mall treatment schedules are available for review.</p> <p><i>A method for the reporting trends of compliance is currently under development.</i></p>

# CONSENT DECREE COMPLIANCE

<u>Subject Area</u>	<u>Standard of Substantial Compliance</u>	<u>Efforts to Comply &amp; Evidence of Compliance</u>
Treatment Planning (cont'd)	<p>An evaluation of treatment planning and implementation, performed in accordance with <b>Attachment D</b>, demonstrates that, for 90% of the cases reviewed quarterly performance data shows that in 4 consecutive quarters:</p> <ul style="list-style-type: none"><li>70% of clients who remained ready for discharge were transitioned out of the hospital within 7 days of a determination that they had received maximum benefit from inpatient care</li><li>80 % of clients who remained ready for discharge were transitioned out of the hospital within 30 days of a determination that they had received maximum benefit from inpatient care</li><li>90% of clients who remained ready for discharge were transitioned out of the hospital within 45 days of a determination that they had received maximum benefit from inpatient care (with certain clients excepted, by agreement of the parties and court master).</li><li>treatment and discharge plans reflect interventions appropriate to address discharge and transition goals</li><li>for patients who have been found not criminally responsible or not guilty by reason of insanity, appropriate interventions include timely reviews of progress toward the maximum levels allowed by court order; and the record reflects timely reviews of progress toward the maximum levels allowed by court order</li><li>interventions to address discharge and transition planning goals are in fact being implemented</li><li>for patients who have been found not criminally responsible or not guilty by reason of insanity, this means that, if the treatment team determines that the patient is ready for an increase in levels beyond those allowed by the current court order, Riverview is taking reasonable steps to support a court petition for an increase in levels.</li></ul>	<p><a href="#">CD-12</a>: Information on this standard is illustrated in the Social Work performance measures related to the aspect of care entitled, "Barriers to Community Placement of Civil Clients"</p> <p><a href="#">CD-13</a>: Information on this standard is illustrated in the Social Work performance measured related to the aspect of care entitled, "Barriers to Community Placement of Civil Clients"</p> <p><a href="#">CD-14</a>: Information on this standard is illustrated in the Social Work performance measured related to the aspect of care entitled, "Barriers to Community Placement of Civil Clients"</p> <p><a href="#">CD-15</a>: This compliance standard is addressed in the Social Work report on "Treatment Plans and Progress Notes."</p> <p><a href="#">CD-16</a>: This compliance standard is addressed in the Social Work report on "Treatment Plans and Progress Notes."</p> <p><a href="#">CD-17</a>: This compliance standard is addressed in the Social Work report on "Treatment Plans and Progress Notes."</p> <p><a href="#">CD-18</a>: This compliance standard is addressed in the Social Work report on "Institutional and Annual Reports."</p>

# CONSENT DECREE COMPLIANCE

<u>Subject Area</u>	<u>Standard of Substantial Compliance</u>	<u>Efforts to Comply &amp; Evidence of Compliance</u>
Staffing and Staff Training	<p>Riverview performance data shows that 95% of all new direct care staff have received 90% of their orientation training before having been assigned to duties requiring unsupervised direct care of patients.</p> <p>Riverview certifies that 95% of professional staff have maintained professionally-required continuing education credits and have received the ten hours of annual cross-training required by ¶216</p>	<p><a href="#">CD-19</a>: Compliance with this standard is documented under the section of Staff Development.</p> <p><a href="#">CD-20</a>: Compliance with this standard is documented under the section of Staff Development.</p>
Seclusion and Restraint	<p>Riverview certifies that staffing ratios required by ¶202 are met, and makes available documentation that shows actual staffing for up to one recent month.</p> <p>The evaluation of treatment and discharge planning, performed in accordance with <b>Attachment D</b>, demonstrates that staffing was sufficient to provide patients access to activities necessary to achieve the patients' treatment goals, and to enable patients to exercise daily and to recreate outdoors consistent with their treatment plans.</p> <p>Quarterly performance data shows that, in 5 out of 6 quarters, total seclusion and restraint hours do not exceed one standard deviation from the national mean as reported by NASMHPD</p> <p>Riverview demonstrates that, based on a review of two quarters of data, for 95% of seclusion events, seclusion was employed only when absolutely necessary to protect the patient from causing physical harm to self or others or for the management of violent behavior.</p> <p>Riverview demonstrates that, based on a review of two quarters of data, for 95% of restraint events involving mechanical restraints, the restraint was used only when absolutely necessary to protect the patient from serious physical injury to self or others.</p> <p>Riverview demonstrates that, based on a review of two quarters of data, for 95% of seclusion and restraint events, the hospital achieved an acceptable rating for meeting the requirements of paragraphs 182 and 184 of the Settlement Agreement, in accordance with a methodology defined in <b>Attachments E-1 and E-2</b>.</p>	<p>CD-21: All required staffing ratios are regularly met. Evidence of compliance can be reviewed through staffing office and other human resource records.</p> <p>CD-22: <i>A process for the review of the requisite 28 client records is being developed and will be conducted on a quarterly basis. To determine substantial compliance in the areas of: 1) treatment and discharge planning and implementation, and 2) staffing.</i></p> <p>Report compiled by the Integrated Quality Team and reported in Comparative Statistics section on...</p> <p><a href="#">CD-23</a>: Seclusion Hours and</p> <p><a href="#">CD-24</a>: Restraint Hours.</p> <p><a href="#">CD-25</a>: Report compiled by the Integrated Quality Team and reported in Comparative Statistics</p> <p><a href="#">CD-26</a>: Report compiled by the Integrated Quality Team and reported in Comparative Statistics</p> <p><a href="#">CD-42</a>: Seclusion and <a href="#">CD-43</a> restraint events are reviewed as part of a regular analysis of performance by the Nursing Department.</p>

# CONSENT DECREE COMPLIANCE

<u>Subject Area</u>	<u>Standard of Substantial Compliance</u>	<u>Efforts to Comply &amp; Evidence of Compliance</u>
Elopement	Quarterly performance data shows that, in 5 out of 6 quarters, the number of client elopements does not exceed one standard deviation from the national mean as reported by NASMHPD.	<a href="#">CD-27</a> : Report compiled by the Integrated Quality Team and reported in Comparative Statistics section on Elopement.
Client Injuries	Quarterly performance data shows that, in 5 out of 6 quarters, the number of client injuries does not exceed one standard deviation from the national mean as reported by NASMHPD.	<a href="#">CD-28</a> : Report compiled by the Integrated Quality Team and reported in Comparative Statistics section on Client Injuries.
Patient Abuse, Neglect, Exploitation, Injury or Death	Riverview certifies that it is reporting and responding to instances of patient abuse, neglect, exploitation, injury or death consistent with the requirements of ¶¶ 192-201 of the Settlement Agreement.	CD-29: Regular reports of any events related to allegations of abuse, neglect, exploitation, injury or death are submitted to the Disability Rights Center, the Human Rights Committee and the Consent Decree Court Master per the requirements of the Settlement Agreement. Minutes of the Human Rights Committee are available for review by regulators and accreditation agencies upon request. The Superintendent also certifies annually according to 22 MRSA, Chapter 1684, and 10-44 CMR Chapter 114, Rules Governing the Reporting of Sentinel Events that all sentinel and serious reportable events are reported to the DHHS DLRS Sentinel Events Team as required by this law.
Performance Improvement	Riverview maintains JCAHO accreditation	CD-30: A joint commission survey conducted on November 15-19, 2010 resulted in a full accreditation determination for both the hospital and the Community Forensic ACT team. Documentation of this action can be viewed in the office of the Superintendent.
	Riverview maintains its hospital license	CD-40: Documentation of the hospital's licensure status can be viewed in the office of the Superintendent and verified with the Maine DHHS Department of Licensure and Regulatory Services.
	The hospital does not lose its CMS certification (for the entire hospital excluding Lower Saco SCU so long as Lower Saco SCU is a distinct part of the hospital for purposes of CMS certification) as a result of patient care issues	CD-41: Documentation of the hospital's CMS certification status can be viewed in the office of the Superintendent.

The items listed in this table were abstracted from the Standards for Defining Substantial Compliance dated October 29, 2007.