QUARTERLY REPORT ON ORGANIZATIONAL PERFORMANCE EXCELLENCE

FOURTH STATE FISCAL QUARTER 2017

April, May, June 2017

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July 25, 2017

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Glossary of Terms, Acronyms & Abbreviations

ADC	Automated Dispensing Cabinets (for medications)
ADON	Assistant Director of Nursing
AOC	Administrator on Call
CCM	Continuation of Care Management (Social Work Services)
CCP	Continuation of Care Plan
CH/CON	Charges/Convicted
CMS	Centers for Medicare & Medicaid Services
CIVIL	Voluntary, No Criminal Justice Involvement
CIVIL-INVOL	Involuntary Civil Court Commitment (No Criminal Justice Involvement)
CoP	Community of Practice or Conditions of Participation (CMS)
CPI	Continuous Process (or Performance) Improvement
CPR	Cardio-Pulmonary Resuscitation
CSP	Comprehensive Service Plan
DCC	Involuntary District Court Committed
DCC-PTP	Involuntary District Court Committed, Progressive Treatment Plan
GAP	Goal, Assessment, Plan Documentation
HOC	Hand off Communication
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
JAIL TRANS	A patient who has been transferred to RPC from jail.
JTF	A patient who has been transferred to RPC from jail.
LCSW	Licensed Clinical Social Worker
LEGHOLD	Legal Hold
LPN	Licensed Practical Nurse
MAR	Medication Administration Record
MHW	Mental Health Worker
MRDO	Medication Resistant Disease Organism (MRSA, VRE, C-Dif)
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.
OPS	Outpatient Services Program (formally the ACT Team)
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
PRET	Pretrial Evaluation
R.A.C.E.	Rescue/Alarm/Confine/Extinguish
RN	Registered Nurse
RPC	Riverview Psychiatric Center
RT	Recreation Therapist
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration (Federal)
SAMHS	Substance Abuse and Mental Health Services, Office of (Maine DHHS)
SBAR	Acronym for a model of concise communications first developed by the US Navy Submarine Command. S = Situation, B = Background, A = Assessment, R = Recommendation
SD	Standard Deviation – a measure of data variability. Staff Development.
Seclusion, Locked	Patient is placed in a secured room with the door locked.
Seclusion, Open	Patient is placed in a room and instructed not to leave the room.
SRC	Single Room Care (seclusion)
STAGE III	60 Day Forensic Evaluation
TJC	The Joint Commission (formerly JCAHO, Joint Commission on Accreditation of Healthcare Organizations)
URI	Upper Respiratory Infection
UTI	Urinary Tract Infection
VOL	Voluntary – Self
VOL-OTHER	Voluntary – Others (Guardian)

Introduction

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

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

There are three major sections that make up this report:

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

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

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

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

CONSENT DECREE

Consent Decree Plan

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

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

Patient Rights

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

Indicators	1Q2017	2Q2017	3Q2017	4Q2017
1. Patients are routinely informed of their rights upon admission.	95% 54/60	95% 57/60	97% 58/60	100% 60/60

Patients are informed of their rights and asked to sign that information has been provided to them. If they refuse, staff documents the refusal and signs, dates & times the refusal.

4Q2017: Eight patients refused, four lacked capacity.

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

Indicators	1Q2017	2Q2017	3Q2017	4Q2017
1. Level II grievances responded to by RPC on time.	0% 0/3	0% 0/4	100% 1/1	0% 0/4
2. Level I grievances responded to by RPC on time.	88% 86/98	83% 87/105	100% 20/20	91% 75/82

CONSENT DECREE

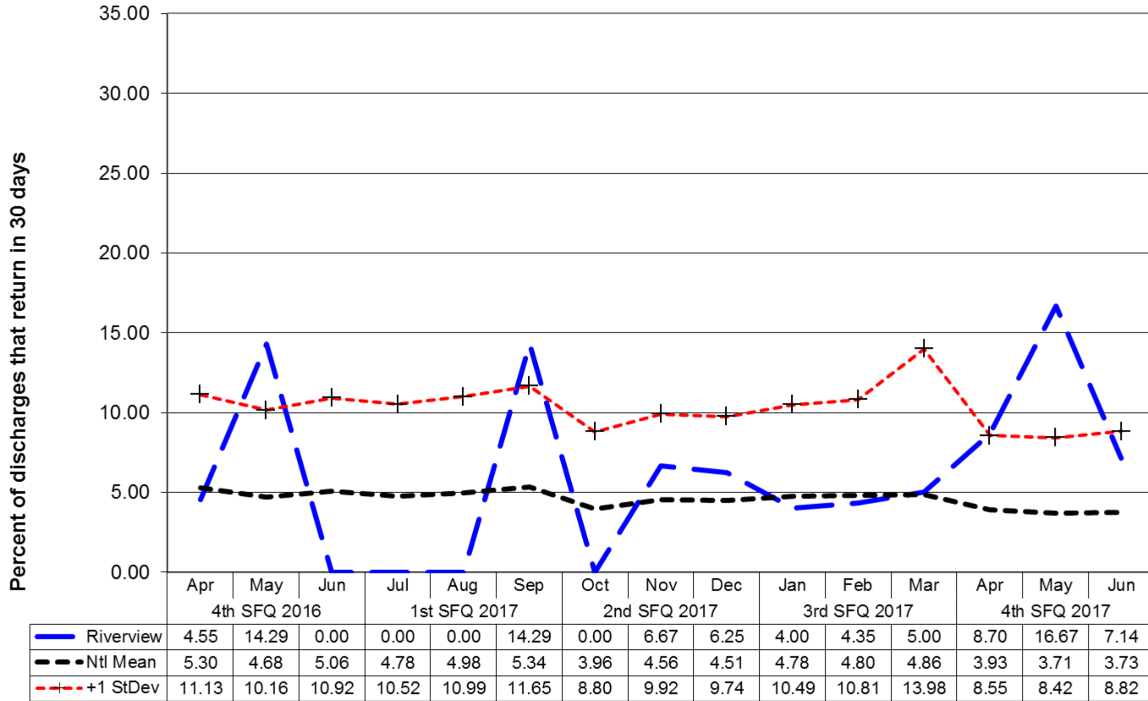
Admissions

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

ADMISSIONS	1Q2017	2Q2017	3Q2017	4Q2017	TOTAL
CIVIL:	**28**	**31**	**32**	**34**	**125**
VOL	0	0	0	2	**2**
INVOL (EIC)	6	9	6	7	**28**
DCC	22	20	26	23	**91**
DCC-PTP	0	2	0	2	**4**
FORENSIC:	**25**	**30**	**26**	**22**	**103**
60 DAY EVAL	8	14	6	10	**38**
JAIL TRANSFER	0	0	5	2	**7**
IST	13	7	7	5	**32**
NCR	4	9	8	5	**26**
TOTAL	**53**	**61**	**58**	**56**	**228**

CONSENT DECREE

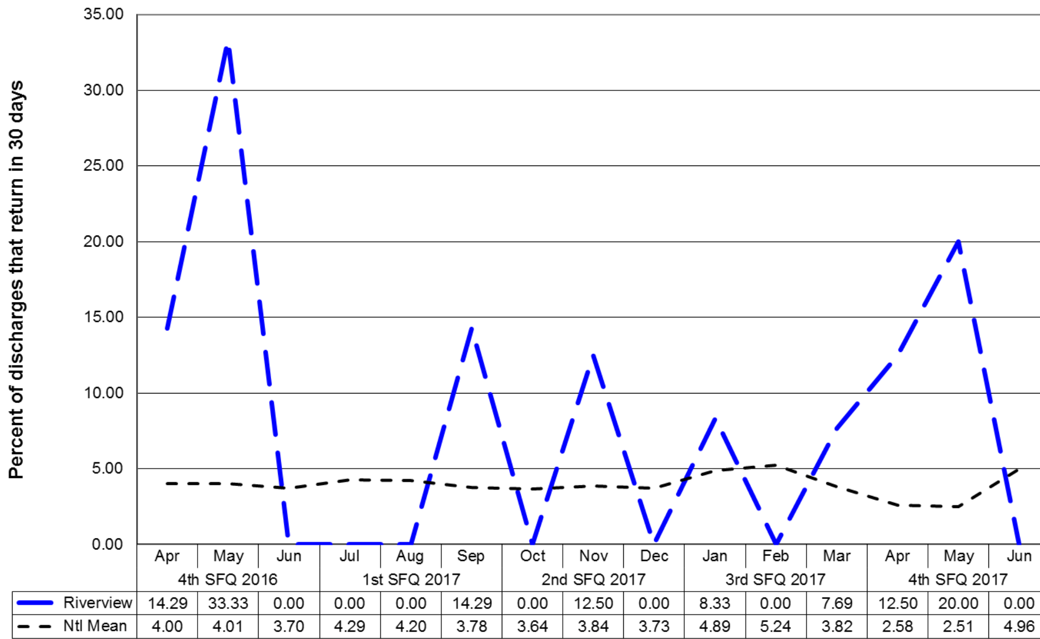
V5) Quarterly performance data shows that in three out of four consecutive quarters, the % of readmissions within 30 days of discharge does not exceed one standard deviation from the national mean as reported by NASMHPD

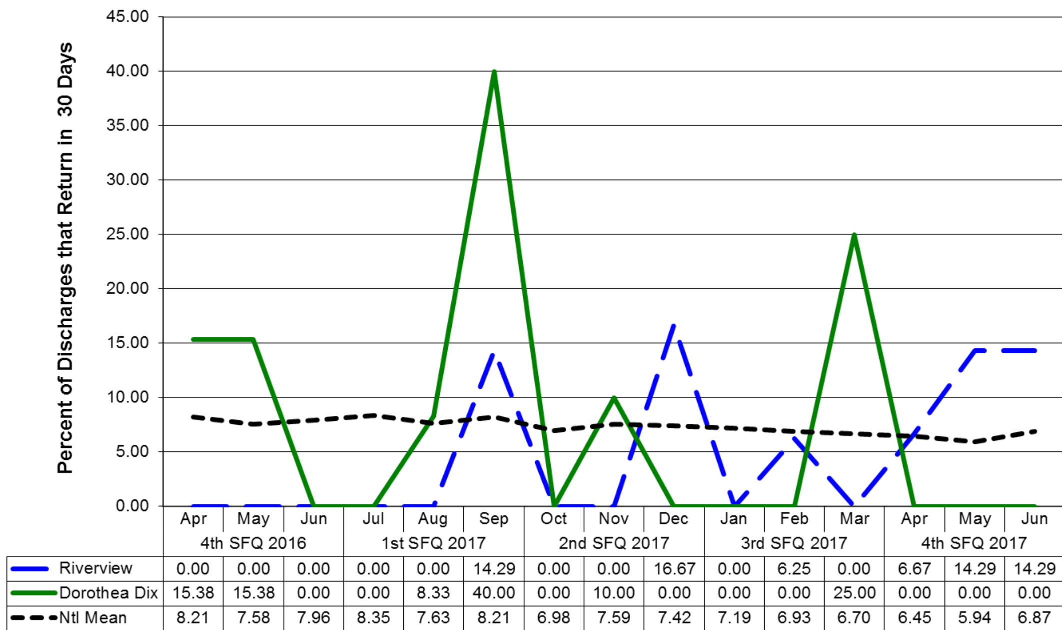


This graph depicts the percent of discharges from the facility that returned within 30 days of a discharge of the same patient from the same facility. For example; a rate of 10.0 means that 10% of all discharges were readmitted within 30 days.

The graphs shown on the next page depict the percent of discharges from the facility that returned within 30 days of a discharge of the same patient 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.

CONSENT DECREE





CONSENT DECREE

V6) Riverview documents, as part of the Performance Improvement & Quality Assurance process, that the Director of Social Work reviews all readmissions occurring within 60 days of the last discharge; and for each patient who spent fewer than 30 days in the community, evaluated the circumstances to determine whether the readmission indicated a need for resources or a change in treatment and discharge planning or a need for different resources and, where such a need or change was indicated, that corrective action was taken;

Review of Re-Admissions Occurring Within 60 Days:

Indicators	1Q2017	2Q2017	3Q2017	4Q2017
Director of Social Services reviews all readmissions occurring within 60 days of the last discharge, and for each patient 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; and, where such a need or change was indicated, that corrective action was taken.	100% 4/4	100% 6/6	100% 6/6	100% 5/5

4Q2017: Five patients were readmitted in the 4Q2017; all five spent less than 30 days in the community. Two patients from the Lower Kennebec unit returned: one spent 27 days in the community after being dismissed from court, and one spent 14 days in the community after he became voluntary and refused services. Two patients from the Upper Kennebec unit spent 16 days and one day respectively in the community. One patient was discharged to her home with her husband and returned on a PTP order. The other patient who remained one day in the community was on medical leave at the general hospital and was readmitted. Additionally, one forensic patient returned from his nursing home after 13 days to be admitted and treated, and then returned to the community.

CONSENT DECREE

Reduction of Re-Hospitalization for Outpatient Services Programs (OPS) Patients

Indicators	1Q2017	2Q2017	3Q2017	4Q2017
1. The Program Service Director of the Outpatient Services Program will review all patient 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 (group home, apartment, etc.) c. Geographic location of residence d. Community support network e. Patient demographics (age, gender, financial) f. Behavior pattern/mental status g. Medication adherence h. Level of communication with Outpatient Treatment	100% 2/2	100% 8/8	100% 8/8	100% 3/3
2. Outpatient Services will work closely with inpatient treatment team to create and apply discharge plan incorporating additional supports determined by review noted in #1.	100%	100%	100%	100%

4Q2017: Three patients returned to RPC: one for violation of court order and two for psychiatric reasons. One patient has since been successfully discharged to a nursing home facility in the community.

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

CONSENT DECREE

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

PATIENT ADMISSION DIAGNOSIS	1Q2017	2Q2017	3Q2017	4Q2017	TOTAL
ADJUSTMENT DISORDER WITH DEPRESSED MOOD			1		**1**
ADJUSTMENT DISORDER WITH DISTURBANCE OF CONDUCT		1			**1**
ANXIETY DISORDER, UNSPECIFIED	1	2			**3**
ASPERGER'S SYNDROME		1			**1**
AUTISTIC DISORDER	1				**1**
BIPOLAR DISORD, CRNT EPISODE MANIC SEVER, W PSYCH FEATURES	1	3	1	1	**6**
BIPOLAR DISORD, CRNT EPISODE MANIC W/O PSYCH FEATURES, MILD	1				**1**
BIPOLAR DISORD, CRNT EPISODE MANIC W/O PSYCH FEATURES, UNSPECIFIED				1	**1**
BIPOLAR DISORD, CRNT EPISODE HYPOMANIC			1		**1**
BIPOLAR DISORD, CRNT EPSD DEPRESS, SEVERE, W PSYCH FEATURES	1				**1**
BIPOLAR DISORDER, UNSPECIFIED	5	3	2	5	**15**
BIPOLAR II DISORDER		1			**1**
BIPOLAR DISORD, CRNT IN REMIS, MOST RECENT EPISODE UNSP			2		**2**
BIPOLAR DISORD, IN FULL REMIS, MOST RECENT EPISODE HYPOMANIC			1		**1**
BIPOLAR DISORD, IN PARTIAL REMIS, MOST RECENT EPISODE MANIC				1	**1**
BORDERLINE PERSONALITY DISORDER			1	4	**5**
DELUSIONAL DISORDERS	1			1	**2**
DEMENTIA IN OTH DISEASES CLASSD ELSWHR W/ BEHAVIORAL DISTURB	1		1		**2**
GENERALIZED ANXIETY DISORDER		1			**1**
IMPULSE CONTROL DISORDER	1				**1**
MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED		3	1	1	**5**

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

CONSENT DECREE

MAJOR DEPRESSV DISORD, RECURRENT, SEVERE W/O PSYCH FEATURES				1	**1**
MAJOR DEPRESSV DISORD, SINGLE EPSD, SEVERE W/O PSYCH FEATURES			1		**1**
MAJOR DEPRESSV DISORD, SINGLE EPSD, SEVERE W/PSYCH FEATURES			1		**1**
MAJOR DEPRESSV DISORDER, RECURRENT, UNSPECIFIED	1	1		2	**4**
MANIC EPISODE W/O PSYCHOTIC SYMPTOMS, UNSPECIFIED	1				**1**
MILD COGNITIVE IMPAIRMENT, SO STATED			1		**1**
MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION, UNSP		1		1	**2**
OTHER BIPOLAR DISORDER		1			**1**
OTHER SCHIZOAFFECTIVE DISORDER				1	**1**
OTHER SCHIZOPHRENIA DISORDER				1	**1**
PARANOID PERSOANLITY DISORDER		1			**1**
PARANOID SCHIZOPHRENIA	4	4	3		**11**
PERSONALITY CHANGE DUE TO KNOWN PHYSIOLOGICAL CONDITION			2		**2**
PERSONALITY DISORDER, UNSPECIFIED			1	1	**2**
POSTTRAUMATIC STRESS DISORDER-UNSPEC	1	4	1	2	**8**
RESIDUAL SCHIZOPHRENIA		1			**1**
SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE	8	12	11	9	**40**
SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE		1	1		**2**
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	4	8	5	11	**28**
SCHIZOPHRENIA, UNSPECIFIED	10	7	10	6	**33**
SCHIZOPHRENIAFORM DISORDER			1		**1**
UNDIFFERENTIATED SCHIZOPHRENIA		1			**1**
UNSP PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOL COND	5	3	4	4	**16**
UNSPECIFIED MOOD DISORDER (AFFECTIVE)	3	1	5	3	**12**
Total Admissions	**50**	**61**	**58**	**56**	**225**
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	**2%**	**0%**	**2%**	**0%**	**<1%**

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

CONSENT DECREE

Peer Supports

Quarterly performance data shows that in three out of four consecutive quarters:

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

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

Indicators	1Q2017	2Q2017	3Q2017	4Q2017
1. Attendance at Comprehensive Treatment Team meetings. (v9)	87% 434/498	86% 440/511	87% 347/400	80% 312/388
2. Attendance at Service Integration meetings. (v8)	74% 35/47	80% 35/44	71% 34/48	80% 45/56
3. Contact during admission. (v8)	100% 53/53	100% 61/61	100% 58/58	100% 56/56
4. Community Integration/Bridging Inpatient & OPS. Inpatient trips OPS	100% 23 216	100% 22 199	100% 26 232	100% 43 166
5. Peer Support will make a documented attempt to have patients fill out a survey before discharge or annually to evaluate the effectiveness of the peer support relationship during hospitalization.	4% 2/51	45% 26/58	41% 28/68	60% 29/49
6. Grievances responded to on time by Peer Support, within one day of receipt.	100% 96/96	100% 105/105	96% 70/73	94% 81/86
7. Peer Specialist will meet with resident's within 48 hours of admission and complete progress note to document meeting.	100% 53/53	100% 61/61	100% 58/58	100% 56/56
8. Each resident has documented contact with a peer supporter during their hospitalization (target is 100%).	100% 53/53	100% 61/61	100% 58/58	100% 56/56

CONSENT DECREE

Treatment Planning

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

Indicators	1Q2017	2Q2017	3Q2017	4Q2017
1. Service Integration Meeting and form completed by the end of the 3rd day.	100% 45/45	95% 43/45	98% 44/45	91% 41/45
2. Patient participation in Service Integration Meeting.	93% 42/45	95% 43/45	96% 43/45	93% 42/45
3. Social Worker participation in Service Integration Meeting.	100% 45/45	100% 45/45	100% 45/45	100% 45/45
4. Initial Comprehensive Psychosocial Assessments completed within seven days of admission.	96% 43/45	93% 42/45	95% 43/45	93% 42/45
5. Initial Comprehensive Assessment contains summary narrative with conclusion and recommendations for discharge and Social Worker role.	100% 45/45	100% 45/45	100% 45/45	100% 45/45
6. Annual Psychosocial Assessment completed and current in chart.	80% 8/10	100% 10/10	90% 9/10	80% 8/10

4Q2017:

1. Four Service Integration Forms were not completed within three days; this was addressed in supervision with individual staff.
2. Three patients declined to meet for the Service Integration Meeting and declined again on follow up.
4. Three Comprehensive Psychosocial Assessments were not completed within the seven day timeframe, they have since been completed and are in the chart. Follow up supervision was done with each individual social worker.
6. Two annual assessments were out of compliance and have since been completed.

CONSENT DECREE

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

Indicators	1Q2017	2Q2017	3Q2017	4Q2017
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all patients on assigned **CCM** caseload.	93% 42/45	100% 45/45	100% 45/45	93% 42/45
2. Treatment plans will have measurable goals and interventions listing patient strengths and areas of need related to transition to the community or transition back to a correctional facility.	100% 45/45	100% 45/45	100% 45/45	100% 45/45

4Q2017: Missing notes were addressed with individual staff members in supervision and notes were entered into the chart as late entries.

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

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

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

CONSENT DECREE

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

V13) The treatment plans reflect:

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

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

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

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

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

Medications

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

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

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

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

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

CONSENT DECREE

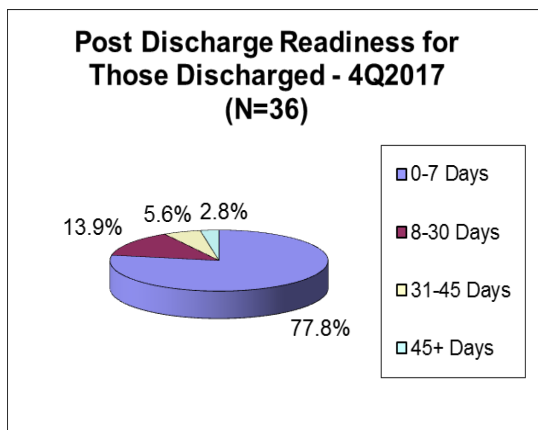
Discharges

Quarterly performance data shows that in three consecutive quarters:

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

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

V19) 90% of patients 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 patients excepted, by agreement of the parties and Court Master).



Cumulative percentages & targets are as follows:

Within 7 days = (28) 78% (target 70%)

Within 30 days = (5) 92% (target 80%)

Within 45 days = (2) 97% (target 90%)

Post 45 days = (1) 3% (target 0%)

Barriers to Discharge Following Clinical Readiness:

Housing (8)

- Five patients discharged within 30 days post clinical readiness (8, 10, 11, 16, and 29 days)
- Two patients discharged within 45 days post clinical readiness (37 and 42 days)
- One patient discharged 45+ days post clinical readiness (68 days)

The previous four quarters are displayed in the table below:

		Within 7 days	Within 30 days	Within 45 days	45+ days
	Target >>	**70%**	**80%**	**90%**	**< 10%**
3Q2017	N=49	78%	88%	92%	8%
2Q2017	N=34	82%	94%	94%	6%
1Q2017	N=32	78%	88%	91%	9%
4Q2016	N=33	79%	88%	88%	12%

CONSENT DECREE

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

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

V20a) For patients who have been found not criminally responsible or not guilty by reason of insanity, appropriate interventions include timely reviews of progress toward the maximum levels allowed by court order; and the record reflects timely reviews of progress toward the maximum levels allowed by court order;

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

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

Indicators	1Q2017	2Q2017	3Q2017	4Q2017
1. The Patient Discharge Plan Report will be reviewed and updated by each **Social Worker minimally one time per week.**	100% 13/13	100% 13/13	100% 12/12	100% 12/12
2. The Patient Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	100% 13/13	100% 13/13	100% 12/12	100% 12/12
3. The Patient Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	85% 11/13	100% 13/13	100% 12/12	100% 12/12
4. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	100% 13/13	100% 13/13	100% 12/12	100% 12/12

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CONSENT DECREE

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

Indicators	1Q2017	2Q2017	3Q2017	4Q2017
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	67% 4/6	0% 0/5	50% 1/2	100% 2/2
2. The assigned **CCM** will review the new court order with the patient and document the meeting in a progress note or treatment team note.	100% 6/6	100% 4/4	100% 3/3	100% 2/2
3. Annual Reports (due in December) to the Commissioner for all inpatient NCR patients are submitted annually	N/A	N/A	100% 17/17	N/A

CONSENT DECREE

Staffing and Staff Training

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

Indicators	1Q2017	2Q2017	3Q2017	4Q2017	YTD
1. Riverview and Contract staff will attend CPR training bi-annually.	81% 65/80	89% 59/66	94% 61/65	94% 45/48	**89% 230/259**
2. Riverview and Contract staff will attend Annual training.	75% 135/179	47% 28/60	56% 24/43	See Below	**66% 187/282**
3. Riverview and contract staff will attend MOAB training bi-annually	66% 52/79	68% 74/109	See below	See Below	**67% 126/188**

4Q2017:

2. In March 2017, the process for meeting annual training requirements was changed. Requirements are now met through submission of monthly competencies, which are consistent with the hospital's training needs. Data is as follows: March-April 235/394 employees submitted their monthly competency, for April-May the number was 279/418, and for May-June it was 325/396.

3. In January 2017, we changed behavior management programs to Behavior Response Options. Since that time, 147 employees have been trained in the new program as they have become due for recertification in the former MOAB program.

CONSENT DECREE

V24) Riverview certifies that 95% of professional staff have maintained professionally-required continuing education credits and have received the 10 hours of annual cross-training required by ¶216;

DATE	HRS	TITLE	PRESENTER
1Q2017	8	July – September 2017	
2Q2017	5	October-December 2017	
3Q2017	5	January-March 2017	
5/11/17	1	Managing your mind and health with spiritual practices	Khenpo Jigme Kelzang
5/25/17	1	Laughter/Humor in Recovery	James Weathersby, Chaplain Sarah Berry, Hab Aid
6/1/17	1	UK Case Conference	Regana Sisson MD George Davis, MD UK Treatment Team
6/15/17	1	Meeting the Functional Needs of Civil & Forensic Patients in a State Hospital	Amy Walsh, MS, OTR/L
6/29/17	1	Rx Drug Abuse & Diversion: What to look for	Liana Nabi, PharmD

CONSENT DECREE

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

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

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

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

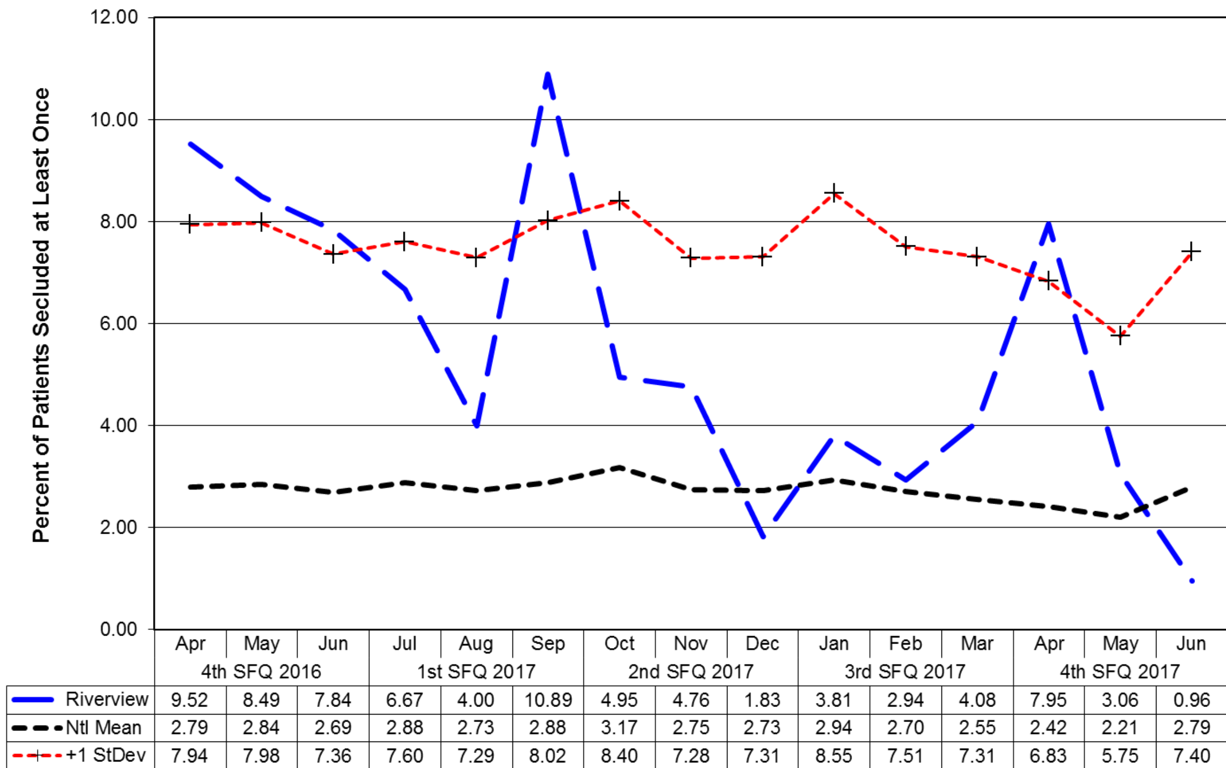
V26) The evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that staffing was sufficient to provide patients access to activities necessary to achieve the patients' treatment goals, and to enable patients to exercise daily and to recreate outdoors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

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

CONSENT DECREE

Use of Seclusion and Restraints

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

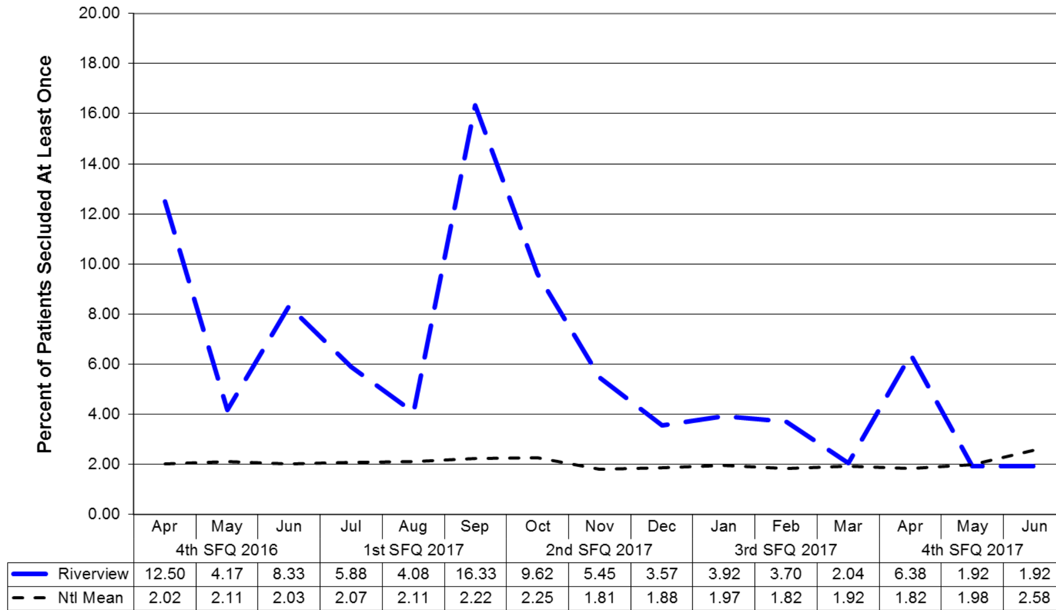


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	9.52	8.49	7.84	6.67	4.00	10.89	4.95	4.76	1.83	3.81	2.94	4.08	7.95	3.06	0.96
Ntl Mean	2.79	2.84	2.69	2.88	2.73	2.88	3.17	2.75	2.73	2.94	2.70	2.55	2.42	2.21	2.79
+1 StDev	7.94	7.98	7.36	7.60	7.29	8.02	8.40	7.28	7.31	8.55	7.51	7.31	6.83	5.75	7.40

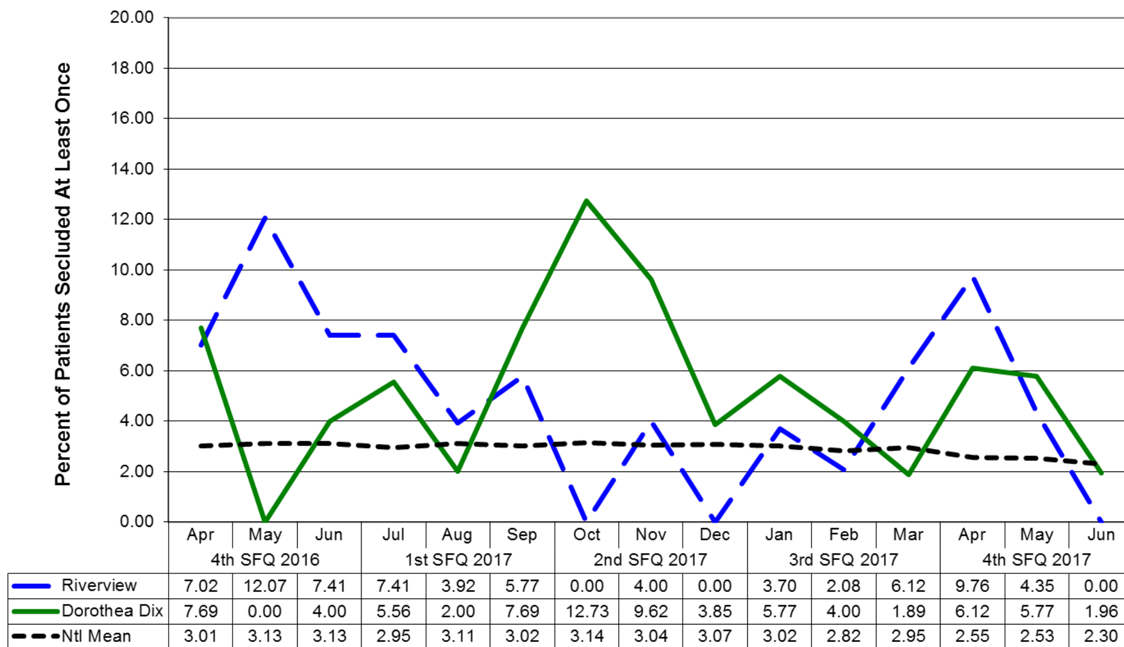
This graph depicts the percent of unique patients who were secluded at least once. For example, rates of 3.0 means that 3% of the unique patients served were secluded at least once.

The following graphs depict the percent of unique patients who were secluded at least once stratified by forensic or civil classifications. For example; rates of 3.0 means that 3% of the unique patients served were secluded at least once. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

CONSENT DECREE

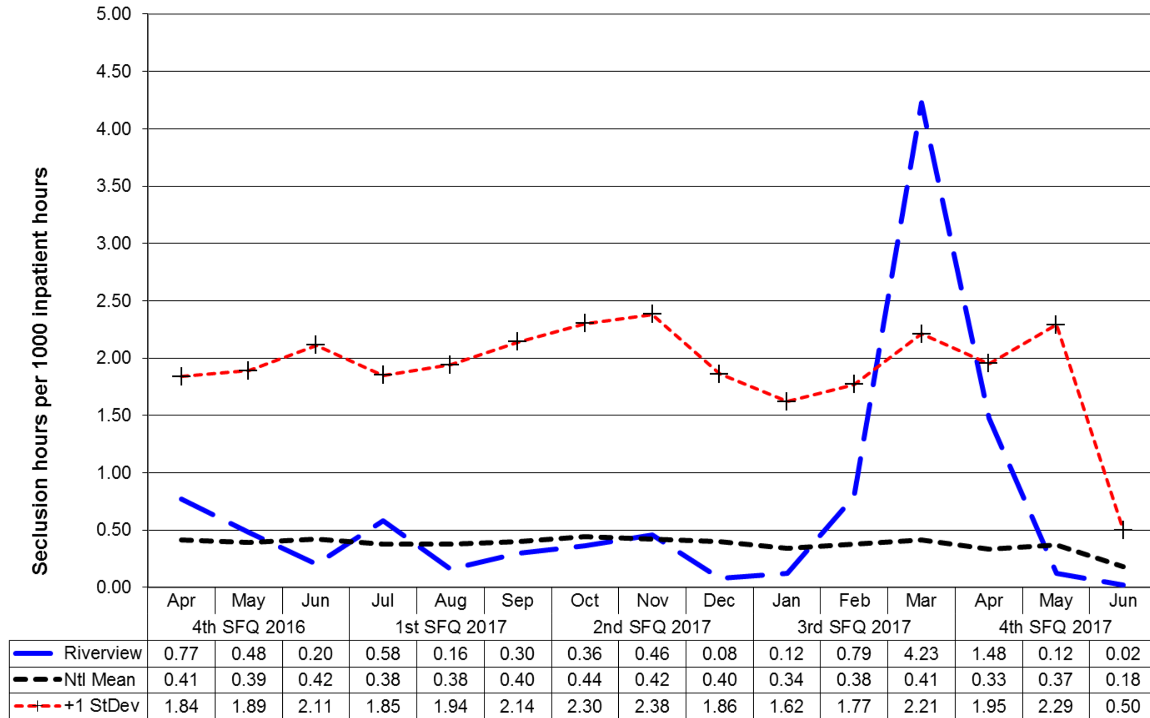


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	12.50	4.17	8.33	5.88	4.08	16.33	9.62	5.45	3.57	3.92	3.70	2.04	6.38	1.92	1.92
Ntl Mean	2.02	2.11	2.03	2.07	2.11	2.22	2.25	1.81	1.88	1.97	1.82	1.92	1.82	1.98	2.58



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	7.02	12.07	7.41	7.41	3.92	5.77	0.00	4.00	0.00	3.70	2.08	6.12	9.76	4.35	0.00
Dorothea Dix	7.69	0.00	4.00	5.56	2.00	7.69	12.73	9.62	3.85	5.77	4.00	1.89	6.12	5.77	1.96
Ntl Mean	3.01	3.13	3.13	2.95	3.11	3.02	3.14	3.04	3.07	3.02	2.82	2.95	2.55	2.53	2.30

CONSENT DECREE

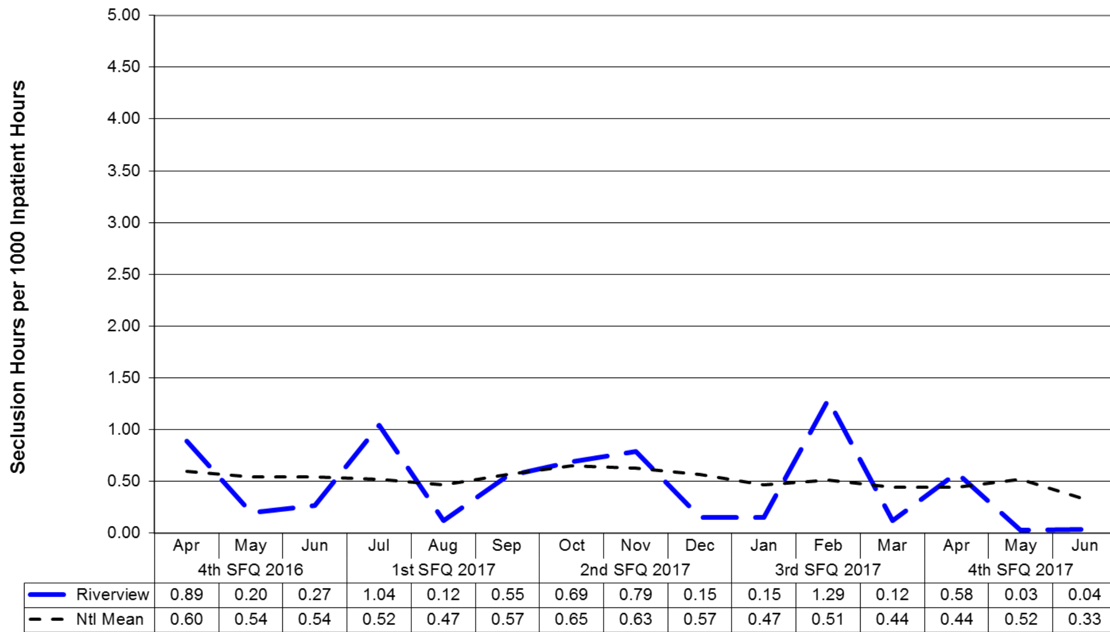


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	0.77	0.48	0.20	0.58	0.16	0.30	0.36	0.46	0.08	0.12	0.79	4.23	1.48	0.12	0.02
Ntl Mean	0.41	0.39	0.42	0.38	0.38	0.40	0.44	0.42	0.40	0.34	0.38	0.41	0.33	0.37	0.18
+1 StDev	1.84	1.89	2.11	1.85	1.94	2.14	2.30	2.38	1.86	1.62	1.77	2.21	1.95	2.29	0.50

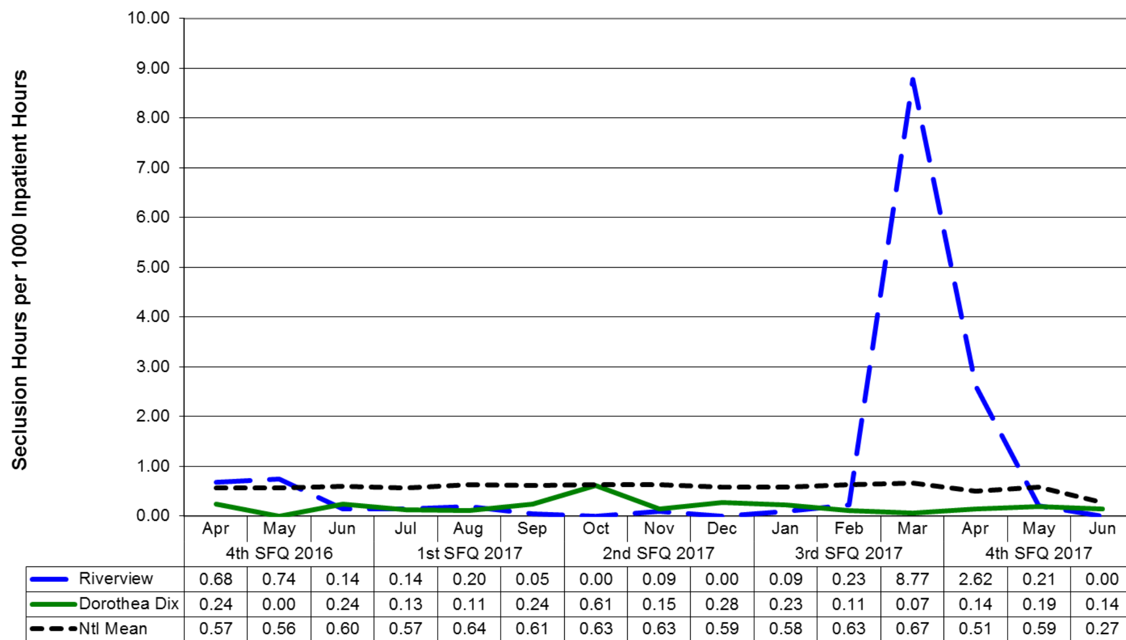
This graph depicts the number of hours patients spent in seclusion for every 1000 inpatient hours. For example, a rate of 0.8 means that one hour was spent in seclusion for each 1250 inpatient hours.

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

CONSENT DECREE

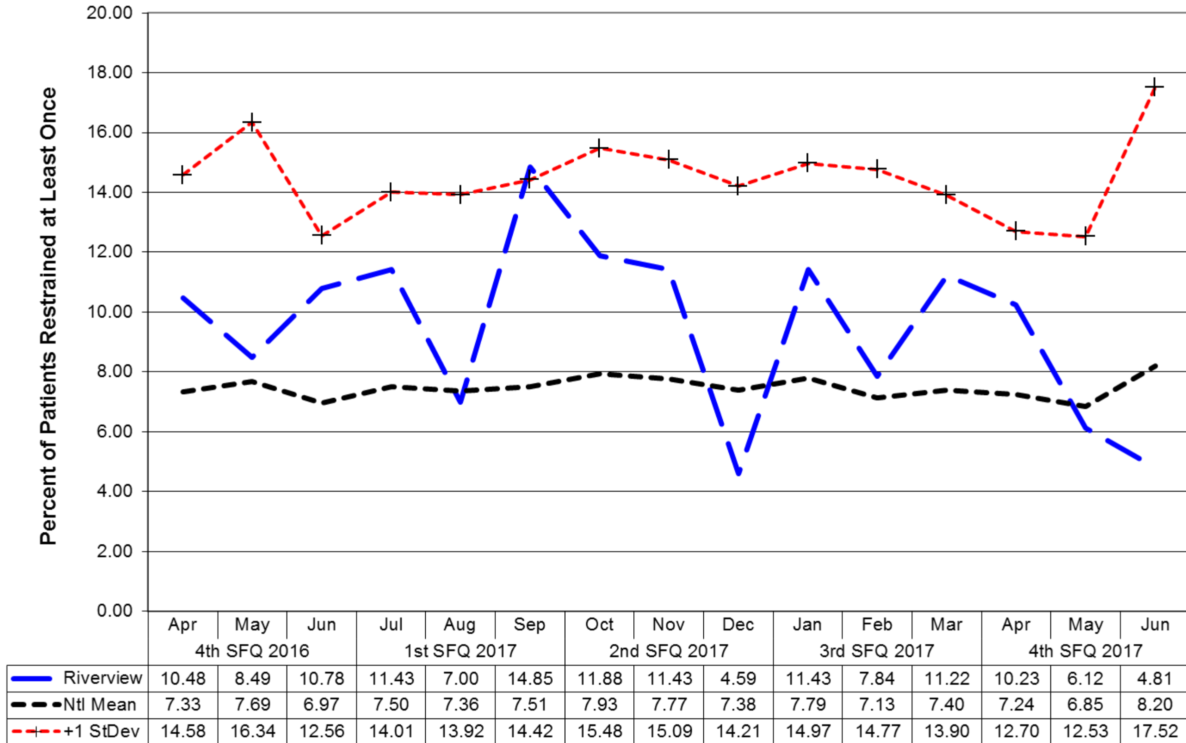


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	0.89	0.20	0.27	1.04	0.12	0.55	0.69	0.79	0.15	0.15	1.29	0.12	0.58	0.03	0.04
Ntl Mean	0.60	0.54	0.54	0.52	0.47	0.57	0.65	0.63	0.57	0.47	0.51	0.44	0.44	0.52	0.33



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	0.68	0.74	0.14	0.14	0.20	0.05	0.00	0.09	0.00	0.09	0.23	8.77	2.62	0.21	0.00
Dorothea Dix	0.24	0.00	0.24	0.13	0.11	0.24	0.61	0.15	0.28	0.23	0.11	0.07	0.14	0.19	0.14
Ntl Mean	0.57	0.56	0.60	0.57	0.64	0.61	0.63	0.63	0.59	0.58	0.63	0.67	0.51	0.59	0.27

CONSENT DECREE

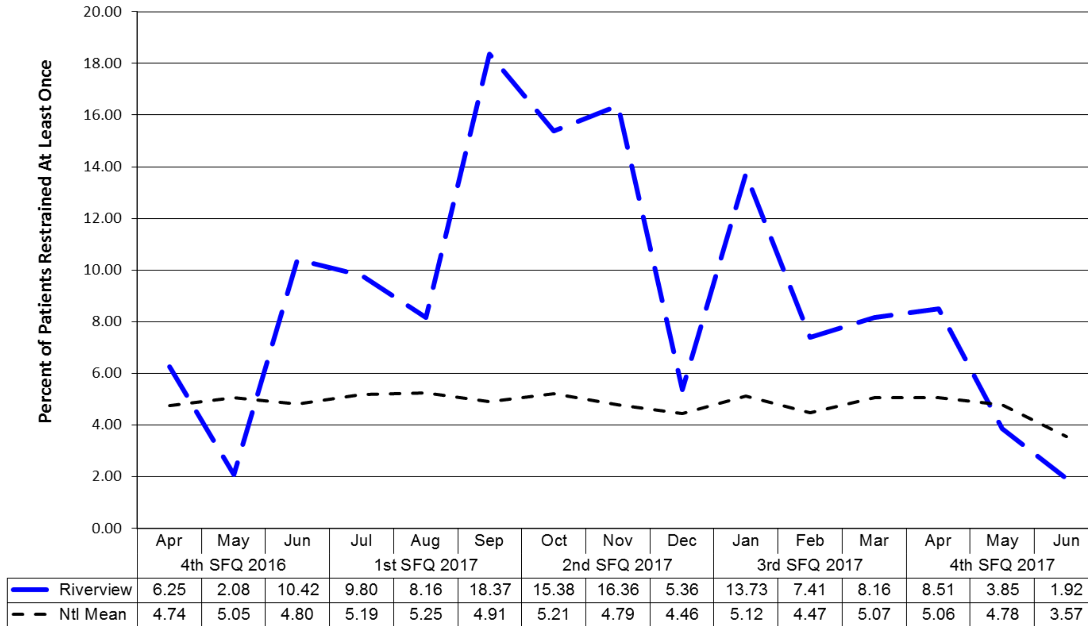


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	10.48	8.49	10.78	11.43	7.00	14.85	11.88	11.43	4.59	11.43	7.84	11.22	10.23	6.12	4.81
Ntl Mean	7.33	7.69	6.97	7.50	7.36	7.51	7.93	7.77	7.38	7.79	7.13	7.40	7.24	6.85	8.20
+1 StDev	14.58	16.34	12.56	14.01	13.92	14.42	15.48	15.09	14.21	14.97	14.77	13.90	12.70	12.53	17.52

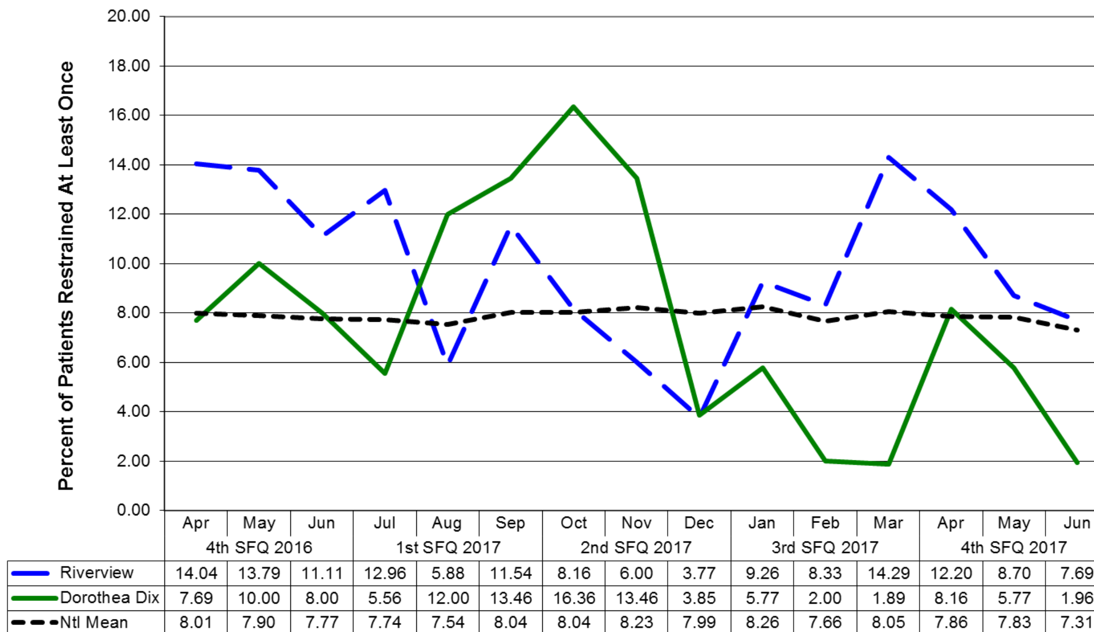
This graph depicts the percent of unique patients who were restrained at least once and includes all forms of restraint of any duration. For example; a rate of 4.0 means that 4% of the unique patients served were restrained at least once.

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

CONSENT DECREE

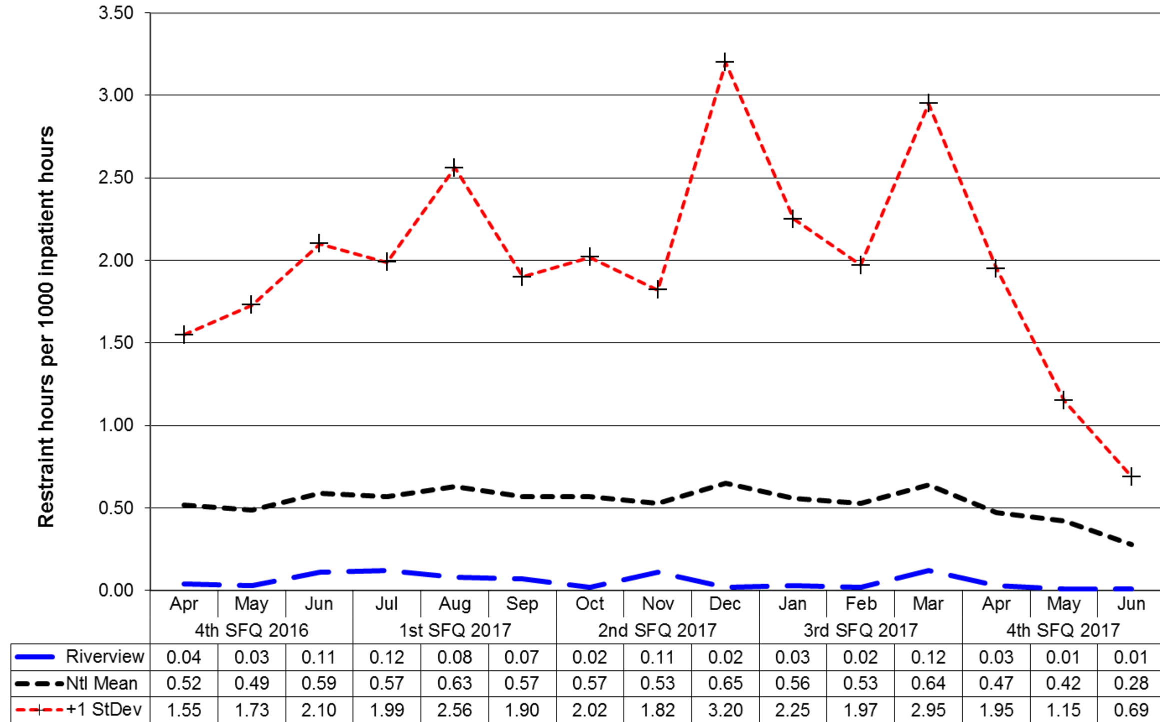


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	6.25	2.08	10.42	9.80	8.16	18.37	15.38	16.36	5.36	13.73	7.41	8.16	8.51	3.85	1.92
Ntl Mean	4.74	5.05	4.80	5.19	5.25	4.91	5.21	4.79	4.46	5.12	4.47	5.07	5.06	4.78	3.57



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	14.04	13.79	11.11	12.96	5.88	11.54	8.16	6.00	3.77	9.26	8.33	14.29	12.20	8.70	7.69
Dorothea Dix	7.69	10.00	8.00	5.56	12.00	13.46	16.36	13.46	3.85	5.77	2.00	1.89	8.16	5.77	1.96
Ntl Mean	8.01	7.90	7.77	7.74	7.54	8.04	8.04	8.23	7.99	8.26	7.66	8.05	7.86	7.83	7.31

CONSENT DECREE

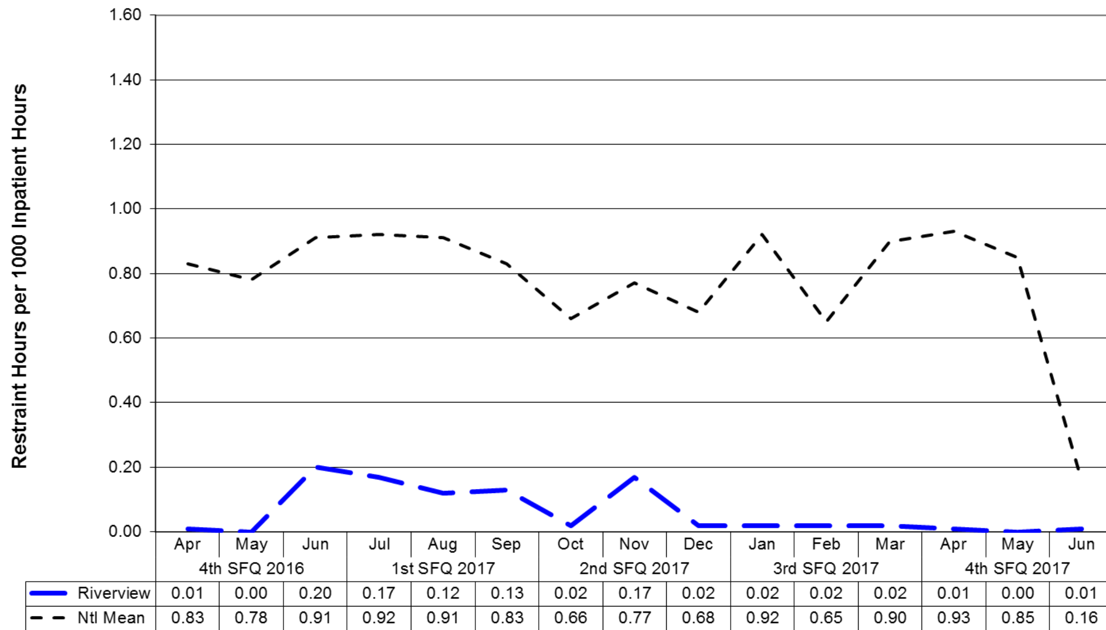


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	0.04	0.03	0.11	0.12	0.08	0.07	0.02	0.11	0.02	0.03	0.02	0.12	0.03	0.01	0.01
Ntl Mean	0.52	0.49	0.59	0.57	0.63	0.57	0.57	0.53	0.65	0.56	0.53	0.64	0.47	0.42	0.28
+1 StDev	1.55	1.73	2.10	1.99	2.56	1.90	2.02	1.82	3.20	2.25	1.97	2.95	1.95	1.15	0.69

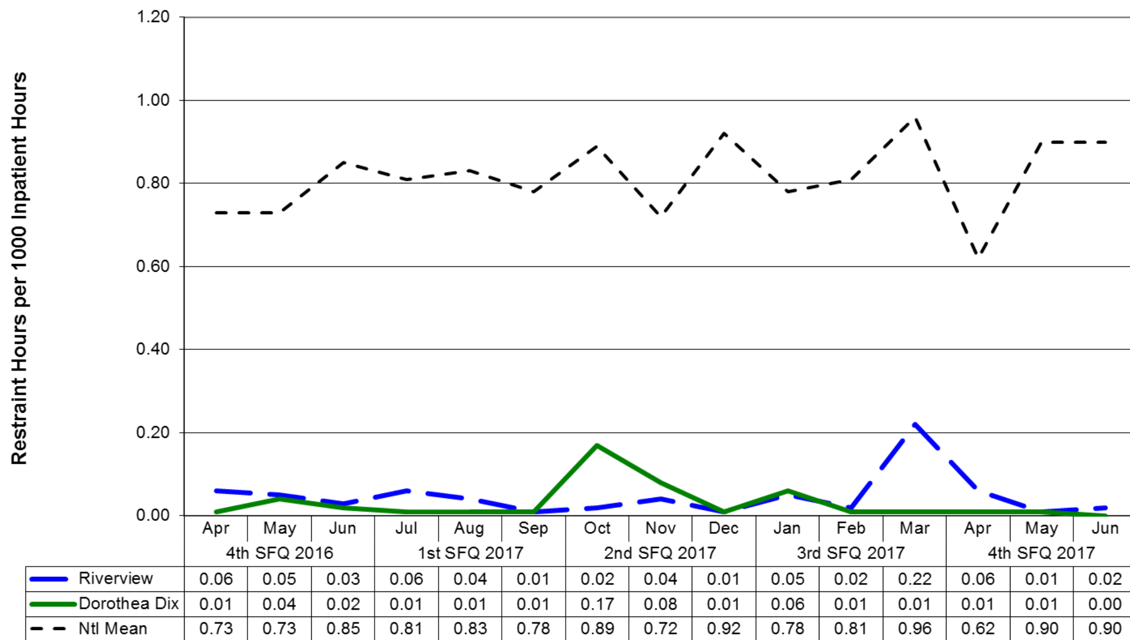
This graph depicts the number of hours patients spent in restraint for every 1000 inpatient hours - includes all forms of restraint of any duration. For example; a rate of 1.6 means those two hours were spent in restraint for each 1250 inpatient hours.

The following graphs depict the number of hours patients 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 those two hours were spent in restraint for each 1250 inpatient hours. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

CONSENT DECREE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	0.01	0.00	0.20	0.17	0.12	0.13	0.02	0.17	0.02	0.02	0.02	0.02	0.01	0.00	0.01
Ntl Mean	0.83	0.78	0.91	0.92	0.91	0.83	0.66	0.77	0.68	0.92	0.65	0.90	0.93	0.85	0.16



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	0.06	0.05	0.03	0.06	0.04	0.01	0.02	0.04	0.01	0.05	0.02	0.22	0.06	0.01	0.02
Dorothea Dix	0.01	0.04	0.02	0.01	0.01	0.01	0.17	0.08	0.01	0.06	0.01	0.01	0.01	0.01	0.00
Ntl Mean	0.73	0.73	0.85	0.81	0.83	0.78	0.89	0.72	0.92	0.78	0.81	0.96	0.62	0.90	0.90

CONSENT DECREE

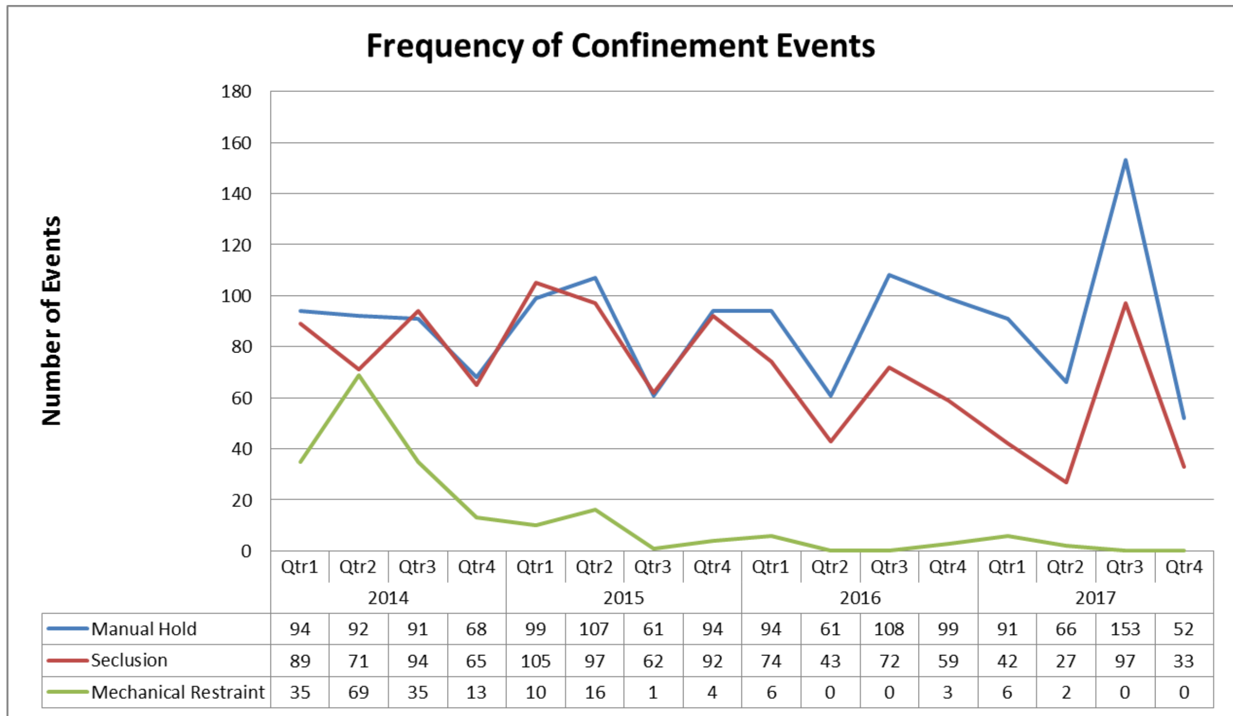
Confinement Event Detail

4Q2017

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR2951	25		19	**44**	51.76%	52%
MR8034	6			**6**	7.06%	59%
MR8038	3		3	**6**	7.06%	66%
MR7177	3		2	**5**	5.88%	72%
MR7950	3		2	**5**	5.88%	78%
MR7994	2		2	**4**	4.71%	82%
MR4974	1		2	**3**	3.53%	86%
MR7278	2		1	**3**	3.53%	89%
MR60	1		1	**2**	2.35%	92%
MR8029	1		1	**2**	2.35%	94%
MR2576	1			**1**	1.18%	95%
MR4814	1			**1**	1.18%	96%
MR6805	1			**1**	1.18%	98%
MR7509	1			**1**	1.18%	99%
MR8036	1			**1**	1.18%	100%
	52	**0**	**33**	**85**	**100%**	

19% (15/80) of the average hospital population experienced some form of confinement event during 4Q2017. Five of these patients (6% of the average hospital population) accounted for 78% of the confinement events.

CONSENT DECREE



	2014				2015				2016				2017			
	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
Manual Hold	94	92	91	68	99	107	61	94	94	61	108	99	91	66	153	52
Seclusion	89	71	94	65	105	97	62	92	74	43	72	59	42	27	97	33
Mechanical Restraint	35	69	35	13	10	16	1	4	6	0	0	3	6	2	0	0

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

Factors of Causation Related to Seclusion Events:

	1Q2017	2Q2017	3Q2017	4Q2017	Total
Danger to Others/Self	40	27	97	33	**221**
Danger to Others					**0**
Danger to Self	2				**2**
% Dangerous Precipitation	100%	100%	100%	100%	**100%**
Total Events	**42**	**27**	**97**	**33**	**225**

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

Factors of Causation Related to Mechanical Restraint Events:

	1Q2017	2Q2017	3Q2017	4Q2017	Total
Danger to Others/Self	6	2			**8**
Danger to Others					**0**
Danger to Self					**0**
% Dangerous Precipitation	100%	100%			**100%**
Total Events	**6**	**2**	**0**	**0**	**8**

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

See Pages 35-38

CONSENT DECREE

Confinement Events Management

4Q2017 Seclusion Events

(33) Events

Standard	Threshold	Compliance
1. 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%
2. The record reflects that lesser restrictive alternatives were inappropriate or ineffective. This can be reflected anywhere in record.	90%	100%
3. The record reflects that the decision to place the patient in seclusion was made by a physician or physician extender.	90%	100%
4. The decision to place the patient in seclusion was entered in the patient's records as a medical order.	90%	100%
5. 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%
6. 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%
7. The record reflects that the patient was monitored every 15 minutes. (Compliance will be deemed if the patient was monitored at least three times per hour.)	90%	100%
8. Individuals implementing seclusion have been trained in techniques and alternatives.	90%	100%
9. 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%
10. The medical order states time of entry of order and that number of hours in seclusion shall not exceed 4.	85%	100%
11. The medical order states the conditions under which the patient may be sooner released.	85%	100%
12. The record reflects that the need for seclusion is re-evaluated at least every two hours by a nurse.	90%	100%

CONSENT DECREE

13. The record reflects that the two hour re-evaluation was conducted while the patient was out of seclusion room unless clinically contraindicated.	70%	100%
14. 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%
15. The record reflects that the patient was released, unless clinically contraindicated, at least every two hours or as necessary for eating, drinking, bathing, toileting or special medical orders.	85%	100%
16. Reports of seclusion events were forwarded to Clinical Director and Patient Advocate.	90%	100%
17. The record reflects that, for persons with mental retardation, the regulations governing seclusion of patients with mental retardation were met.	85%	100%
18. The medical order for seclusion was not entered as a PRN order.	90%	100%
19. Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

Confinement Events Management

4Q2017 Mechanical Restraint Events

(0) Events

Standard	Threshold	Compliance
1. The record reflects that restraint was absolutely necessary to protect the patient from causing serious physical injury to self or others.	95%	N/A
2. The record reflects that lesser restrictive alternatives were inappropriate or ineffective.	90%	N/A
3. The record reflects that the decision to place the patient in restraint was made by a physician or physician extender	90%	N/A
4. The decision to place the patient in restraint was entered in the patient's records as a medical order.	90%	N/A
5. 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%	N/A
6. 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%	N/A
7. The record reflects that the patient was kept under constant observation during restraint.	95%	N/A
8. Individuals implementing restraint have been trained in techniques and alternatives.	90%	N/A
9. The record reflects that reasonable efforts taken to notify guardian or designated representative as soon as possible that patient was placed in restraint.	75%	N/A
10. The medical order states time of entry of order and that number of hours shall not exceed four.	90%	N/A
11. The medical order shall state the conditions under which the patient may be sooner released.	85%	N/A
12. The record reflects that the need for restraint was re-evaluated every two hours by a nurse.	90%	N/A
13. The record reflects that re-evaluation was conducted while the patient was free of restraints unless clinically contraindicated.	70%	N/A
14. 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%	N/A

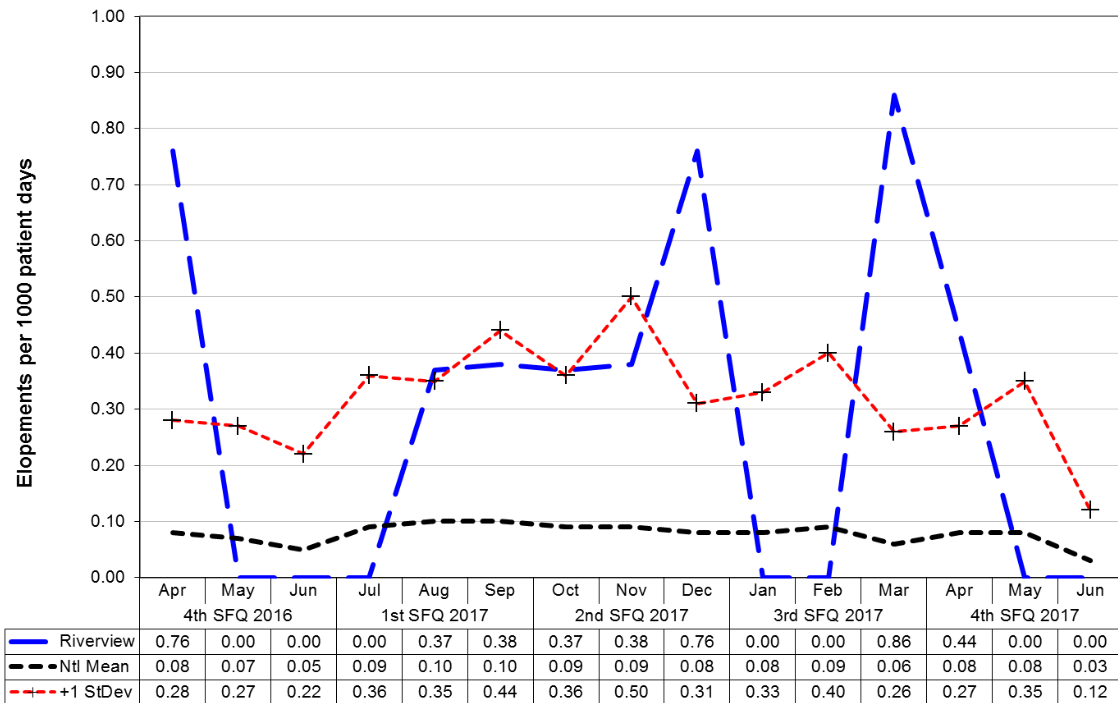
CONSENT DECREE

15. The record reflects that the patient was released as necessary for eating, drinking, bathing, toileting or special medical orders.	90%	N/A
16. The record reflects that the patient's extremities were released sequentially, with one released at least every fifteen minutes.	90%	N/A
17. Copies of events were forwarded to Clinical Director and Patient Advocate.	90%	N/A
18. For persons with mental retardation, the applicable regulations were met.	85%	N/A
19. The record reflects that the order was not entered as a PRN order.	90%	N/A
20. Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A
21. 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 Clinical Director (or if the Clinical Director is out of the hospital, by the individual acting in the Clinical Director's stead) following examination of the patient; and that the patient's guardian or representative has been notified.	90%	N/A

CONSENT DECREE

Patient Elopements

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

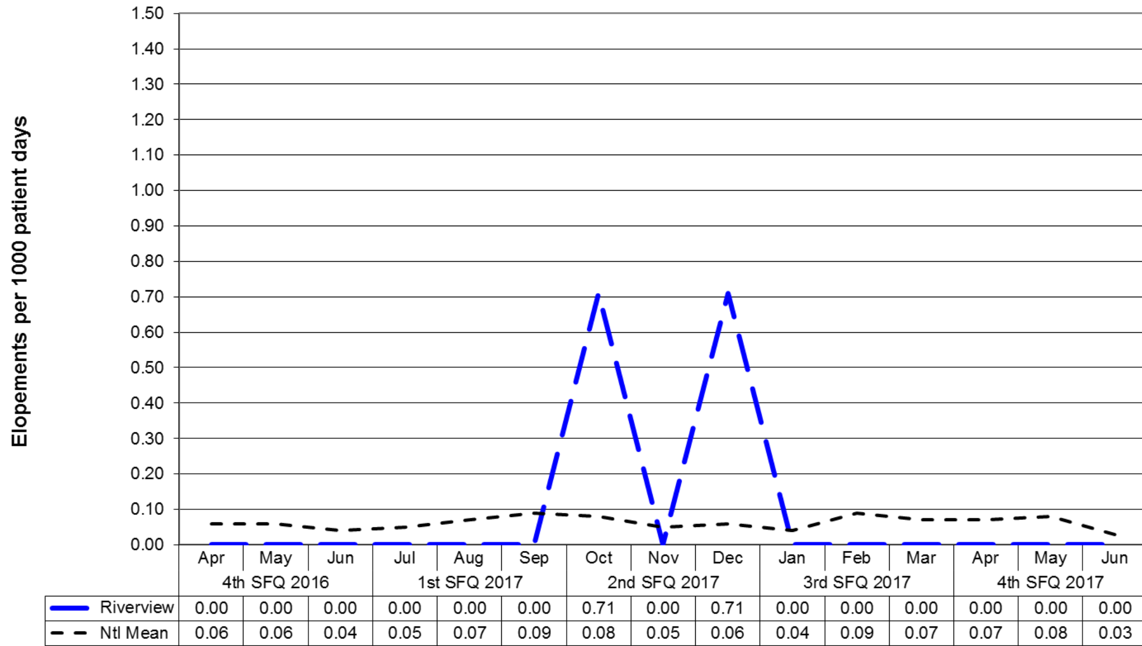


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	0.76	0.00	0.00	0.00	0.37	0.38	0.37	0.38	0.76	0.00	0.00	0.86	0.44	0.00	0.00
Ntl Mean	0.08	0.07	0.05	0.09	0.10	0.10	0.09	0.09	0.08	0.08	0.09	0.06	0.08	0.08	0.03
+1 StDev	0.28	0.27	0.22	0.36	0.35	0.44	0.36	0.50	0.31	0.33	0.40	0.26	0.27	0.35	0.12

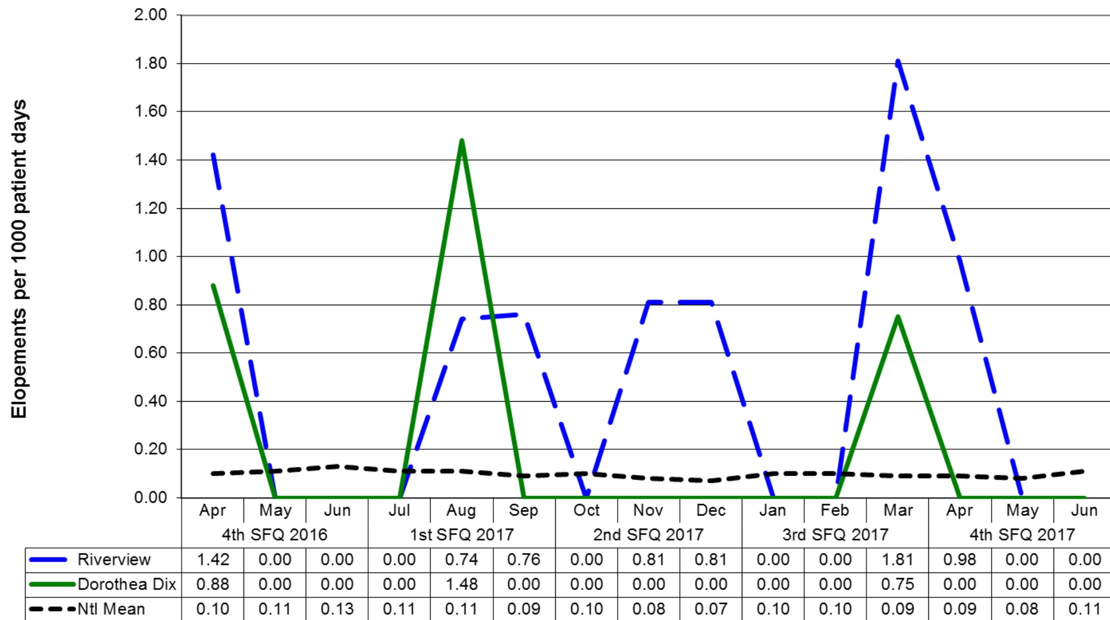
This graph depicts the number of elopements that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that one elopement occurred for each 4000 inpatient days. An elopement is defined as any time a patient is "absent from a location defined by the patient's privilege status regardless of the patient's leave or legal status."

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

CONSENT DECREE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.71	0.00	0.71	0.00	0.00	0.00	0.00	0.00	0.00
Ntl Mean	0.06	0.06	0.04	0.05	0.07	0.09	0.08	0.05	0.06	0.04	0.09	0.07	0.07	0.08	0.03



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	1.42	0.00	0.00	0.00	0.74	0.76	0.00	0.81	0.81	0.00	0.00	1.81	0.98	0.00	0.00
Dorothea Dix	0.88	0.00	0.00	0.00	1.48	0.00	0.00	0.00	0.00	0.00	0.00	0.75	0.00	0.00	0.00
Ntl Mean	0.10	0.11	0.13	0.11	0.11	0.09	0.10	0.08	0.07	0.10	0.10	0.09	0.09	0.08	0.11

CONSENT DECREE

Patient Injuries

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

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

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

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

The comparative statistics graph only includes those events that are considered "Reportable" by NASMHPD.

Type and Cause of Injury by Month

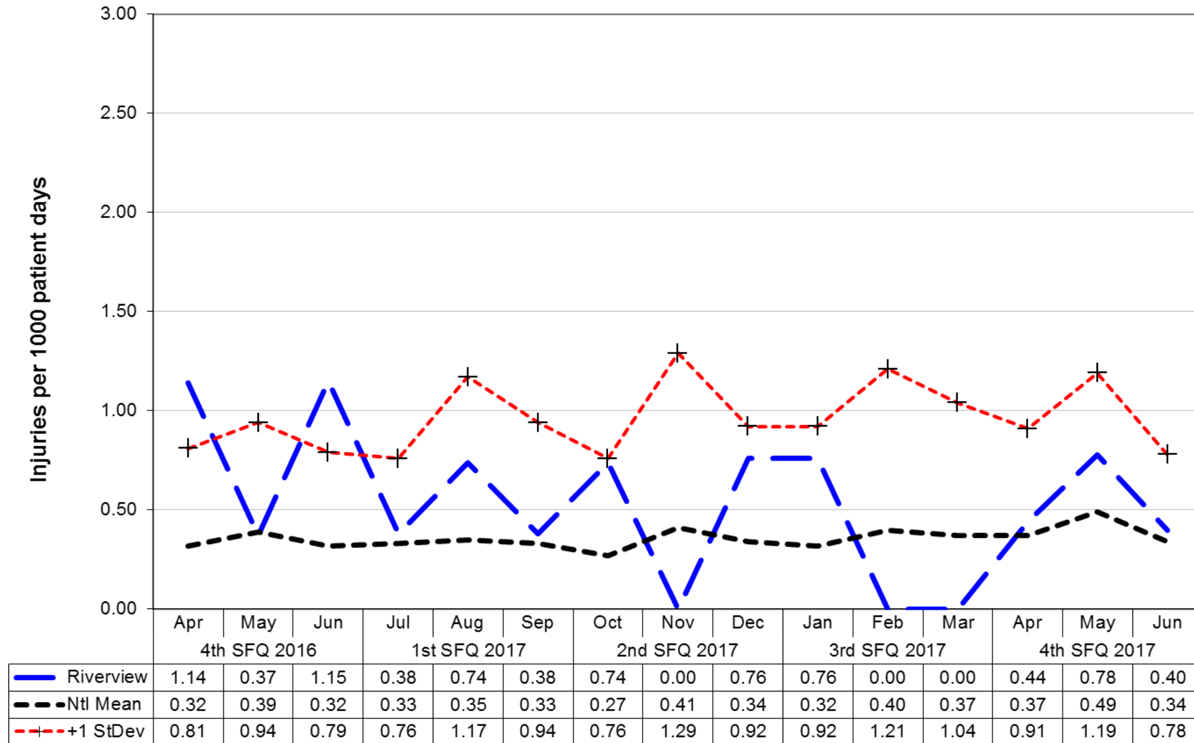
Type - Cause	April	May	June	4Q2017
Accident	2	3	3	**8**
Assault (Patient to Patient)	7		3	**10**
Fall	2	2	1	**5**
Injury – Other			1	**1**
Self-Injurious Behavior	1	3		**4**
Total	**12**	**8**	**8**	**28**

Severity of Injury by Month

Severity	April	May	June	4Q2017
No Treatment	1	2	1	**4**
Minor First Aid	11	4	5	**20**
Medical Intervention Required		2	2	**4**
Hospitalization Required				
Death Occurred				
Total	**12**	**8**	**8**	**28**

CONSENT DECREE

Patient Injury Rate

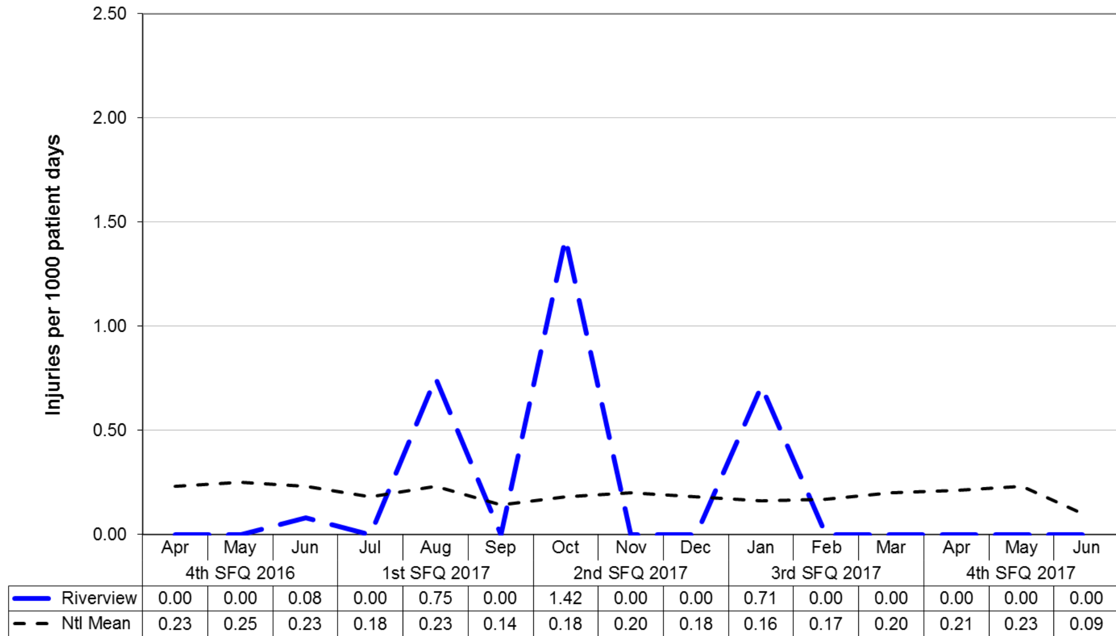


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	1.14	0.37	1.15	0.38	0.74	0.38	0.74	0.00	0.76	0.76	0.00	0.00	0.44	0.78	0.40
Ntl Mean	0.32	0.39	0.32	0.33	0.35	0.33	0.27	0.41	0.34	0.32	0.40	0.37	0.37	0.49	0.34
+1 StDev	0.81	0.94	0.79	0.76	1.17	0.94	0.76	1.29	0.92	0.92	1.21	1.04	0.91	1.19	0.78

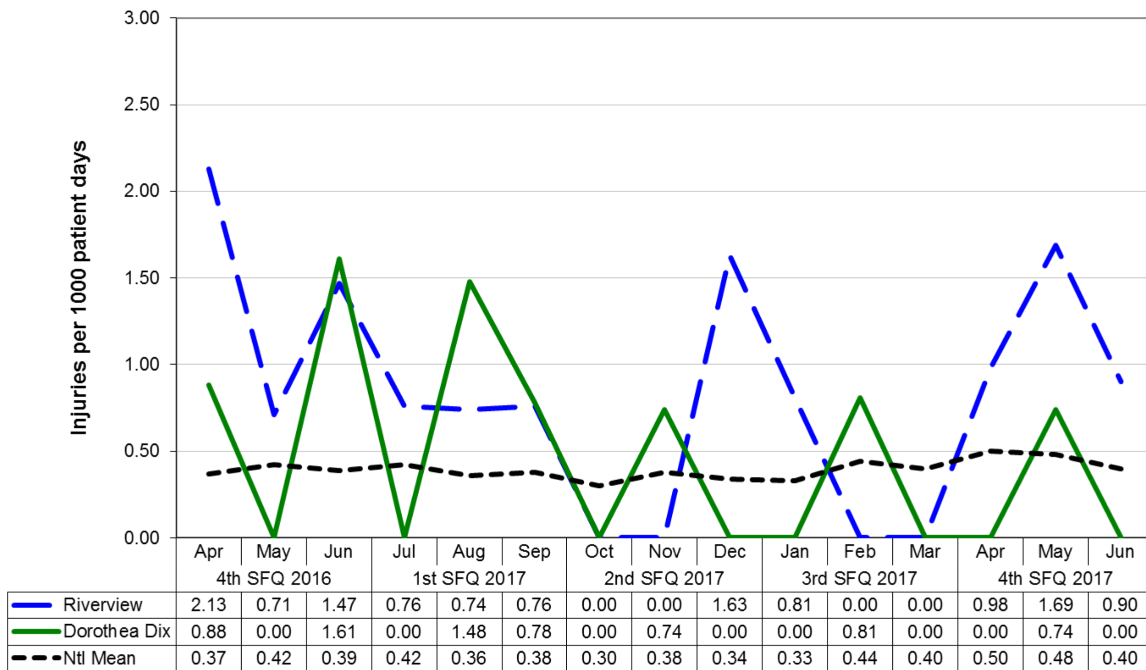
This graph depicts the number of patient injury events that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that one injury occurred for each 2000 inpatient days.

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

CONSENT DECREE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	0.00	0.00	0.08	0.00	0.75	0.00	1.42	0.00	0.00	0.71	0.00	0.00	0.00	0.00	0.00
Ntl Mean	0.23	0.25	0.23	0.18	0.23	0.14	0.18	0.20	0.18	0.16	0.17	0.20	0.21	0.23	0.09



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	2.13	0.71	1.47	0.76	0.74	0.76	0.00	0.00	1.63	0.81	0.00	0.00	0.98	1.69	0.90
Dorothea Dix	0.88	0.00	1.61	0.00	1.48	0.78	0.00	0.74	0.00	0.00	0.81	0.00	0.00	0.74	0.00
Ntl Mean	0.37	0.42	0.39	0.42	0.36	0.38	0.30	0.38	0.34	0.33	0.44	0.40	0.50	0.48	0.40

Patient Abuse, Neglect, Exploitation, Injury or Death

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

Type of Allegation	1Q2017	2Q2017	3Q2017	4Q2017	Total
Abuse Verbal	13	3	2	3	**21**
Abuse Physical	11	9	2	6	**28**
Abuse Sexual	17	3	4	7	**31**
Neglect	2	1	1	1	**5**
Coercion/Exploitation	2	5	0	0	**7**
Total	**45**	**21**	**9**	**17**	**92**

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

1. Staff members complete an incident report upon becoming aware of an incident or an allegation of any form of abuse, neglect, or exploitation.

2. Patients have the option to complete a grievance or communicate allegations of abuse, neglect, or exploitation during any interaction with staff at all levels, Peer Support personnel, or the Patient Advocate(s).

3. Any allegation of abuse, neglect, or exploitation is reported both internally and externally to appropriate stakeholders, including:
   - Superintendent and/or AOC
   - Adult Protective Services
   - Guardian
   - Patient Advocate

4. Allegations are reported to the Risk Manager through the incident reporting system and fact-finding or investigations occur at multiple levels. The purpose of this investigation is to evaluate the event to determine if the allegations can be substantiated or not and to refer the incident to the patient's treatment team, hospital administration, or outside entities.

5. When appropriate to the allegation and circumstances, investigations involving law enforcement, family members, or human resources may be conducted.

6. The Human Rights Committee, a group consisting of consumers, family members, providers, and interested community members, and the Medical Executive Committee receive a report on the incident of alleged abuse, neglect, and exploitation monthly.

Regulatory Compliance

V34) Riverview maintains Joint Commission accreditation;

Riverview successfully completed an accreditation survey with The Joint Commission in October 2016. The Hospital and the Outpatient Services (OPS) were both fully accredited until October 2019.

V35) Riverview maintains its hospital license;

Riverview maintains its licensing status as required through the Maine Department of Health and Human Services Division of Licensing and Regulatory Services. The hospital is licensed through October 31, 2017. Outpatient Services (OPS) is licensed until November 2, 2018.

V36) The hospital seeks CMS certification;

The hospital was terminated from the Medicare Provider Agreement on September 2, 2013 for failing to show evidence of substantial compliance in eight areas by August 27, 2013. Plans are being developed to apply for certification.

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

Riverview complies with this element of substantial compliance as evidenced by the current Integrated Plan for Performance Excellence, the data and reports presented in this document, the work of the Integrated Performance Excellence Committee, and sub-groups of this committee that are engaged in a transition to an improvement orientated methodology that is supported by The Joint Commission and is consistent with modern principles of process management and strategic methods of promoting organizational performance excellence. The Advisory Board approved the Integrated Plan for Performance Excellence in November 2016.

THE JOINT COMMISSION

Hospital-Based Inpatient Psychiatric Services (HBIPS)

The Inpatient Psychiatric Facility Quality Reporting System (IPFQRS) measures are required by the Centers for Medicare & Medicaid Services (CMS) and The Joint Commission (Riverview's accrediting agency). These measures were created due to a request made to The Joint Commission in 2003 to identify and implement a set of core performance measures for hospital-based inpatient psychiatric services. The measures have changed over the years.

IPFQRS Measures	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017
HBIPS-1: Percent of inpatients screened within the first three days of admission for risk of violence to self or others, substance use, psychological trauma history, and patient strengths. *TJC target: 94%*	71%	100%	100%	83%	100%	95%	100%	88%	90%	100%	83%	91%
HBIPS-2: Number of hours patients spent in physical restraint for every 1000 inpatient hours. *TJC target: < 0.48*	0.12	0.08	0.07	0.02	0.10	0.02	0.03	0.02	0.12	0.03	0.01	0.01
HBIPS-3: Number of hours patients spent in seclusion for every 1000 inpatient hours. *TJC target: < 0.39*	0.60	0.16	0.30	0.36	0.46	0.08	0.12	0.79	4.23	1.48	0.12	0.02
HBIPS-5: Percept of patients with appropriate justification for discharge on multiple antipsychotic medications. *TJC target: 61%*	50%	N/A*	N/A*	0%	67%	100%	50%	33%	100%	0%	N/A*	100%

*No patients were discharged on multiple antipsychotics this month

Note: TJC targets typically run approximately 6 months behind, the TJC target above was for December 2016.

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THE JOINT COMMISSION

Contract Performance Indicators

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

4Q2017 Results		
Contractor	**Program Administrator**	**Summary of Performance**
Amistad Peer Support Services	Rodney Bouffard Superintendent	One indicator did not meet the standard: Attendance by Peer Support Staff at Treatment Team Meetings. All other indicators met or exceeded standards.
Community Dental, Region II	Dr. Joanna Gratton Clinical Director	All indicators met or exceeded standards.
Comprehensive Pharmacy Services	Dr. Joanna Gratton Clinical Director	All indicators met standards.
Comtec Security	Richard Levesque Director of Support Services	Indicator met standards.
Cummins Northeast	Richard Levesque Director of Support Services	No services were provided during this timeframe.
Disability Rights Center	Rodney Bouffard Superintendent	All indicators met standards.
G & E Roofing	Richard Levesque Director of Support Services	No services were provided during this timeframe.
Goodspeed & O'Donnell	Dr. Joanna Gratton Clinical Director	No services were provided during this timeframe.
Liberty Healthcare – After Hours Coverage	Dr. Joanna Gratton Clinical Director	All indicators met or exceeded standards.
Liberty Healthcare – Physician Staffing	Dr. Joanna Gratton Clinical Director	All indicators met or exceeded standards.
Main Security Surveillance	Richard Levesque Director of Support Services	All indicators met standards.
Maine General Community Care/HealthReach	Dr. Joanna Gratton Clinical Director	All indicators met standards.
Maine General Medical Center Laboratory Services	Dr. Joanna Gratton Clinical Director	All indicators met standards.
MD-IT Transcription Service	Samantha Brockway Medical Records Administrator	All indicators met standards.
Mechanical Services	Richard Levesque Director of Support Services	No services were provided during this timeframe.

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

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Contractor	Program Administrator	Summary of Performance
Medical Staffing and Services of Maine	Dr. Joanna Gratton Clinical Director	All indicators met standards.
Norris	Richard Levesque Director of Support Services	No services were provided during this timeframe.
Occupational Therapy Consultation and Rehabilitation Services	Janet Barrett Director of Rehabilitation	Both indicators failed to meet standards: Provider will attend scheduled appointments or provide alternative dates and OT staff will integrate clinical suggestions into OT services.
Otis Elevator	Richard Levesque Director of Support Services	All indicators exceeded standards.
Pine Tree Legal Assistance	Dr. Judy Burk	Indicator exceeded standards.
Project Staffing	Cindy Michaud Business Services Manager	All indicators exceeded standards.
Securitas Security Services	Philip Tricarico Safety Compliance Officer	All indicators met or exceeded standards.
UniFirst Corporation	Richard Levesque Director of Support Services	One indicator did not meet standards: Infection control measures taken at the provider's facility. All other indicators met standards.
Waste Management	Debora Proctor Executive Housekeeper	All indicators met standards.
Worldwide Travel Staffing	Renee Pfingst Director of Nursing	All indicators met standards.

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

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Adverse Reactions to Sedation or Anesthesia

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

Capital Community Clinic - Dental Clinic

Dental Clinic Timeout/Identification of Patient

<table>
<tr><th>Indicators</th><th>1Q2017</th><th>2Q2017</th><th>3Q2017</th><th>4Q2017</th><th>YTD</th></tr>
<tr><td rowspan="4">National Patient Safety Goals

Goal 1: Improve the accuracy of Patient Identification.

Capital Community Dental Clinic assures accurate patient identification by asking the patient to state his/her name and date of birth.

A time out will be taken before the procedure to verify location and numbered tooth. The time out section is in the progress notes of the patient chart. This page will be signed by the Dental as well as the Dental Assistant.</td><td>July
N/A</td><td>Oct
100%
4/4</td><td>Jan
N/A</td><td>Apr
100%
3/3</td><td rowspan="4">100%
25/25</td></tr>
<tr><td>Aug
N/A</td><td>Nov
N/A</td><td>Feb
N/A</td><td>May
100%
1/1</td></tr>
<tr><td>Sept
100%
7/7</td><td>Dec
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6/6</td></tr>
<tr><td>Total
100%
7/7</td><td>Total
100%
5/5</td><td>Total
100%
3/3</td><td>Total
100%
10/10</td></tr>
</table>

THE JOINT COMMISSION

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	1Q2017	2Q2017	3Q2017	4Q2017	YTD
1. All patients with tooth extractions will be assessed and have teaching post procedure on the following topics, as provided by the Dentist or Dental Assistant: • Bleeding • Swelling • Pain • Muscle soreness • Mouth care • Diet • Signs/symptoms of infection 2. The patient, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist. Post dental extraction patients will receive a follow-up phone call from the clinic within 24 hours of procedure to assess for post procedure complications	July N/A	Oct 100% 4/4	Jan N/A	Apr 100% 3/3	**100% 25/25**
	Aug N/A	Nov N/A	Feb N/A	May 100% 1/1	
	Sept 100% 7/7	Dec 100% 1/1	Mar 100% 3/3	Jun 100% 6/6	
	Total 100% 7/7	**Total 100% 5/5**	**Total 100% 3/3**	**Total 100% 10/10**	

Healthcare Acquired Infections Monitoring and Management

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

Hospital Associated Infection (HAI) Rate:

Results							
Target	**Unit**	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Within 1 STDV of the Mean	Hospital Associated Infection Rate	FY2016 1 STDV within the mean	16 HAI/IC Rate 2.65	19 HAI/IC Rate 3.78	16 HAI/IC Rate 2.65	2HAI/IC Rate 0.67	HAI/IC 2.43
Actual Outcome			>1 STDV within the mean	>1 STDV within the mean	>1 STDV within the mean	>1 STDV within the mean	>1 STDV within the mean

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

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

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

THE JOINT COMMISSION

Infections:

Lower Kennebec:
Dental Abscess (ISI)
Dental Abscess (ISI)
Paronychia (ISI)
Abdominal wound prophylaxis (POA)
Paronychia (ISI)

Lower Saco:
Dental Pulpitis (ISI)
Paronychia (ISI)
Left Foot topical (POA)
Paronychia (ISI)
Acne Vulgaris (ISI)
Otitis Externa Cellulitis (ISI)
Pneumonia (HAI)

Upper Saco:
Otitis media (HAI)
Otitis Externa (ISI)
Otitis Externa (ISI)
Paronychia (ISI)
Prostatitis (ISI)

Upper Kennebec:
Hidradenitis Suppurativa (ISI)
Dental root Abscess (ISI)
Dental Abscess (ISI)
Rhinitis (POA)
Pulpitis (ISI)

Data Analysis:
HAI: 2
POA: 3
Idiosyncratic Infections: 17
Total Infections: 22

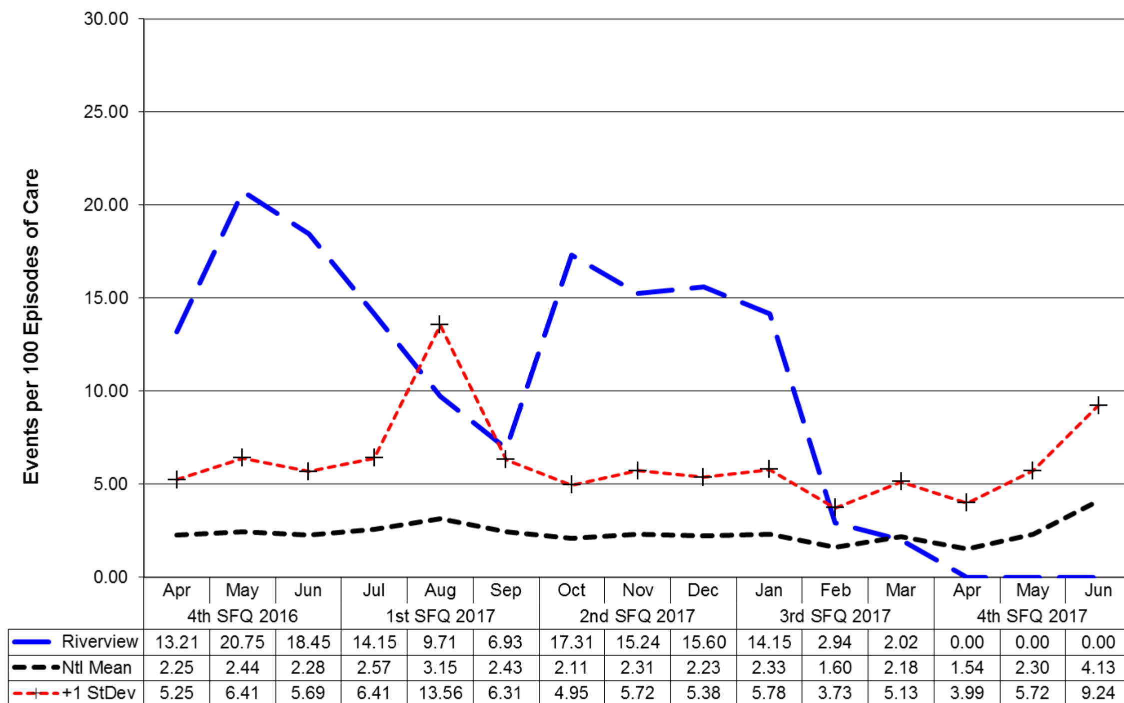
Action Plan: Ongoing surveillance

JOINT COMMISSION

Medication Errors and Adverse Reactions

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

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

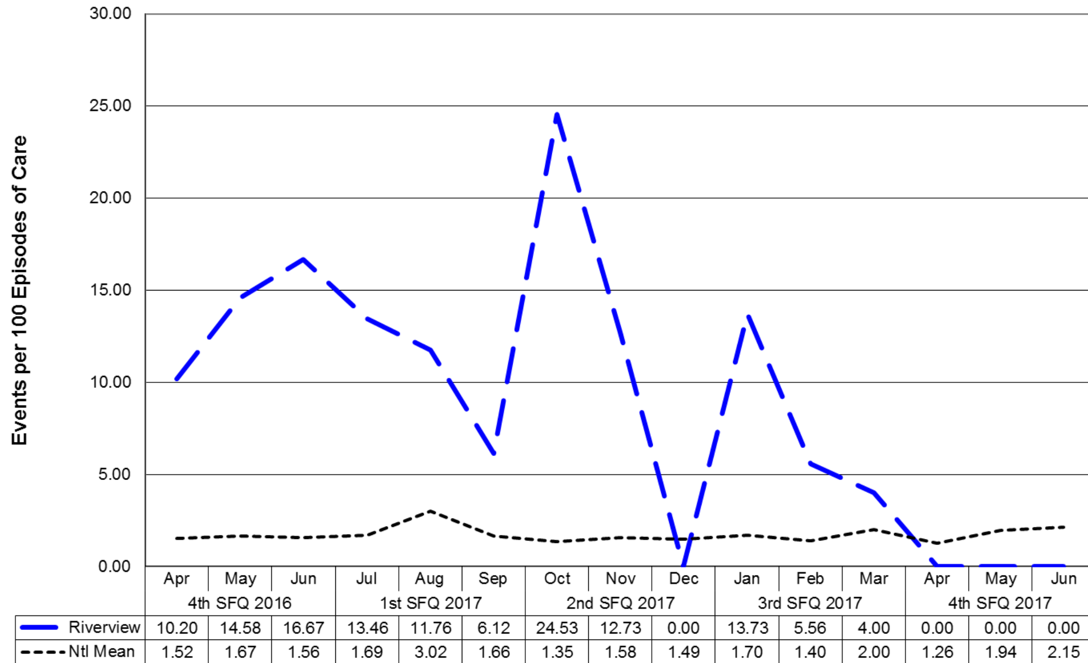


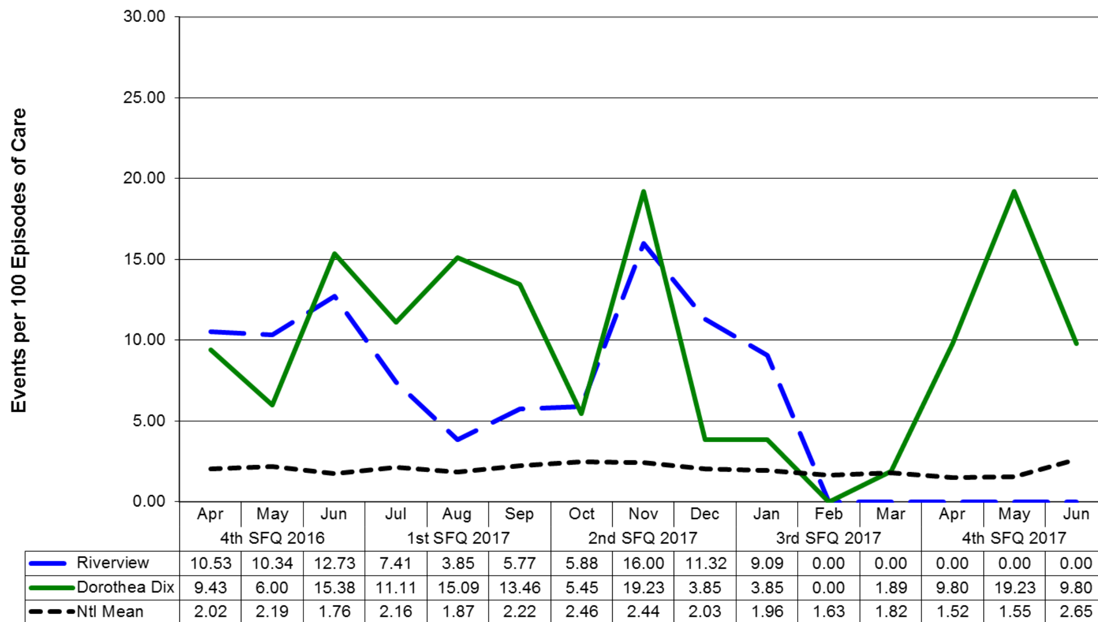
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	13.21	20.75	18.45	14.15	9.71	6.93	17.31	15.24	15.60	14.15	2.94	2.02	0.00	0.00	0.00
Ntl Mean	2.25	2.44	2.28	2.57	3.15	2.43	2.11	2.31	2.23	2.33	1.60	2.18	1.54	2.30	4.13
+1 StDev	5.25	6.41	5.69	6.41	13.56	6.31	4.95	5.72	5.38	5.78	3.73	5.13	3.99	5.72	9.24

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

The following graphs depict the number of medication error events that occurred for every 100 episodes of care (duplicated patient count) stratified by forensic or civil classifications. For example, a rate of 1.6 means that two medication error events occurred for each 125 episodes of care. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

JOINT COMMISSION





JOINT COMMISSION

Medication Variances

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

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

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

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

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

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

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

4Q2017: There were no Medication Variances during 4Q2017.

JOINT COMMISSION

Inpatient Consumer Survey

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

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

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

Rate of Response for the Inpatient Consumer Survey:

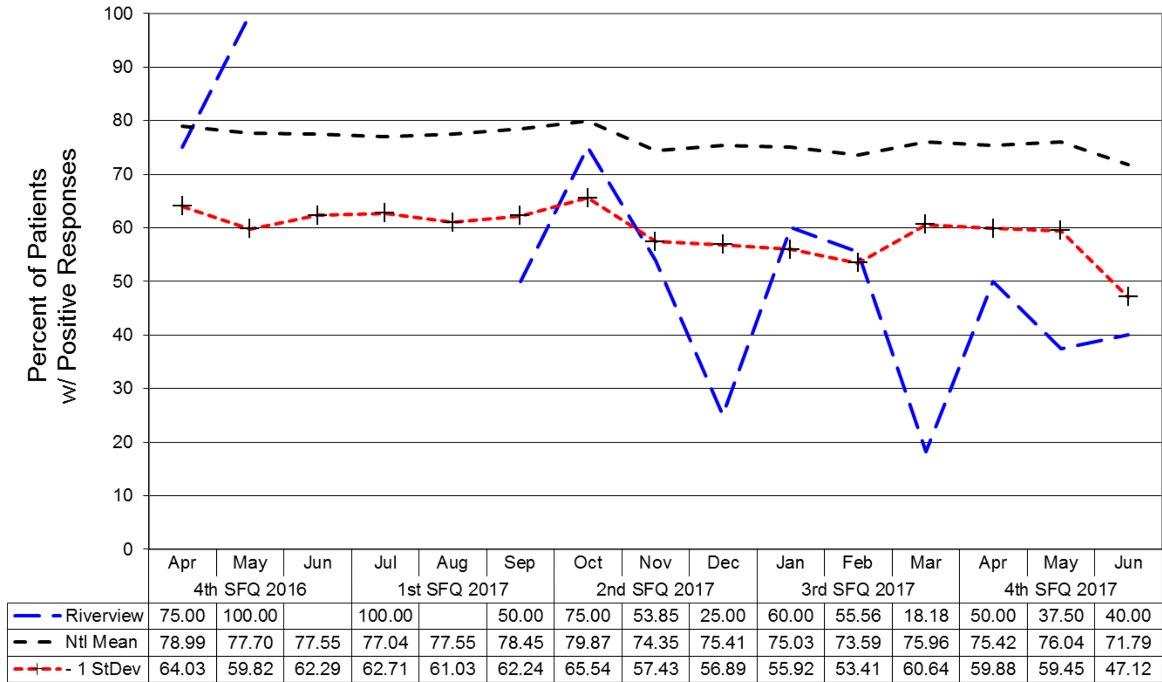
Due to the operational and safety need to refrain from complete openness regarding plans for discharge and dates of discharge for forensic patients, the process of administering the inpatient survey is difficult to administer. Whenever possible, Peer Support staff work to gather information from patients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

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

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

Note: When the Riverview field is blank for a month it means that no patients responded to the survey questions on that page in that particular month.

JOINT COMMISSION



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	75.00	100.00		100.00		50.00	75.00	53.85	25.00	60.00	55.56	18.18	50.00	37.50	40.00
Ntl Mean	78.99	77.70	77.55	77.04	77.55	78.45	79.87	74.35	75.41	75.03	73.59	75.96	75.42	76.04	71.79
1 StDev	64.03	59.82	62.29	62.71	61.03	62.24	65.54	57.43	56.89	55.92	53.41	60.64	59.88	59.45	47.12

Outcome Domain Questions:

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

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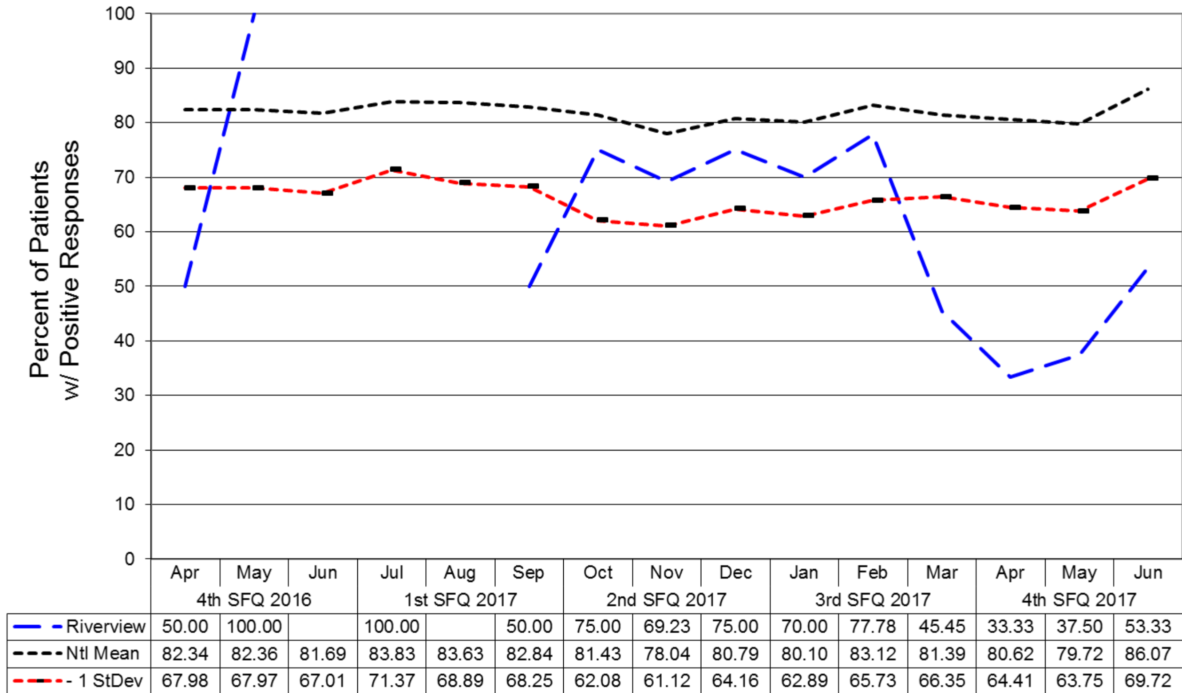
JOINT COMMISSION

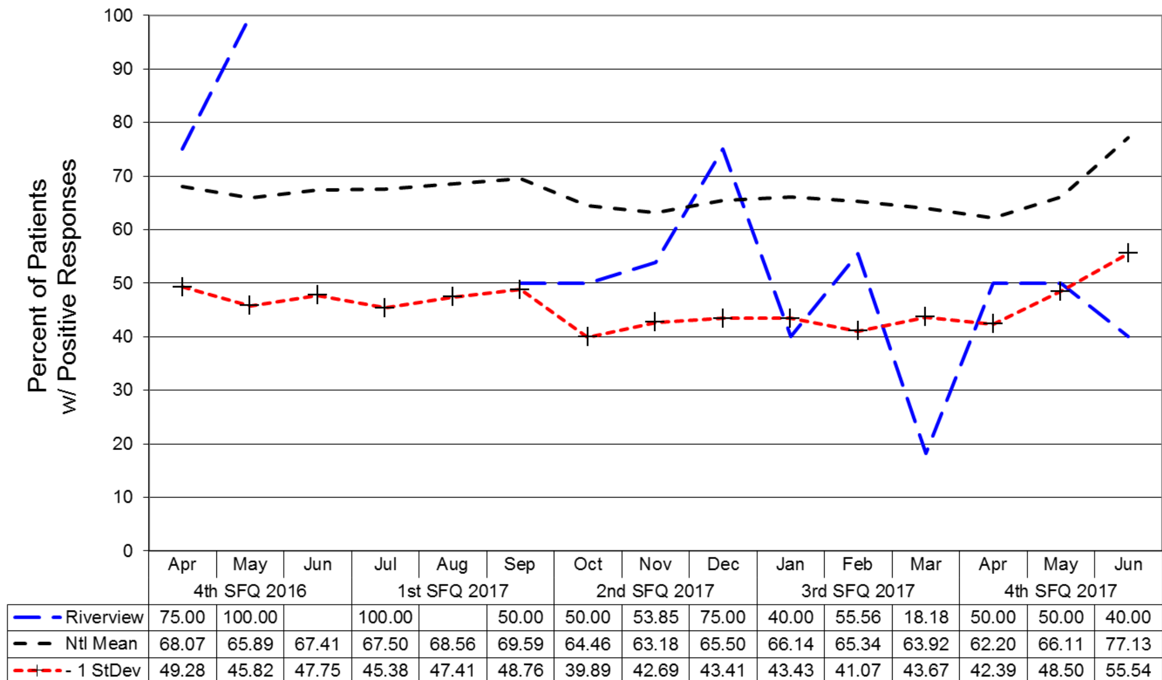


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	50.00	100.00		100.00		50.00	75.00	69.23	75.00	70.00	77.78	45.45	33.33	37.50	53.33
Ntl Mean	82.34	82.36	81.69	83.83	83.63	82.84	81.43	78.04	80.79	80.10	83.12	81.39	80.62	79.72	86.07
1 StDev	67.98	67.97	67.01	71.37	68.89	68.25	62.08	61.12	64.16	62.89	65.73	66.35	64.41	63.75	69.72

Dignity Domain Questions:

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

JOINT COMMISSION

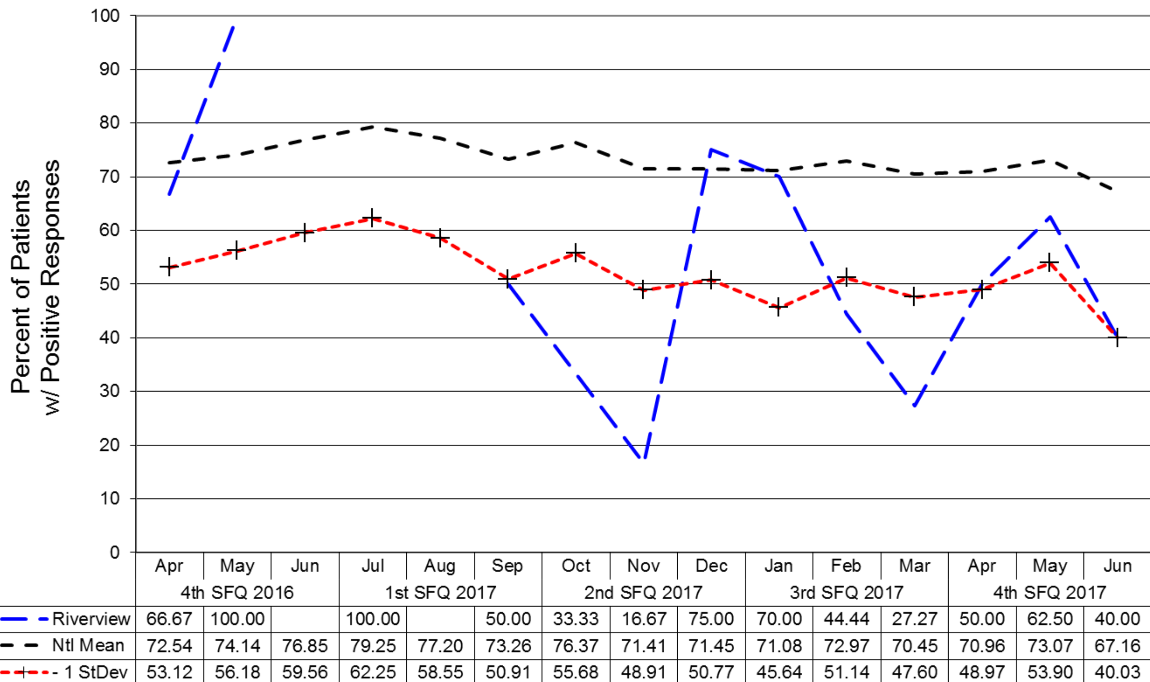


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	75.00	100.00		100.00		50.00	50.00	53.85	75.00	40.00	55.56	18.18	50.00	50.00	40.00
Ntl Mean	68.07	65.89	67.41	67.50	68.56	69.59	64.46	63.18	65.50	66.14	65.34	63.92	62.20	66.11	77.13
1 StDev	49.28	45.82	47.75	45.38	47.41	48.76	39.89	42.69	43.41	43.43	41.07	43.67	42.39	48.50	55.54

Rights Domain Questions:

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

JOINT COMMISSION

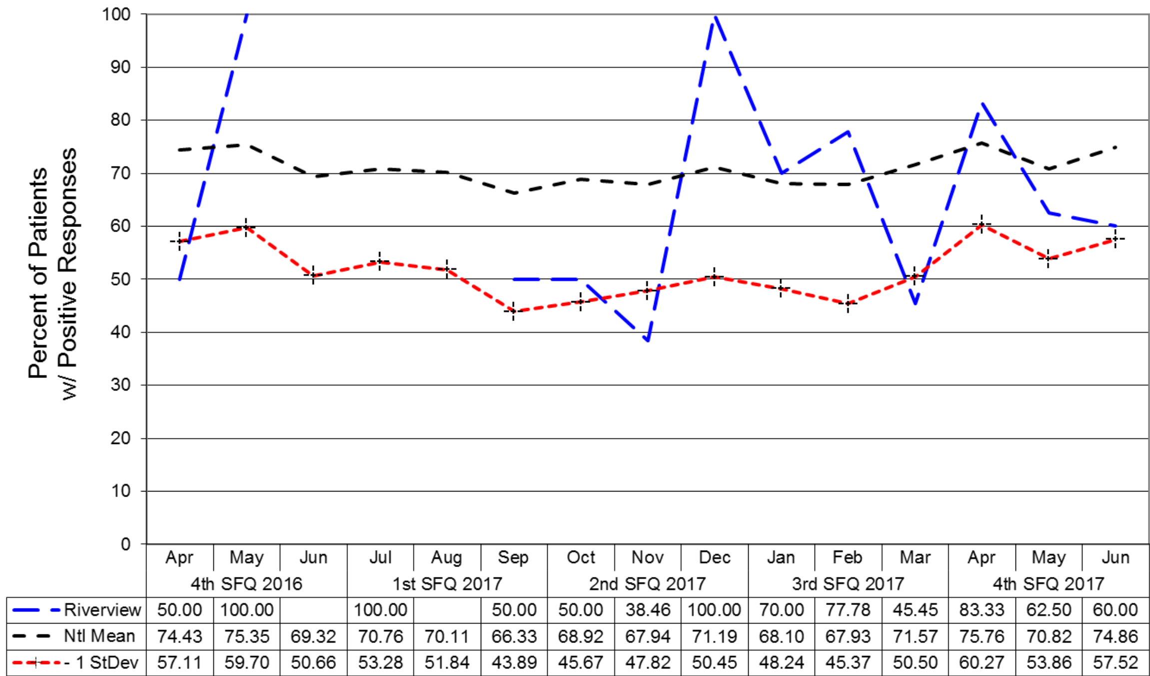


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	66.67	100.00		100.00		50.00	33.33	16.67	75.00	70.00	44.44	27.27	50.00	62.50	40.00
Ntl Mean	72.54	74.14	76.85	79.25	77.20	73.26	76.37	71.41	71.45	71.08	72.97	70.45	70.96	73.07	67.16
1 StDev	53.12	56.18	59.56	62.25	58.55	50.91	55.68	48.91	50.77	45.64	51.14	47.60	48.97	53.90	40.03

Participation Domain Questions:

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

JOINT COMMISSION

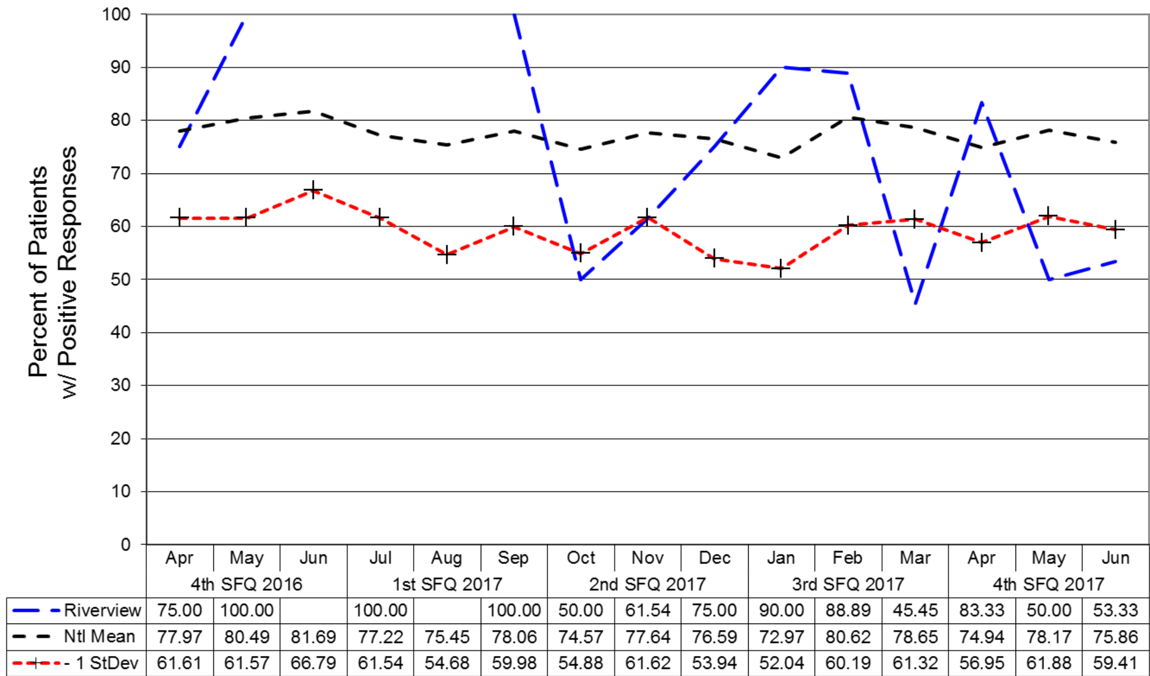


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	50.00	100.00		100.00		50.00	50.00	38.46	100.00	70.00	77.78	45.45	83.33	62.50	60.00
Ntl Mean	74.43	75.35	69.32	70.76	70.11	66.33	68.92	67.94	71.19	68.10	67.93	71.57	75.76	70.82	74.86
1 StDev	57.11	59.70	50.66	53.28	51.84	43.89	45.67	47.82	50.45	48.24	45.37	50.50	60.27	53.86	57.52

Environment Domain Questions:

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

JOINT COMMISSION



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	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Riverview	75.00	100.00		100.00		100.00	50.00	61.54	75.00	90.00	88.89	45.45	83.33	50.00	53.33
Ntl Mean	77.97	80.49	81.69	77.22	75.45	78.06	74.57	77.64	76.59	72.97	80.62	78.65	74.94	78.17	75.86
1 StDev	61.61	61.57	66.79	61.54	54.68	59.98	54.88	61.62	53.94	52.04	60.19	61.32	56.95	61.88	59.41

Empowerment Domain Questions:

1. I had a choice of treatment options.
2. My contact with my Doctor was helpful.
3. My contact with nurses and therapists was helpful.

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

JOINT COMMISSION

Fall Reduction Strategies

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

TJC PC.01.02.08: The hospital assesses and manages the patient's risks for falls.
EP01: The hospital assesses the patient’s risk for falls based on the patient population and setting.
EP02: The hospital implements interventions to reduce falls based on the patient’s assessed risk.

Type of Fall by Patient and Month

Fall Type	Patient	April	May	June	4Q2017
Un-witnessed	MR684*	1			**1**
	MR726	1			**1**
	MR1872		1		**1**
	MR4974*		4		**4**
	Totals	**2**	**5**	**0**	**7**
Fall Type	**Patient**	**April**	**May**	**June**	**4Q2017**
Witnessed	MR83		1		**1**
	MR86	2			**2**
	MR107	4			**4**
	MR684*		2		**2**
	MR2951	1			**1**
	MR4702		1		**1**
	MR4974*		2		**2**
	MR7809		2		**2**
	MR7983	1			**1**
	MR8044			2	**2**
	Totals	**8**	**8**	**2**	**18**

*Indicates that the patient had both un-witnessed and witnessed falls in the 4Q2017

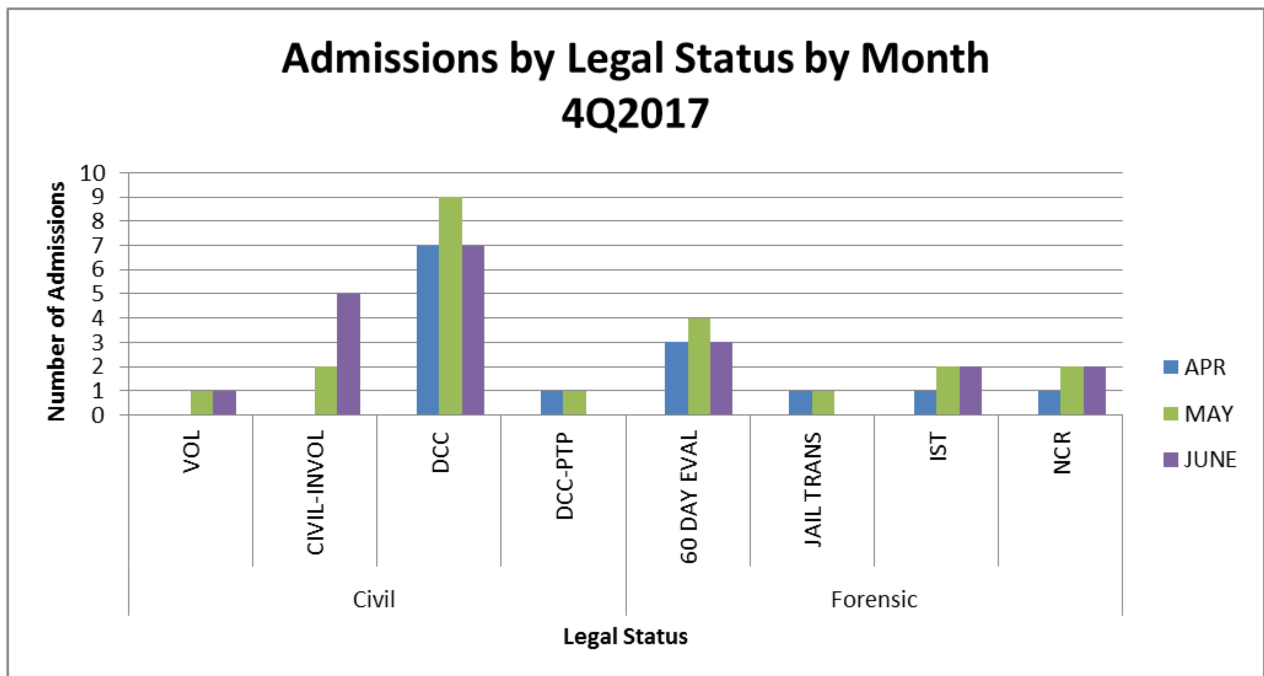
QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

Admissions

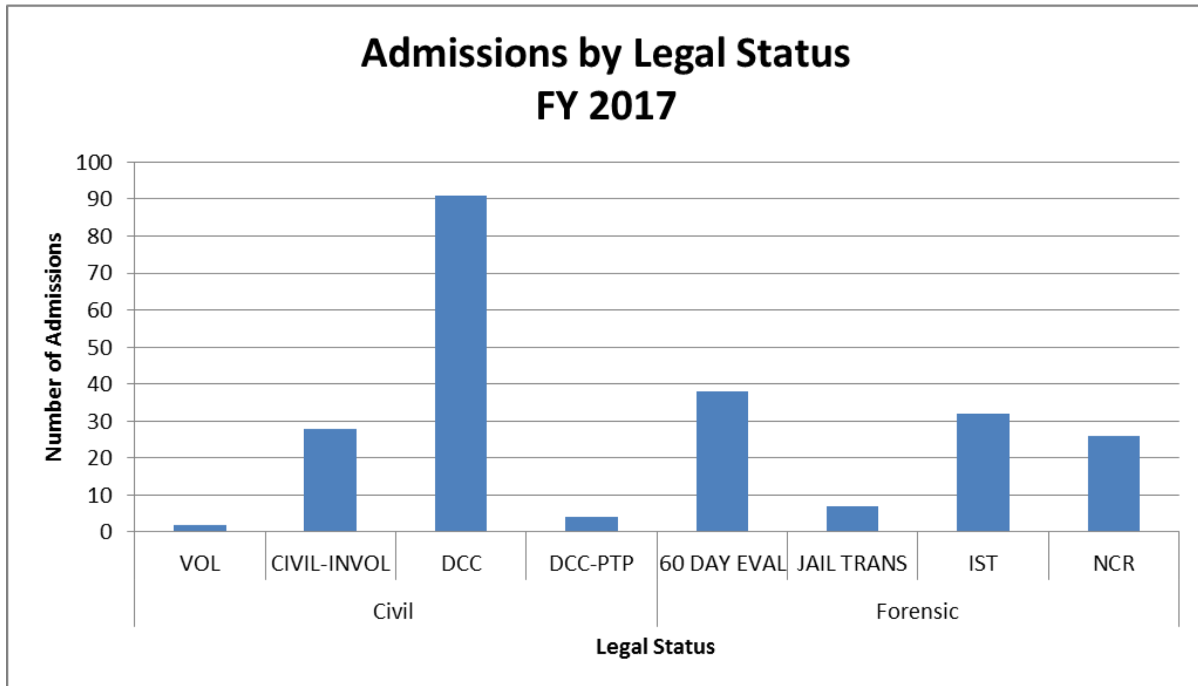
Responsible Party: Samantha Newman, RN, Admissions Nurse

Number of Admissions:

ADMISSIONS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL:	**10**	**11**	**7**	**11**	**8**	**12**	**15**	**9**	**8**	**8**	**13**	**13**	**125**
VOL	0	0	0	0	0	0	0	0	0	0	1	1	**2**
CIVIL-INVOL	0	3	3	3	2	4	3	1	2	0	2	5	**28**
DCC	10	8	4	8	6	6	12	8	6	7	9	7	**91**
DCC-PTP	0	0	0	0	0	2	0	0	0	1	1	0	**4**
FORENSIC:	**10**	**9**	**6**	**9**	**10**	**11**	**7**	**10**	**9**	**6**	**9**	**7**	**103**
60 DAY EVAL	5	2	1	4	4	6	1	3	2	3	4	3	**38**
JAIL TRANS	0	0	0	0	0	0	1	2	2	1	1	0	**7**
IST	4	7	2	1	4	2	3	2	2	1	2	2	**32**
NCR	1	0	3	4	2	3	2	3	3	1	2	2	**26**
TOTAL	**20**	**20**	**13**	**20**	**18**	**23**	**22**	**19**	**17**	**14**	**22**	**20**	**228**



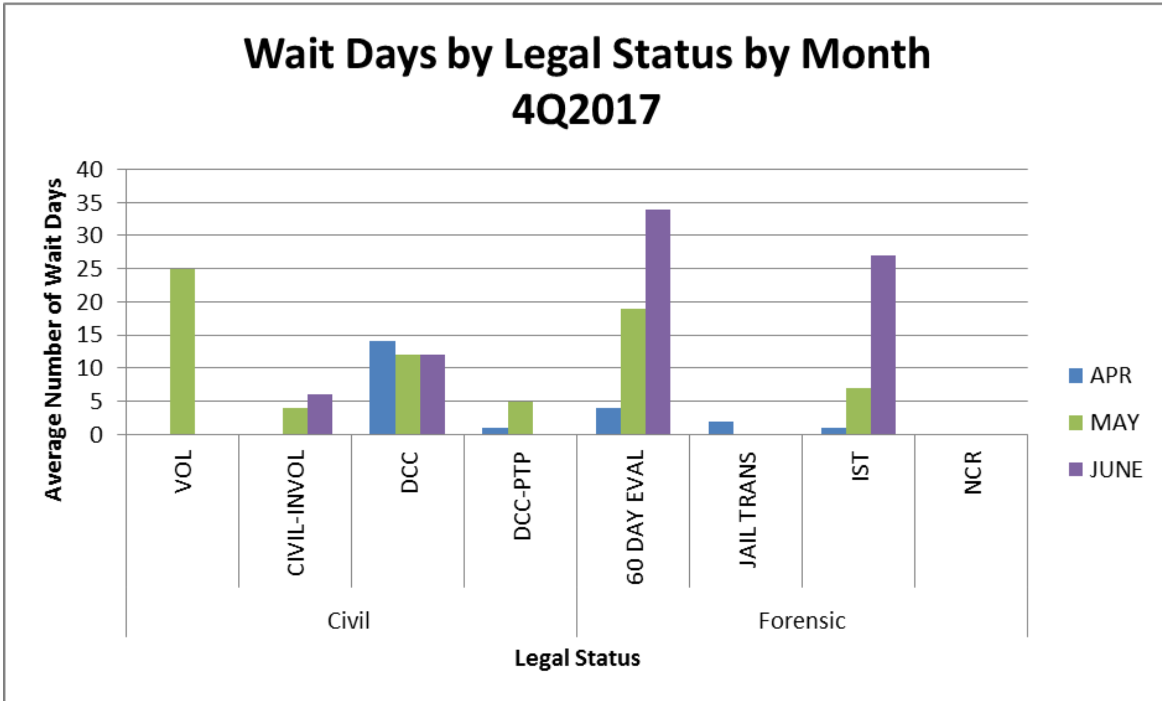
QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

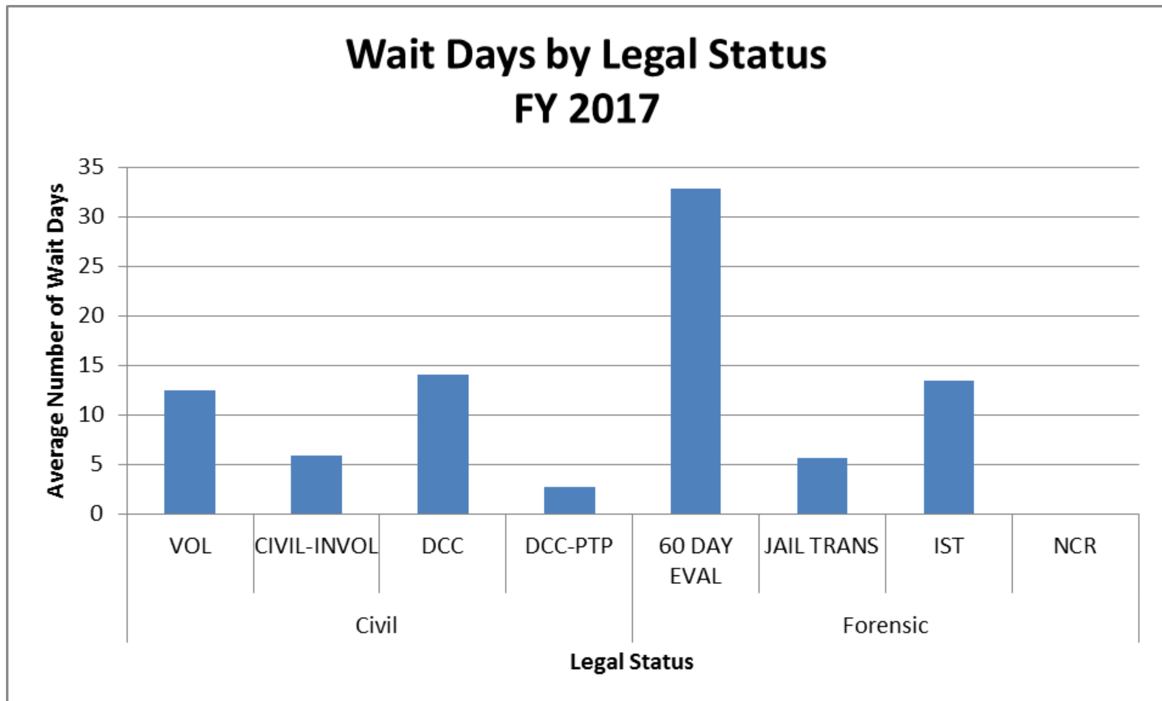


Average Number of Wait Days:

WAIT DAYS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	AVG
CIVIL:	**10**	**9**	**11**	**11**	**14**	**9**	**19**	**18**	**12**	**12**	**12**	**9**	**12**
VOL											25	0	**13**
CIVIL-INVOL		4	11	3	5	7	4	9	6		4	6	**6**
DCC	10	12	10	14	17	11	23	20	14	14	12	12	**14**
DCC-PTP						5				1	5	0	**3**
FORENSIC:	**35**	**11**	**15**	**38**	**24**	**26**	**8**	**8**	**4**	**3**	**10**	**22**	**17**
60 DAY EVAL	64	32	63	75	35	39	16	8	5	4	19	34	**33**
JAIL TRANS							5	16	5	2	0		**6**
IST	6	5	13	20	26	26	12	13	6	1	7	27	**14**
NCR	0		0	0	0	0	0	0	0	0	0	0	**0**
AVERAGE	**22**	**10**	**12**	**23**	**20**	**17**	**16**	**13**	**8**	**8**	**11**	**13**	**14**

*If a field is blank it means that there were no admissions for that legal status during that timeframe

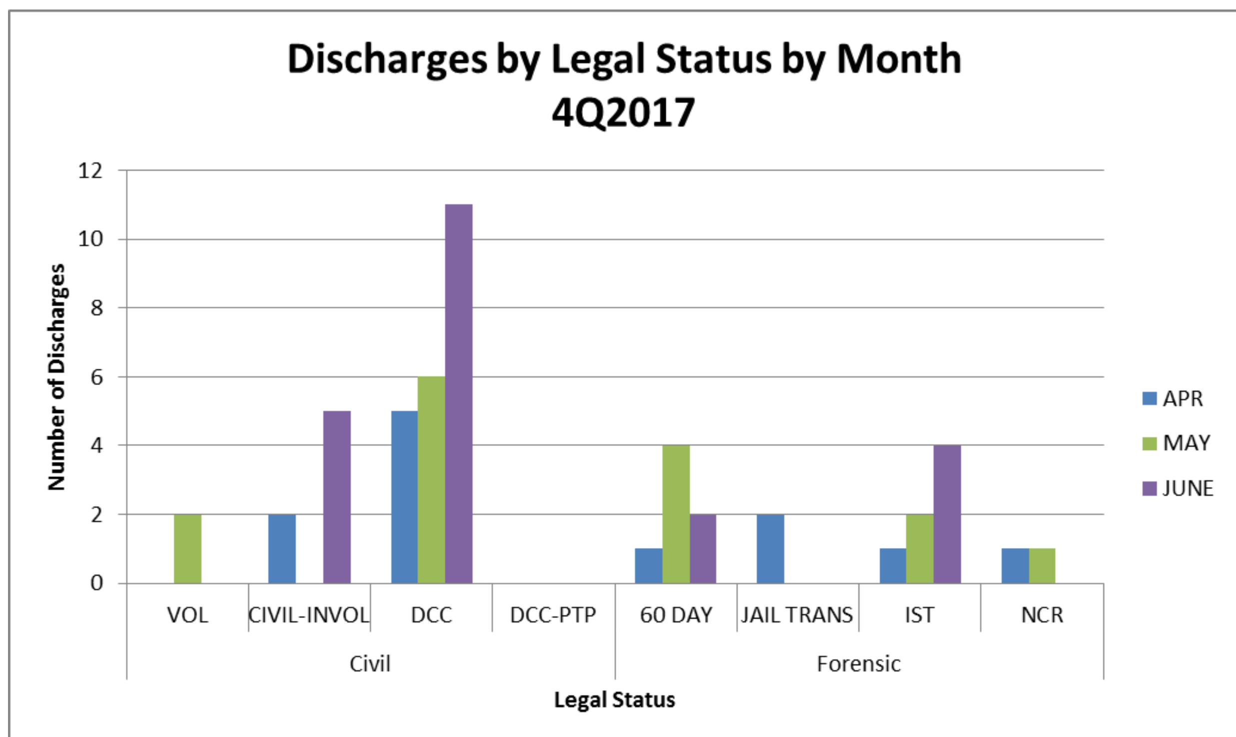

Wait Days by Legal Status by Month
4Q2017
Average Number of Wait Days
40
35
30
25
20
15
10
5
0
VOL
CIVIL-INVOL
DCC
DCC-PTP
60 DAY EVAL
JAIL TRANS
IST
NCR
Civil
Forensic
Legal Status
APR
MAY
JUNE


Wait Days by Legal Status
FY 2017
Average Number of Wait Days
35
30
25
20
15
10
5
0
VOL
CIVIL-INVOL
DCC
DCC-PTP
60 DAY EVAL
JAIL TRANS
IST
NCR
Civil
Forensic
Legal Status

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

Number of Discharges:

DISCHARGES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL:	**13**	**7**	**12**	**9**	**8**	**13**	**16**	**7**	**16**	**7**	**8**	**16**	**132**
VOL	0	0	0	0	0	0	1	0	0	0	2	0	**3**
CIVIL-INVOL	1	0	2	3	2	2	2	2	5	2	0	5	**26**
DCC	12	7	10	6	6	11	11	5	9	5	6	11	**99**
DCC-PTP	0	0	0	0	0	0	2	0	2	0	0	0	**4**
FORENSIC:	**10**	**8**	**5**	**8**	**11**	**12**	**7**	**13**	**8**	**5**	**7**	**6**	**100**
60 DAY	1	4	1	2	4	5	4	2	2	1	4	2	**32**
JAIL TRANS	1	0	0	0	0	0	0	1	1	2	0	0	**5**
IST	4	2	3	0	3	0	3	4	4	1	2	4	**30**
NCR	4	2	1	6	4	7	0	6	1	1	1	0	**33**
TOTAL	**23**	**15**	**17**	**17**	**19**	**25**	**23**	**20**	**24**	**12**	**15**	**22**	**232**



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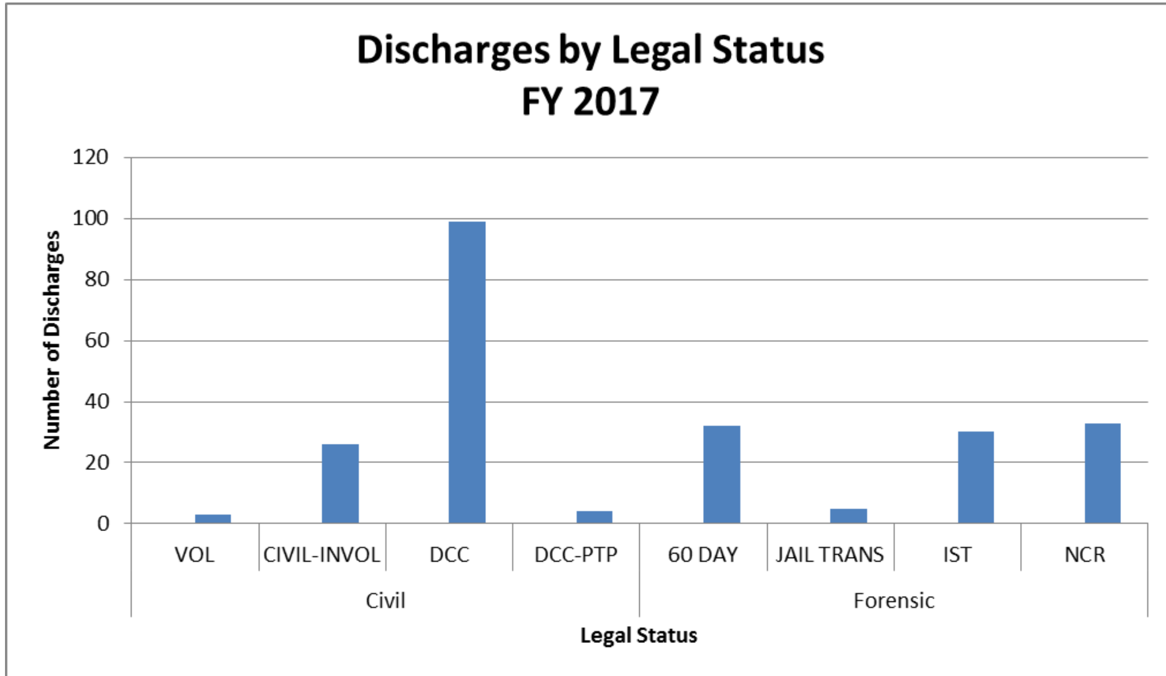
QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

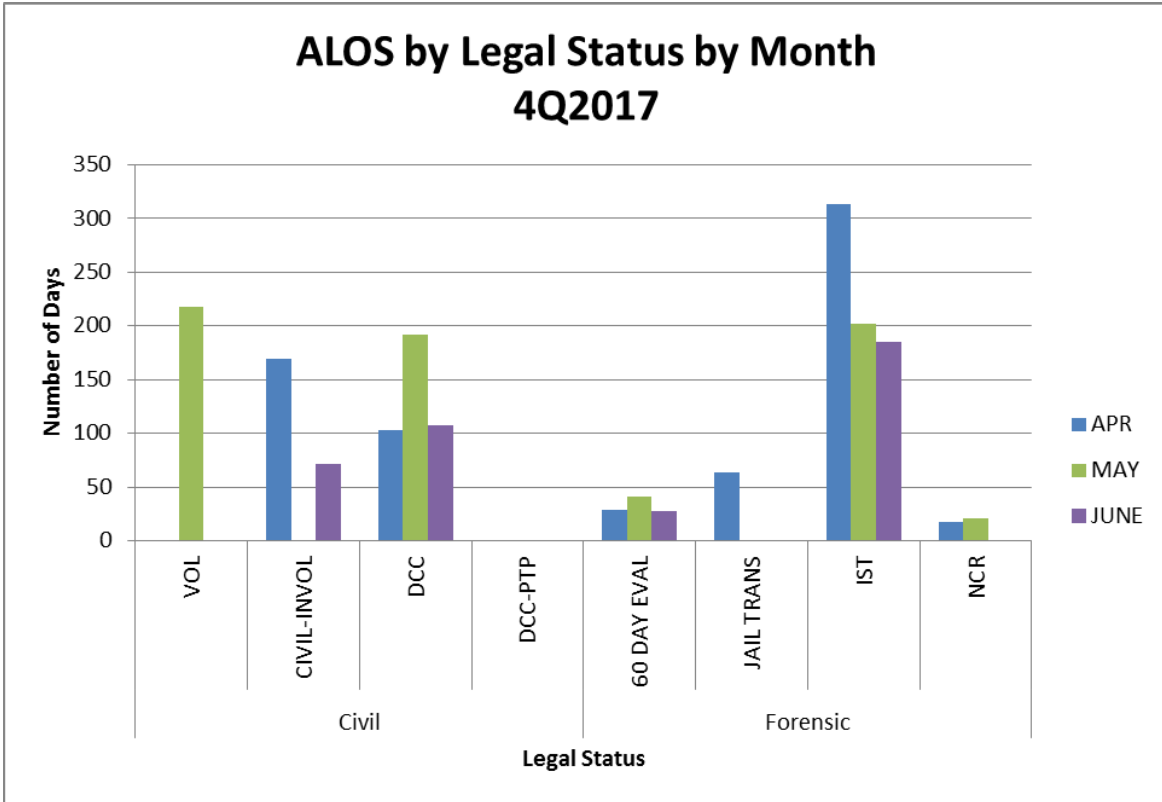


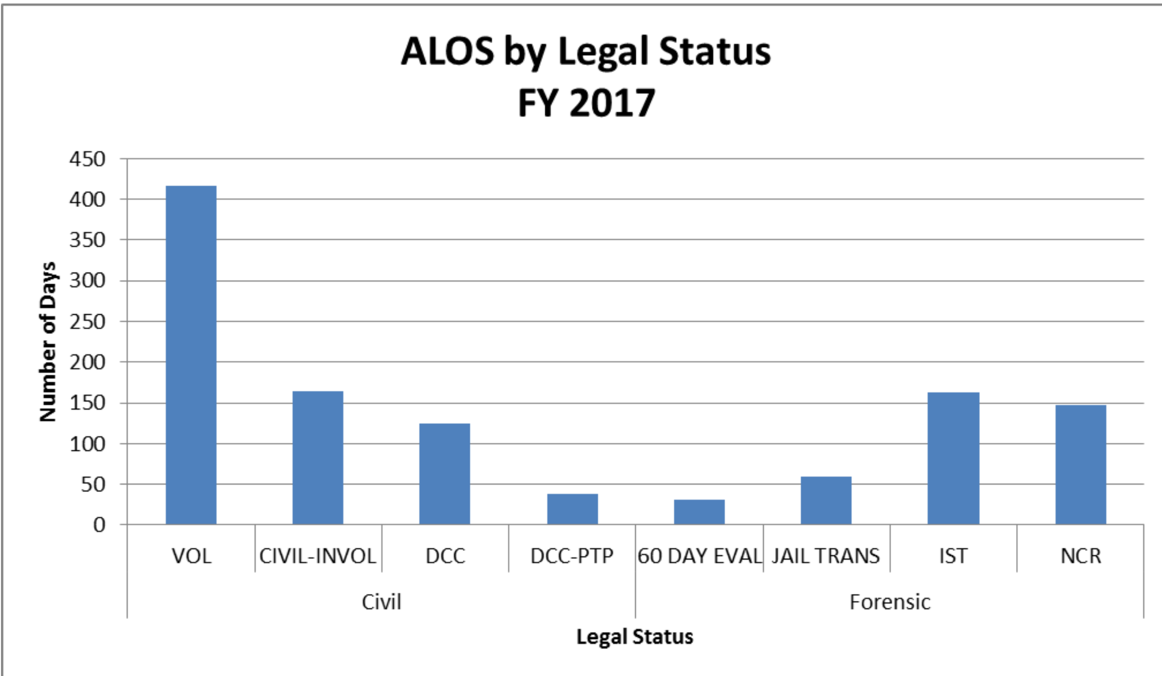
Average Length of Stay (Days):

ALOS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	AVG
CIVIL:	**99**	**79**	**145**	**174**	**273**	**97**	**104**	**109**	**148**	**122**	**198**	**96**	**137**
VOL							616				218		**417**
CIVIL-INVOL	106		31	149	691	68	46	56	260	169		71	**165**
DCC	98	76	168	186	134	102	86	131	104	103	192	107	**124**
DCC-PTP							10		65				**38**
FORENSIC:	**84**	**91**	**104**	**170**	**103**	**434**	**84**	**163**	**57**	**97**	**84**	**133**	**134**
60 DAY EVAL	9	30	23	18	43	30	34	50	30	29	41	28	**30**
JAIL TRANS	170							2	3	64			**60**
IST	107	33	86		194		156	255	96	313	202	185	**163**
NCR	58	273	238	220	94	379		167	10	17	21		**148**
AVERAGE	**92**	**85**	**133**	**172**	**174**	**162**	**99**	**144**	**118**	**112**	**145**	**106**	**129**

*If a field is blank it means that there were no discharges for that legal status during that timeframe

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT





QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

I. Measure Name: NCR Admissions

Measure Description: Admittance of all NCR patients within 24 hours of referral

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	NCR referrals admitted within 24 hours	FY2014 75% 75/100	100%	100%	100%	100%	**100%**
Actual			100% 4/4	100% 9/9	100% 8/8	100% 5/5	**100% 26/26**

Data Analysis: There were five NCR admissions this quarter. All were admitted the day of referral.

Action Plan: Continue to gather data on wait days for NCR admissions. Keep one bed available on the Forensic unit for NCR admissions when possible.

	April 2017	May 2017	June 2017	4Q2017
# of NCR Admissions	1	2	2	**5**
Average Wait Days	0	0	0	**0**

II. Measure Name: Jail Transfer Bed

Measure Description: Keep one Jail Transfer bed open and track length of stay and legal outcomes.

Type of Measure: Performance Improvement

	April 2017	May 2017	June 2017	4Q2017
# of Jail Transfer Admissions	1	1	0	**2**
# of Jail Transfer Discharges	2	0	0	**2**

Data Analysis: There were two Jail Transfers admitted this quarter, due to a lower wait list.

Capital Community Clinic
Dental Clinic

Responsible Party: Dr. Ingrid Prikryl, DMD

I. Measure Name: Yearly Periodontal Charting

Measure Description: Complete a full mouth periodontal charting.

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	% of recall appointments where full mouth periodontal charting was completed	FY2016 51%	50%	55%	60%	65%	**65%**
Actual			33%	69%	68%	76%	**62%**

Data Analysis: To better report this measure, we will only measure periodontal charting on existing patients during their prophylactic recall appointments. Hygienist will note in the chart those patients that she is unable to chart because of limited chair time (i.e. patients with low function intellectual disability.)

April 2017 = 51/65 = 78% May 2017 = 66/96 = 68% June 2017 = 44/58 = 76%

Action Plan: Charting to be completed by the hygienist during prophy appointments only and not during emergency or new patient appointments, in order to get a more accurate percentage.

Comments: Definite improvement throughout the year. We will continue to monitor next year.

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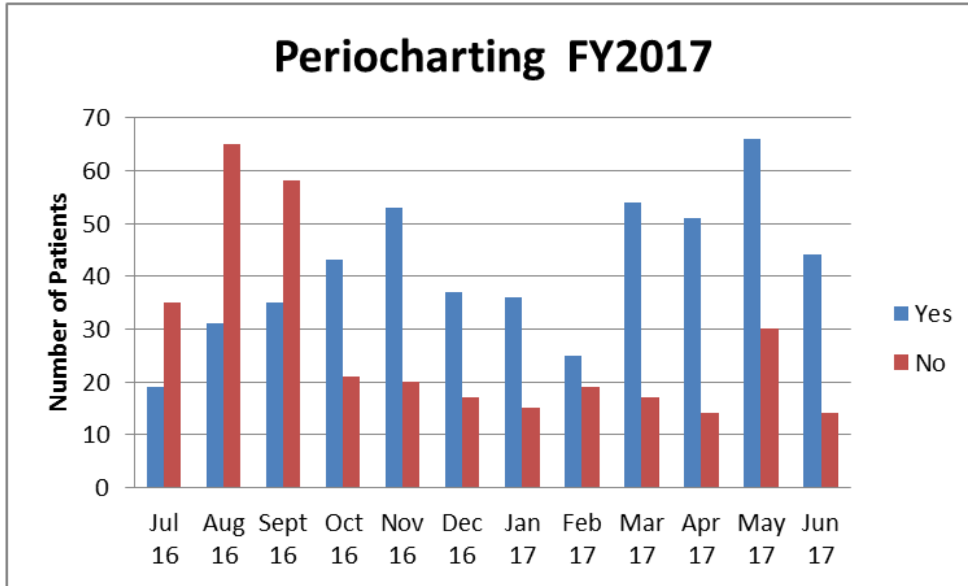


II. Measure Name: Improving Oral Hygiene

Measure Description: Monitoring and working to improve patients' oral hygiene

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Recall Hygiene Prophy	**New Measure**	50%	55%	60%	65%	**65%**
Actual			50%	44%	56%	42%	**48%**

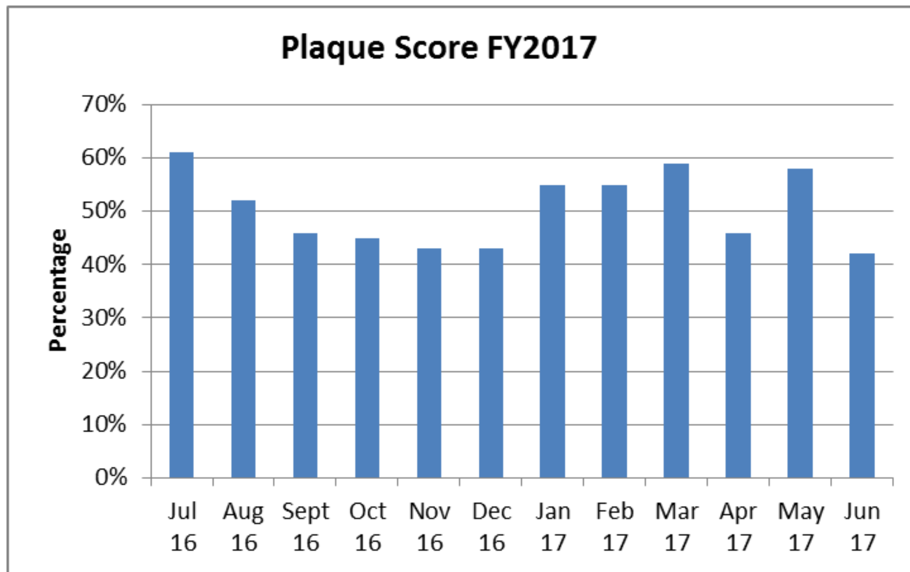
Data Analysis: Percentage of patients with Excellent or Good Hygiene. The goal is to stay above 65% and continuously improve to 75%.

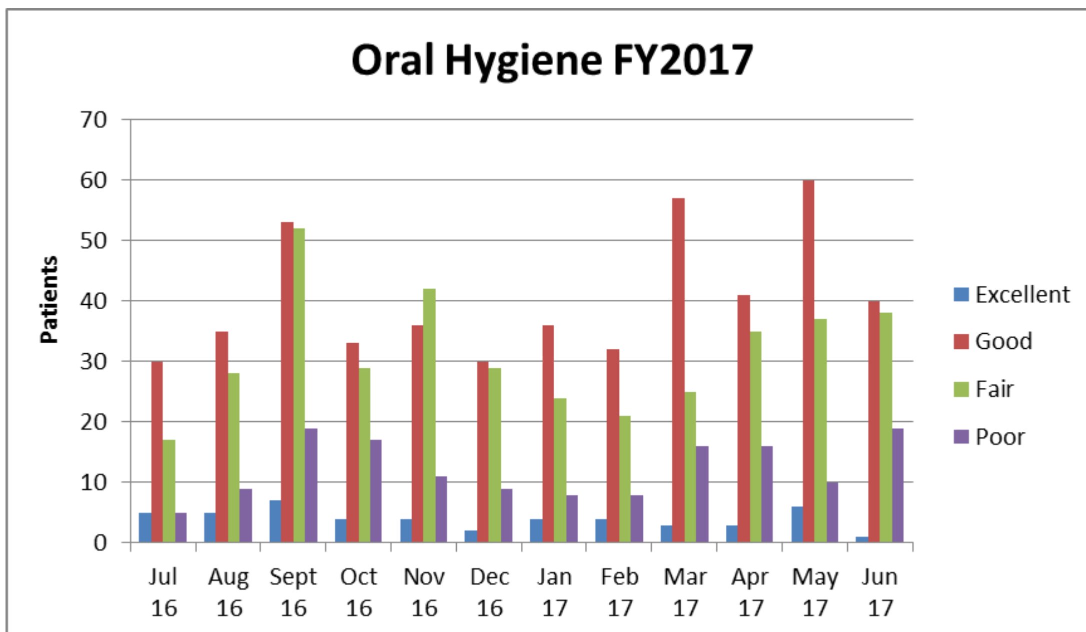
April 2017 = 4/95 = 46%
May 2017 = 66/113 = 58%
June 2017 = 44/58 = 76%
4Q2017 = 154/266 = 58%

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

Action Plan: Plaque scores are measured/recorded on each patient and tallied during prophy recall appointments. Excellent, Good, Fair, and Poor are added up monthly. Excellent and good are added up and shown in a percentage. We would like the excellent/good to increase and fair/poor to decrease.

Comments: Trying to educate our patients on brushing DAILY and its importance for proper oral care and retention of teeth.





QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

III. Measure Name: Next Visit

Measure Description: Writing Next Visit in progress note.

Type of Measure: Quality Assurance

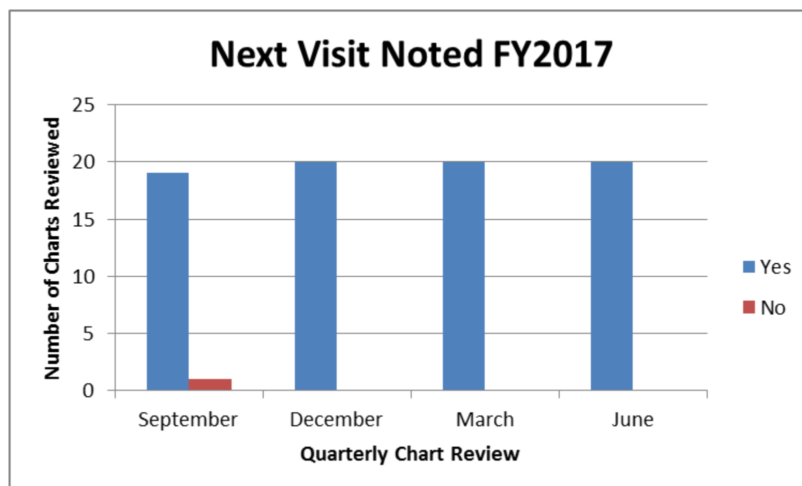
Results							
	Unit	Baseline	1Q2017	2Q2017	3Q2017	4Q2017	YTD
Target	# of progress notes with next visit documented	FY2016 95%	90-100%	90-100%	100%	100%	**100%**
Actual			95%	100%	100%	100%	**99%**

Data Analysis: This continues to be a good quality assurance measure.

1Q2017	Yes: 19	No: 1
2Q2017	Yes: 20	No: 0
3Q2017	Yes: 20	No: 0
4Q2017	Yes: 20	No: 0

Action Plan: Write at the end of every progress note what the next visit is going to be even if it is a three MRC or denture adjustment as needed.

Comments: Data is collected from quarterly reviews by Community Dental. Twenty random charts were evaluated.



QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

IV. Measure Name: RMH and MEDS

Measure Description: Review medical history and medications at the start of each appointment.

Type of Measure: Quality Assurance

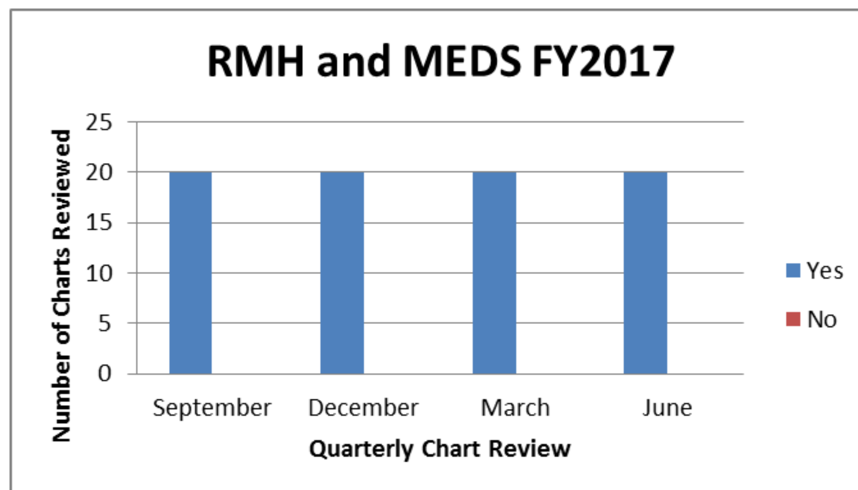
Results							
	Unit	Baseline	1Q2017	2Q2017	3Q2017	4Q2017	YTD
Target	Daily noted	FY2016 95%	90-100%	90-100%	100%	100%	**100%**
Actual			100%	100%	100%	100%	**100%**

Data Analysis: Continued QA from FY2016. Medical history and medication list will be reviewed at each appointment.

1Q2017	Yes: 20	No: 0
2Q2017	Yes: 20	No: 0
3Q2017	Yes: 20	No: 0
4Q2017	Yes: 20	No: 0

Action Plan: Continue to review patient medical history and medication list at the start of each appointment.

Comments: Data is collected from quarterly reviews by Community Dental. Twenty random charts were evaluated.



V. Measure Name: Blood Pressure

Measure Description: Blood pressure and pulse taken at each dental appointment

Type of Measure: Quality Assurance

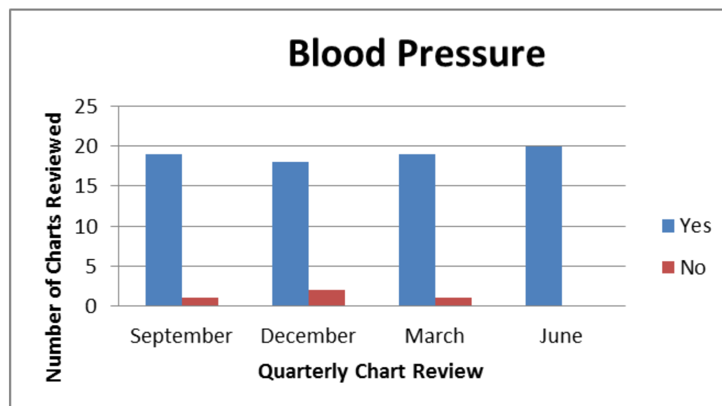
Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Daily noted; Quarterly reviewed	90-100%	90-100%	90-100%	90-100%	90-100%	**90-100%**
Actual			95%	90%	95%	100%	**95%**

Data Analysis: All patients that are seen prior to restorations and prophy appointments; denture patients do not always have their blood pressure taken, especially on denture deliveries.

1Q2017	Yes: 19	No: 1
2Q2017	Yes: 18	No: 2
3Q2017	Yes: 19	No: 1
4Q2017	Yes: 20	No: 0

Action Plan: Continue to take blood pressure and pulse at the start of all dental appointments. To withstand dental care, blood pressure should be less than 160/90.

Comments: Data is collected from quarterly reviews by Community Dental. Twenty random charts were evaluated.



Dietetic Services

Responsible Party: Kristen Piela, RDN, LDN, Dietetic Services Manager

I. Measure Name: Infection Control

Measure Description: The Food Service Manager or designee will verify that Dietary staff have maintained proper sanitation processes for 18 specified pieces of foodservice equipment. A Sanitation Schedule and Checklist will be used to validate equipment is clean and sanitary. Dietary staff will be responsible for cleaning and documenting completion of each task. The supervisor will review sheets and complete a sanitation inspection weekly.

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Percent of Equipment Cleaned as Assigned	65% 1QFY17	70% 38/54	75% 41/54	80% 43/54	90% 49/54	**90% 195/216**
Actual			65% 35/54	74% 40/54	81% 44/54	43% 23/54	**66% 142/216**

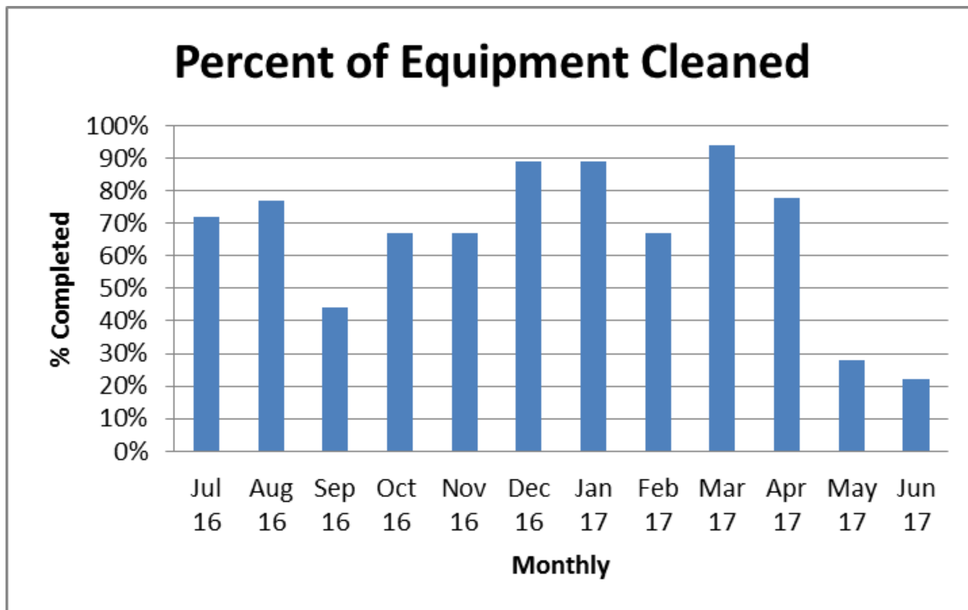
Data Analysis: Data analysis by month indicates a high of 78% in April, a low of 22% in June, and a 28% compliance rate in May. Further analysis of the 50% decrease from April to May is a result of a change in procedure; this adjustment was due to updated recommendations ascertained in the National Restaurant Associations ServSafe Food Protection Managers Certification program. Instruction in this course identified specific protocols for the development of an effective cleaning program. As a result, the Food Service Manager modified the Master Cleaning Schedule for the kitchen equipment. This adjustment increased the frequency and detail of cleaning each piece of equipment. Data analysis indicates that during the 4Q2017, there was a subsequent 38% decrease in compliance of these cleaning tasks.

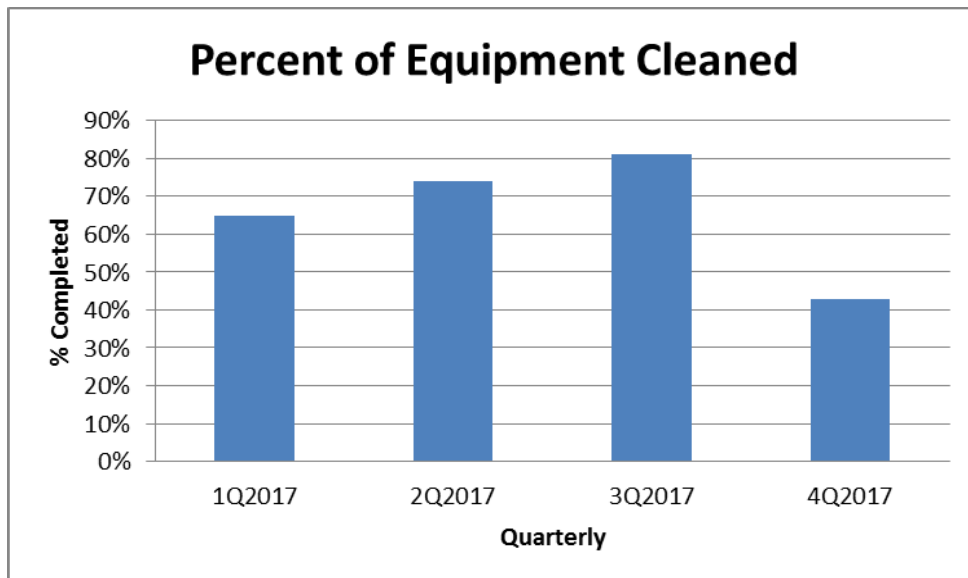
Action Plan:

- Food Service Manager:
  - Will develop clear written procedures for cleaning each piece of equipment
  - Will schedule time to train small groups or individuals
  - Will immediately assign the task of cleaning equipment that has not been deep cleaned in quarter 4 by the end of July.

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

- Cook III's:
  - Will supervise cleaning routines
  - Will review the Master Cleaning Schedule daily to assure that staff has allotted time within their work day to complete specific cleaning assignments.
  - Will ask staff during meetings for input on the program.
  - Will review and explain this report in a general staff meeting in the month of July.





QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

II. Measure Name: Nutrition Screen Accuracy

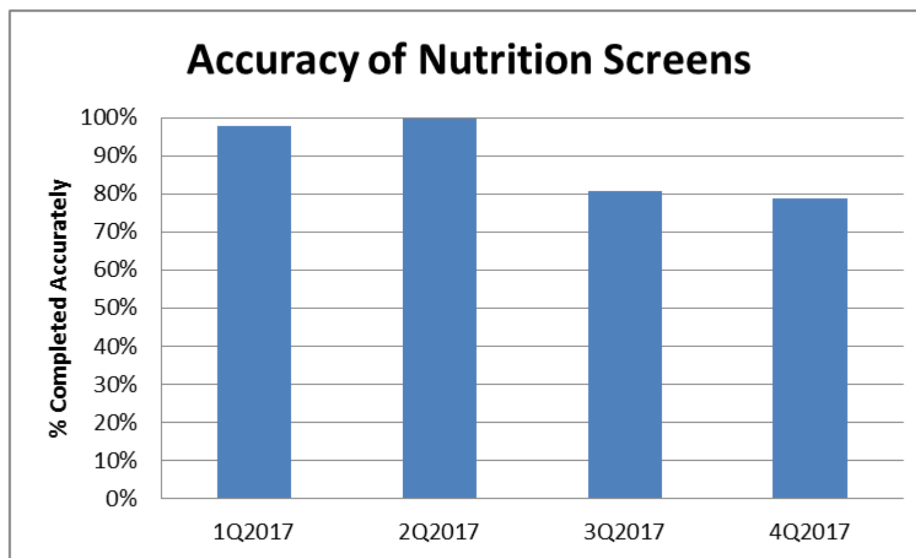
Measure Description: The Registered Dietitian will review every patient's Nursing Admission Data upon admission to assess ongoing compliance with the accuracy of the Nutrition Screen tool. This screen is utilized to attain nutrition indicators that necessitate dietary intervention.

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Percent of Nutrition screens completed accurately	FY2016 93% 161/173	94% 47/50	95% 52/55	95% 51/54	95% 55/58	**95% 206/217**
Actual			98% 49/50	100% 55/55	81% 44/54	79% 46/58	**89% 194/217**

Data Analysis: These results indicate there has been a 2% decrease in the accuracy of the information gathered on the nutrition screen this quarter. The nutrition screen is completed by the nurse responsible for the admission. Data analysis indicates that the decrease is attributed to change in the admission process. There is no longer a primary admission nurse.

Action Plan: The Dietetic Services Manager/Registered Dietitian spoke with the Director of Nursing regarding the importance of the accurate completion of the nutrition screen. The DON will review this with the nurses and place the nutrition screen on the monthly audit.



QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

III. Measure Name: Hand Hygiene Compliance

Measure Description: Supervisory staff including the Food Service Manager and Cook III's will observe all dietary employees as they return from break for proper hand hygiene.

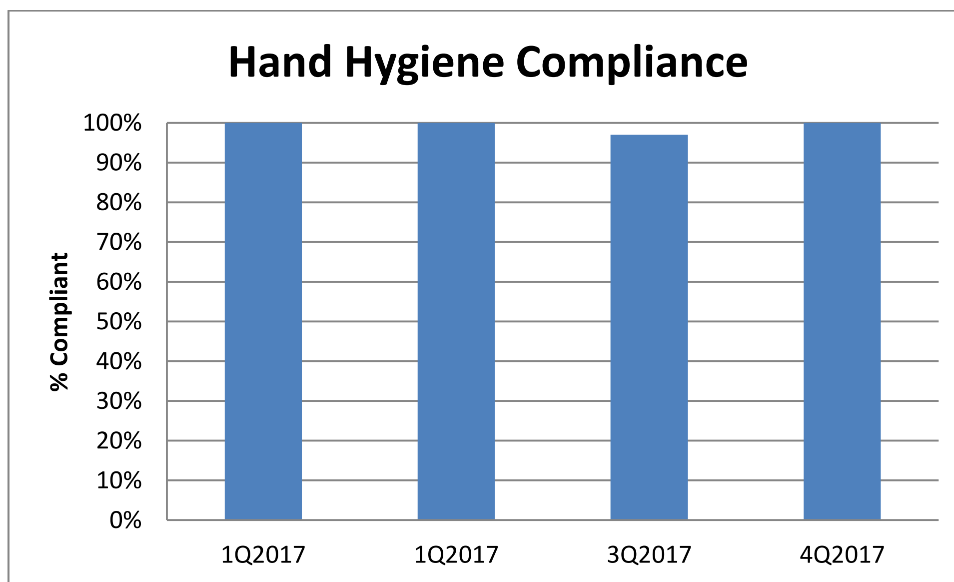
Type of Measure: Quality Assurance

<table>
<tr><th colspan="8">Results</th></tr>
<tr><th></th><th>Unit</th><th>Baseline</th><th>1Q2017</th><th>2Q2017</th><th>3Q2017</th><th>4Q2017</th><th>YTD</th></tr>
<tr><td>Target</td><td rowspan="2">Percent of Dietary employees washing hands after break</td><td rowspan="2">FY2016 95.7%</td><td>95%
245/258</td><td>95%
221/232</td><td>95%
308/323</td><td>95%
408/429</td><td>95%
1184/1242</td></tr>
<tr><td>Actual</td><td>100%
258/258</td><td>100%
232/232</td><td>97%
312/323</td><td>100%
428/429</td><td>99%
1230/1242</td></tr>
</table>

Data Analysis: This monitor remains above 95%. The submitted data portrays a 100% compliance rate. Total observations increased by 25%. All employees were observed greater than 15 times this reporting period. There were two observers this quarter.

Action Plan:

- Dietetic Services Manager reviewed this data with the Food Service Manager.
- Food Service Manager will observe the employees collecting the data to assure accuracy of the data collection process.
- Provide a review of the proper hand washing times and techniques as quarterly training.
- Encourage front line supervisors to promote hand hygiene with their staff throughout the day.
- Provide this Quality Assurance measure for review by staff to highlight the continued success.



QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

Emergency Management

Responsible Party: Robert Patnaude, Emergency Management Coordinator

I. Measure Name: Communications Equipment/Two-way radios

Measure Description: The Joint Commission states the following in EM.02.02.01: "As part of its Emergency Operations Plan, the hospital prepares for how it will communicate during emergencies. *The hospital maintains reliable communications capabilities for the purpose of communicating response efforts to staff, patients, and external organizations."*

In the event of an unforeseen emergency which could impact the safety and security of patients, staff, and visitors, communications equipment, more specifically, two-way radios are a major solution to getting accurate information to and from staff in a timely manner. The objective of the Emergency Management Communications PI measure is to ensure compliance with The Joint Commission standard with the overall objective of ensuring that the two-way radio system is fully functional and that staff are proficient in its use.

Type of Measure: Performance Improvement

Methodology: Each month, the Emergency Management Coordinator or designee will perform a combination of partial and hospital-wide radio drills. Such drills will utilize a specific form to track the drills (see attached). In conjunction with the drills, environmental rounds will be conducted for the purpose of inspecting communications equipment. Any deficiencies shall have the appropriate corrective measure immediately instituted until compliance is met.

The numerator is the number of timely and appropriate responses by staff utilizing the two-way radios by assignments. The denominator will be the total number of two-way radios by assignments.

Baseline Data: To assure that critical emergency information is disseminated in a timely and accurate manner, **a minimum of 90%** compliance has been established. This data will be reported monthly to the Emergency Management Committee, IPEC, and the Environment of Care (EOC) Committee. Areas that fail to meet the threshold will be immediately reported to the aforementioned committees.

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Results							
	Unit	Baseline	1Q2017	2Q2017	3Q2017	4Q2017	YTD
Target	Percent of timely and appropriate responses	FY2016 90% 144/159	90% 144/159	90% 144/159	90% 165/183	90% 165/183	**90% 453/501**
Actual			98% 157/159	98% 157/159	98% 181/183	96% 194/201	**98% 689/702**

Data Analysis: With a significant amount of hands-on demonstrations, radio tests, and an increase in the use of radios, data showed that majority of the radios are being deployed in a timely manner and that staff is familiar with operating the radio.

Riverview's BERT Program is supported and dependent on the additional (2) two-way radios on each of the Main Units. Staff from all departments continues to receive education on radio etiquette and protocol through one-on-one instruction and hospital-wide emails. Based on the occurrences listed here, the Emergency Management Coordinator felt that these educational programs augment the objectives sought after during the typical monthly radio drills.

Special Note: *Information contained within the "AREAS/GROUPS MONITORED" has changed to reflect the addition of and relocation of two-way radios. Therefore, 4Q data reflects those changes.*

Action Plan:
1. Continued tests and remedial training to staff along with supporting handouts as needed.
2. Increased surveillance of mass notification equipment such as alert pagers.
3. Investigate various media to notify staff to employ radios.
4. Continue to send out periodic educational information through the email system and to ensure that orientation covers all of the components of this Quality Assessment and Performance Improvement Program.
5. Complete the comprehensive review of the locations of two-way radios and the impact that those locations may have on the communications during normal and emergency operations at the facility and its remote-care site, Outpatient Services.

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

Areas/Groups Monitored N=Numerator D=Denominator	JULY 2016	AUG 2016	SEPT 2016	OCT 2016	NOV 2016	DEC 2016	JAN 2017	FEB 2017	MAR 2017	APR 2017	MAY 2017	JUNE 2017
Patient Care Areas/ # of radios												
Job Coach/1	1/1	1/1	***	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
OPS/2	2/2	2/2	***	2/2	2/2	2/2	2/2	2/2	2/2	1/1	1/1	**0/1+1**
Tx Mall, Clinic, Dietary, Med Rec/5	5/5*	5/5	***	5/5	5/5	5/5	5/5	5/5	5/5	5/5	5/5	**3/5+2**
US, UK, LS, LSSCU, LK, LKSCU/10	9/ 10**	10/10	***	10/10	9/10**	10/10	10/18	17/18#	17/18#	18/18	18/18	**17/18+3**
Support Services/ # of radios			***									
Administration/3	3/3	3/3	***	3/3	3/3	3/3	3/3	3/3	3/3	4/4	4/4	**2/4+4**
Housekeeping/ 10	9/10*	10/10	***	10/10	10/10	9/10*	10/10	10/10	10/10	14/14	14/14	14/14
Maintenance/14	14/14	14/14	***	14/14	14/14	14/14	14/14	14/14	14/14	15/15	15/15	15/15
NOD/1	1/1	1/1	***	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Nursing Services/1	1/1	1/1	***	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Operations/1	1/1	1/1	***	1/1	1/1	1/1	1/1	1##/1	1##/1	1/1	**1/1##**	**1/1##**
Security/4	4/4	4/4	***	4/4	4/4	4/4	4/4	4/4	4/4	5/5	5/5	5/5
State Forensic Services/1	1/1	1/1	***	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	**0/1+**
Patient Care Areas	**17/ 18**	**18/18**	**18/18**	**18/18**	**17/18**	**18/18**	**26/26**	**25/26**	**25/26**	**25/25**	**25/25**	**21/25**
Support Services	**34/ 35**	**35/35**	**35/35**	**35/35**	**35/35**	**34/35**	**35/35**	**35/35**	**35/35**	**42/42**	**42/42**	**39/42**
Total	**51/ 53**	**53/53**	**53/53**	**53/53**	**52/53**	**52/53**	**61/61**	**60/61**	**60/61**	**67/67**	**67/67**	**60/67**

*Some radio units not on duty due to shift assignment therefore given the same weight in order not to have a negative impact.

EMC: Emergency Management Coordinator

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

*1 One housekeeper reported that their radio was not working. The antenna needed to be replaced. After replacement, the test was performed as expected.

**2 LS-1 did not transmit since the radio was not seated in the charger properly. Remedial training was conducted reference to setting the radio into the slot of charger.

+1 Out Patient Services did not respond. They did not receive the page.

+2 Dietary did not respond to notification (Code Triage). Medical records attempted to respond. Radio battery problems, battery replaced.

+3 US did not respond to notification. Operations called to advise them of the Code Triage. Radios later tested and OK.

+4 One Admin staff was in a meeting and did not respond. Two other Admin staff did not respond to Code Triage. Radios later tested and OK.

For February and March, (2) unit BERT radios were not discernable due to antennas damaged. Replaced and retested. Emails sent to Supervisors and staff hospital-wide.

Note: Operations base radio has been sent for repair. Radio in EM office placed in Operations until a determination is made as to the status of the radio.

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

Harbor Treatment Mall

Responsible Party: Janet Barrett CTRS, Director of Rehabilitation Services

I. Measure Name: Harbor Mall Hand-Off Communication (HOC)

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

Type of Measure: Performance Improvement

Objectives	1Q2017	2Q2017	3Q2017	4Q2017	YTD
Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	65% 309/479	69% 306/445	78% 357/455	75% 351/471	**72%** **1323/1850**
SBAR information completed from the units to the Harbor Mall.	84% 403/479	86% 384/445	88% 401/455	93% 440/471	**88%** **1628/1850**
Accuracy of information from the units.	76% 363/479	86% 383/445	96% 435/455	90% 424/471	**87%** **1605/1850**
Overall Compliance	**75%** **1075/1437**	**80%** **1073/1335**	**87%** **1193/1365**	**86%** **1215/1413**	**82%** **4556/5550**

Data Analysis: Overall compliance decreased 1%, from 87% last quarter to 86% this quarter. Indicator one decreased three points from 78% to 75%, indicator two increased five points from 88% to 93%, and indicator three decreased six points from 96% to 90%. The goal is to achieve and maintain 100% compliance for all indicators throughout four consecutive quarters.

Action Plan: Continue to monitor HOC sheets daily to encourage accuracy and timeliness, review this information with the RN4 and RN5 from each unit, and to emphasize the importance of complete and accurate information as pertaining to safety and continuity of care for patients. Continue highlighted time designation at the bottom of each HOC to emphasize importance of returning HOC to the Harbor Mall by the designated time.

Health Information Technology (Medical Records)

Responsible Party: Samantha Brockway, RHIT, Medical Records Administrator

I. Measure Name: Documentation and Timeliness

Indicators	4Q2017 Findings	4Q2017 Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements, and Medical Staff bylaws timeframes.	There were 49 discharges in the 4Q2017. Of those, 48 were completed within 30 days.	98%	80%
Discharge summaries will be completed within 15 days of discharge.	Out of 49 discharge summaries, 47 were completed within 15 days of discharge.	96%	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	Six revised forms and two new forms in 4Q2017 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	607 dictated reports were completed within 24 hours.	100%	90%

Data Analysis: The indicators are based on the review of all discharged records. There was 98% compliance with 30 day record completion. Weekly "charts needing attention" lists are distributed to medical staff, including the Medical Director, along with the Superintendent, Risk Manager and the Quality Improvement Manager. There was 100% compliance with timely & accurate medical transcription services

Actions: Continue to monitor.

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

II. Measure Name: Confidentiality

Indicators	4Q2017 Findings	4Q2017 Compliance	Threshold Percentile
All patient information released from the Health Information Department will meet all Joint Commission, State, Federal & HIPAA standards.	2749 Requests for information (172 requests for patient information and 2,577 police checks) were released.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	All new employees/contract staff attended confidentiality/ HIPAA training.	100%	100%
Patient confidentiality/privacy issues tracked through incident reports.	0 privacy-related incident reports.		

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 4Q2017 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 needs to be strictly adhered to requiring training, education, and policy development at all levels.

Actions: The above indicators will continue to be monitored.

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

III. Measure Name: Regulatory and Compliance Standards in Documentation
Ensuring Fiscal Responsibility in Documentation and Billing Practices

Indicator and Rationale for Selection	1Q2017	2Q2017	3Q2017	4Q2017	YTD
Identification Data	98% 54/55	100% 61/61	98% 66/67	100% 49/49	99% 230/232
Medical History, including chief complaint; HPI; past, social & family hx.; ROS, and physical exam w/in 24 hr. conclusion and plan	93% 55/55 4 Refused	100% 61/61 7 Refused	100% 67/67 11 Refused	98% 48/49 1>24 hrs	100% 231/232
Summary of patient's psychosocial needs as appropriate to the patients *	71% 39/55 16>7 days	82% 50/61 11>7 days	81% 54/67 13>7 days	90% 44/49 5>7 days	81% 187/232
Psychiatric Evaluation in patient's record w/in 24 hrs. of admission	95% 52/55 1>24 hrs 2>60 hrs	100% 61/61	93% 62/67 5>60 hrs	86% 43/49 6>60 hrs	94% 218/232
Physician (TO/VO w/in 72 hr.)	96% 151/157	98% 127/130	94% 128/135	92% 133/144	95% 539/566
Evidence of appropriate informed consent	100% 55/55	100% 61/61	100% 67/67	100% 49/49	100% 232/232
Clinical observations including the results of therapy.	100% 55/55	100% 61/61	100% 67/67	100% 49/49	100% 232/232
Nursing discharge Progress Note with time of discharge departure	95% 52/55	87% 53/61	84% 56/67	92% 45/49	89% 206/232
Consultation reports, when applicable	80% 99/123	82% 300/365	75% 190/253	80% 136/171	79% 725/912
Results of autopsy, when performed	N/A	N/A	N/A	N/A	N/A
Advance Directive Status on admission and SW follow up after	93% 51/55	87% 53/61	93% 62/67	96% 47/49	92% 213/232
Notice of Privacy	100% 55/55	100% 61/61	98% 66/67	98% 48/49	99% 230/232
Chart Completion w/in 30 days of discharge date/discharge summary completed within 30 days	100% 55/55 100% 55/55	100% 61/61 100% 61/61	100% 67/67 100% 67/67	98% 48/49 96% 47/49	100% 231/232 99% 230/232
Discharge Packet sent to follow up provider within five days of discharge.	98% 54/55	100% 61/61	100% 67/67	100% 49/49	100% 232/232

* The parameters for this measure will be changed to meet applicable goals as defined by the Director of Social Work. The current measure is more stringent than regulatory standards dictate.

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

IV. Measure Name: Release of Information for Concealed Carry Permits:

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

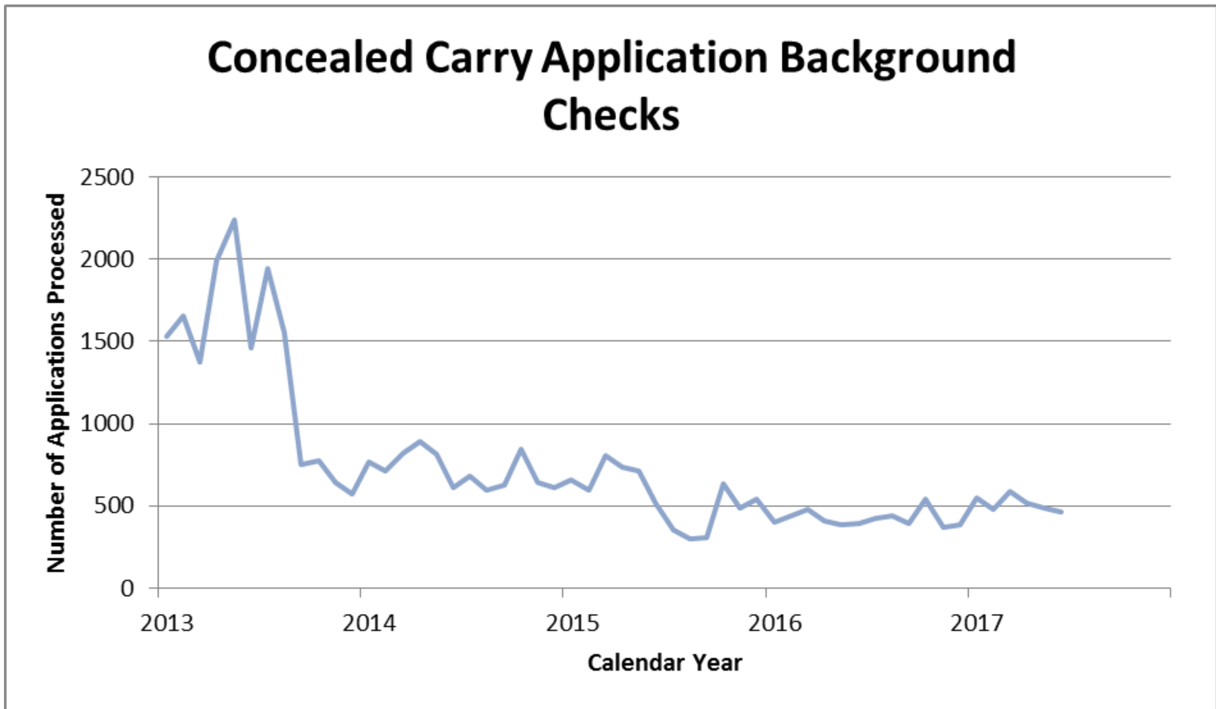
Analyze:
Data collected for the 4Q2017 showed that we received 1468 applications. This is a decrease from last quarter, 3Q2017, when we received 1622 applications.

Improve:
The process has been streamlined as we have been working with the state police by eliminating the mailing of the applications from them to RPC and DDPC. RPC has reactivated the medical records email to receive lists of the applicants from the state police that include the DOB and any alias they may have had. This has cut down on paper as well as time taken sorting all the applications. OIT has also created a new patient index in which we are in the process of consolidating sources we search into this one system. Over time this will decrease time spent searching as we will no longer have to search several sources. This is ongoing.

Note: In July 2015, a new State of Maine law was approved effective October 2015. This law no longer requires citizens to have a concealed carry permit to carry a concealed weapon within the State of Maine. However, if citizens want to carry concealed outside Maine they will still need to apply for a concealed carry permit. We expect this to decrease the number of concealed carry permit applications we receive and process.

Year	**FY2017**												**Total**
Month	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	
# Applications Received	425	443	392	543	371	383	552	480	590	517	486	465	**5647**

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT



Housekeeping

Responsible Party: Debora Proctor, Housekeeping Supervisor

I. Measure Name: Patient Living Area

The Housekeeping Department will maintain an acceptable standard of cleanliness and sanitation in patient living areas.

Measure Description: The Housekeeping Supervisor or designee will perform a monthly inspection of the patient living area and record the findings on the Housekeeping Inspection Form. Any unit not meeting the threshold will be inspected every two weeks until compliance is met

Method of Monitoring: Inspection scores will be summarized monthly. Patient areas that fail to meet the threshold will be reported to the IPEC group, EOC, and the Director of Support Services. This report will include any actions taken.

Results:

Unit	Target	1Q2017	2Q2017	3Q2017	4Q2017	YTD
Lower Saco	95%	93%	91%	92%	96%	**93%**
Upper Saco		93%	93%	93%	95%	**94%**
Lower Kennebec		91%	91%	91%	91%	**91%**
Upper Kennebec		86%	93%	94%	96%	**92%**
Overall Average		**91%**	**92%**	**93%**	**95%**	**93%**

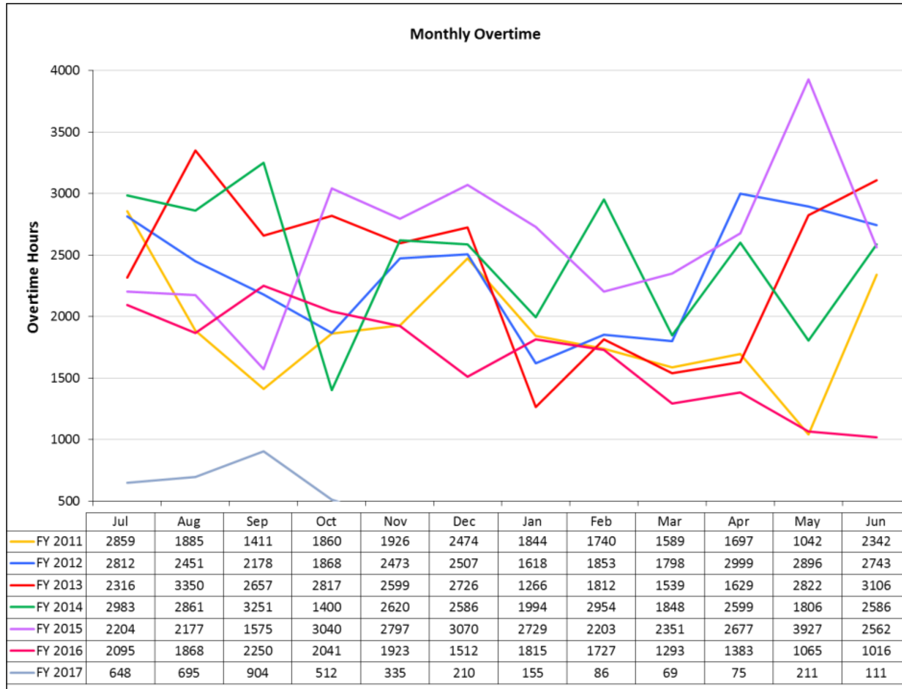
Data Analysis: The Housekeeping Supervisor inspected units monthly. 4Q2017 resulted in 95% which is a 2% increase over last quarter. Fiscal year results were within 2% of goal.

Action Plan: The Housekeeping Supervisor will continue to do monthly inspections to assure that cleanliness of the environment continues to improve.

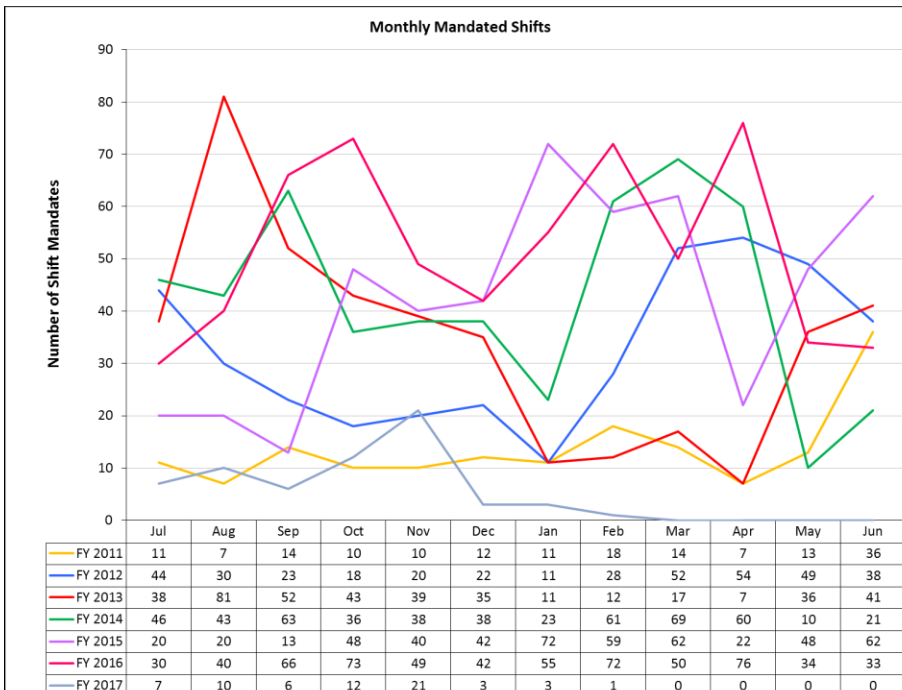
QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

Human Resources

Person Responsible: Aimee Rice, Human Resources Manager



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2011	2859	1885	1411	1860	1926	2474	1844	1740	1589	1697	1042	2342
FY 2012	2812	2451	2178	1868	2473	2507	1618	1853	1798	2999	2896	2743
FY 2013	2316	3350	2657	2817	2599	2726	1266	1812	1539	1629	2822	3106
FY 2014	2983	2861	3251	1400	2620	2586	1994	2954	1848	2599	1806	2586
FY 2015	2204	2177	1575	3040	2797	3070	2729	2203	2351	2677	3927	2562
FY 2016	2095	1868	2250	2041	1923	1512	1815	1727	1293	1383	1065	1016
FY 2017	648	695	904	512	335	210	155	86	69	75	211	111



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2011	11	7	14	10	10	12	11	18	14	7	13	36
FY 2012	44	30	23	18	20	22	11	28	52	54	49	38
FY 2013	38	81	52	43	39	35	11	12	17	7	36	41
FY 2014	46	43	63	36	38	38	23	61	69	60	10	21
FY 2015	20	20	13	48	40	42	72	59	62	22	48	62
FY 2016	30	40	66	73	49	42	55	72	50	76	34	33
FY 2017	7	10	6	12	21	3	3	1	0	0	0	0

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QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

I. Measure Name: License Reviews

Measure Description: Ensuring that licenses/registry entries are verified via the appropriate source prior to hire for all licensed (or potentially licensed) new hires.

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Percentage Licenses Reviewed	FY2014 98%	100%	100%	100%	100%	**100%**
Actual			100% 24/24	100% 15/15	100% 22/22	100% 20/20	**100% 81/81**

Data Analysis: During 4Q2017, there were 25 new hires. Of those, 20 were licensed, or potentially licensed. License verification was completed on all 20 employees with potential licenses.

Action Plan: No action is needed at this time.

Infection Control

Person Responsible: Donna Bradeen, RN, Infection Control Nurse

I. Measure Name: Employee Hand Hygiene Rate

Measure Description:

- Staff will observe the hand hygiene practice of nurses as they pass medications. (10 observations per month)
- Staff will do 10 hand hygiene observations per month (before & after patient contact) in the milieu on the **7AM-7PM shift.**
- Staff will do 10 hand hygiene observations per month (before & after patient contact) in the milieu on the **7PM-7AM shift**

Measure Type: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2016**	**4Q2017**	**YTD**
Target	Employee Hand Hygiene Compliance	FY2016 69%	>90%	>90%	>90%	>90%	**>90%**
Actual			99%	96%	99%	94%	**97%**

Data:

Upper Saco Meds – 100%
Upper Saco Milieu 7AM-7PM – 100%
Upper Saco Milieu 7PM-7AM – 100%

Upper Kennebec Meds – 100%
Upper Kennebec Milieu 7AM-7PM – 100%
Upper Kennebec Milieu 7PM-7AM – 100%

Lower Kennebec Meds – 100%
Lower Kennebec Milieu 7AM-7PM – 100%
Lower Kennebec Milieu 7PM-7AM – 98%

Lower Saco Meds – 100%
Lower Saco Milieu 7AM-7PM – 67%
Lower Saco Milieu 7PM-7AM – 67%

Plan: Continue to monitor and measure.

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

II. Measure Name: Assisting Patients with Daily Hygiene

Measure Description: Staff offer hand gel to patients prior to breakfast, lunch, and dinner, 10 days per month.

Measure Type: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Employee Hand Hygiene Compliance	FY2016 88%	>90%	>90%	>90%	>90%	**>90%**
Actual			98%	94%	98%	83%	**96%**

Data:
The mean compliance rate for April 2017 is 50%.
The mean compliance rate for May 2017 is 99%.
The mean compliance rate for June 2017 is 100%.

Plan: Continue to monitor and measure.

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

Medical Staff

Responsible Party: Dr. Joanna Gratton, Clinical Director

Quality Improvement Plan
2016-2017

As specified in Article Seven of the Medical Staff Bylaws, the improvement and assurance of medical staff quality and performance is of paramount importance to the hospital. This plan insures that the standards of patient care are consistent across all clinical services and all specialties and categories of responsible practitioners. Through a combination of internal and external peer review, indicator monitoring, focused case reviews of adverse outcomes or sentinel events, routine case reviews of patients with less than optimal outcomes, and the establishment of performance improvement teams when clinical process problems arise, the medical staff will insure quality surveillance and intervention activities appropriate to the volume and complexity of Riverview's clinical workload. Medical Staff Quality Improvement efforts will be fully integrated with the hospital-wide Integrated Performance Excellence Committee (IPEC) so that information can be sent to and received from other clinical and administrative units of the hospital. The Clinical Director, assisted by the President of the Medical Staff, will serve as the primary liaison between the MEC and IPEC. Oversight of the Medical Staff Performance Improvement Plan is primarily delegated to the Clinical Director in conjunction with the President of the Medical Staff, the Director of Integrated Quality and Informatics, the Superintendent, and ultimately to the Advisory Board.

The goal of the Medical Staff Quality Improvement Plan is to provide care that is:

Designed to improve clinical outcomes
Effective
Efficient
Patient centered
Equitable
Safe
Timely

To achieve this goal, medical staff members will participate in ongoing and systematic performance improvement efforts. The performance improvement efforts will focus on direct patient care processes and support processes that promote optimal patient outcomes. This is accomplished through peer review, clinical outcomes review, variance analysis, performance appraisals, and other appropriate quality improvement techniques.

1. **Peer Review Activities**:
    a. Regularly scheduled internal peer review by medical staff occurs on a quarterly basis at the Med Staff QA and PI Committee. The group of assembled clinicians will review case histories and treatment plans, and offer recommendations for possible changes in treatment plans, for any patient judged by the attending physician or psychologist, or others (including

nursing, administration, the risk manager, or the Clinical Director) , and upon request, to not be exhibiting a satisfactory response to their medical, psychological, or psychiatric regimens. Our goal is to discuss a case quarterly. Detailed minutes of these reviews will be maintained, and the effectiveness of the reviews will be determined by recording feedback from the reviewed clinician as to the helpfulness of the recommendations, and by subsequent reports of any clinical improvements or changes noted in the patients discussed over time. Such intensive case reviews can also serve as the generator of new clinical monitors if frequent or systematic problem areas are uncovered.

In addition all medical staff members (full and part-time) will have a minimum of six charts per year peer reviewed and rated for clinical pertinence of diagnosis and treatment as well as for documentation. These may include admission histories and physicals, discharge summaries, and progress notes. The results of these chart audits are available to the reviewed practitioners and trends will be monitored by the Clinical Director as part of performance review and credentialing decisions.

b. Special internal peer review or focused review. At the direction of the Clinical Director a peer chart review is ordered for any significant adverse clinical event or significant unexpected variance. Examples would be a death, seclusion or restraint of one patient for eight or more continuous hours, patient elopement, the prescribing of three or more atypical antipsychotics for the same patient at the same time, or significant patient injury attributable to a medical intervention or error. This may be in conjunction with, lead to, or result from a Root Cause Analysis requested by the hospital Superintendent.

c. External peer review occurs regularly through contracts with the Maine Medical Association and the Community Dental Clinic program. We plan to continue our recent tradition of assessment of the psychiatry service and the medical service by peers in those clinical areas based on random record assessment of 25 cases in each service through the Maine Medical Association (MMA). Our contract with MMA also allows for special focused peer reviews of any unexpected death or when there is a question of a significant departure from the standard of care. An outside dentist from Community Dental will also review 20 charts of the hospital dentist for clinical appropriateness quarterly.

2. **MEC Subcommittee and IPEC Indicator Monitoring Activities**:

The subcommittees of the MEC and the Integrated Performance Excellence Committee are the primary methods by which the medical staff monitor and analyze for trends all hospital-wide quality performance data as well as trends more specific to medical staff performance. The subcommittees, in turn, report their findings on a monthly basis to the Medical Executive Committee and to the Clinical Director for any needed action. The respective committees monitor the following indicators:

a. Integrated Performance Excellence Committee (this is not a subcommittee of the Medical Staff but the Clinical Director serves as a member and is the primary liaison to the Medical Executive Committee).
    - Psychiatric Emergencies

- Seclusion and Restraint Events
- Staff or Patient Injuries
- Priority I Incident Reports
- Other clinical/administrative department monitoring activity

b. Pharmacy and Therapeutics Committee:
- Medication Errors Including Unapproved abbreviations
- Adverse Drug Reactions
- Pharmacy Interventions
- Antibiotic Monitoring
- Medication Use Evaluations
- Psychiatric Emergency process

c. Medical Records Committee:
- Chart Completion Rate/Delinquencies

d. Infection Control Committee:
- Infection Rates (hospital acquired and community acquired)
- Staff Vaccination Rates/Titers

e. Utilization Management Committee:
- Insurance Denials

f. Med Staff QA & PI Committee:
- Hospital-wide Core Measures and NASMHPD Data
- Patient Satisfaction Surveys
- Administrative concerns about quality
- Special quality improvement monitors for the current year (see also the Appendix and number six below).
- Reports from the Human Rights Committee regarding patient rights and safety issues
- Specific case reviews

3. **Performance or Process Improvement Teams**:
When requested by or initiated by other disciplines or by hospital administration, or when performance issues are identified by the medical staff itself during its monitoring activities, the Clinical Director will appoint a medical staff member to an ad hoc performance improvement team. This is generally a multidisciplinary team looking at ways to improve hospital wide processes. Currently the following performance improvement teams involving medical staff are in existence or have recently completed their reviews:
   a. Review of treatment plans
   b. Review of mealtimes and fresh air breaks for whole hospital

4. **Miscellaneous Performance Improvement Activities**:
In addition to the formal monitoring and peer review activities described above, the Clinical Director is vigilant for methods to improve the delivery of clinical care in the hospital from interactions with, and feedback from, other discipline chiefs, from patients or from their complaints and grievances, and from community practitioners who interact with hospital medical staff. These interactions may result in reports to the Medical Executive Committee, in

the creation of performance improvement teams, performance of a root-cause analysis, or counseling of individual practitioners.

5. **Reports of Practitioner-specific Data to Individual Practitioners**:
The office of the Clinical Director will provide confidential outcomes of practitioner-specific data to each medical staff member within 30 days of the end of the fiscal year. It will be placed in the confidential section of the practitioner's medical staff file and freely accessible during normal business hours. The office of the Clinical Director will notify all medical staff members when the data is available for review. Each medical staff member may discuss the data with the Clinical Director at any.

6. Upon the recommendation of the Clinical Director, upon recommendation of the MEC as a whole after a request from any member of the medical staff, from a recommendation of the Integrated Performance Excellence Committee, or upon recommendation of the Advisory Board, this plan may be amended with appropriate approvals at any time. Examples of when amendments might be necessary are the detection of new clinical problems requiring monitoring or when it is discovered that current monitors are consistently at or near target thresholds for six consecutive months. Should the number of active clinical monitors fall below four at any time, replacement monitors will be activated within two months of termination of the previous monitor (s). The Clinical Director, the Medical Staff President, and the MEC are jointly responsible for maintaining an active monitoring system at all times and to insure that all relevant clinical service areas or services are involved in monitoring. The Director of Integrated Quality will also assist in assuring the ongoing presence of appropriate monitors.

Quality Improvement Reporting Schedule to
Medical Executive Committee

Pharmacy & Therapeutics Committee:	Chair reports monthly
Medical Records Committee:	Chair reports monthly
Infection Control Committee:	Chair reports monthly
Utilization Management Committee:	Chair reports bimonthly
Med Staff QA and PI Committee:	Clinical Director reports monthly and to individual practitioners as necessary
Research Committee	Clinical Director reports bimonthly
CME Committee	Chair reports bimonthly
Human Rights Committee (Allegations of Abuse, Neglect and Exploitation)	Clinical Director reports monthly

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

I. Measure Name: Polyantipsychotic Therapy

Measure Description: The use of two or more antipsychotic medications (polyantipsychotic therapy) is discouraged as current evidence suggests little to no added benefit with an increase in adverse effects when more than one antipsychotic is used. The Joint Commission Core (TJC) Measure HBIPS-5 requires that justification be provided when more than one antipsychotic is used. Three appropriate justifications are recognized: 1) Failure of three adequate monotherapy trials, 2) Plan to taper to monotherapy (cross taper) and 3) Augmentation of clozapine therapy. This measure aligns itself with the HBIPS-5 core measure and requires the attending psychiatrist to provide justification for using more than one antipsychotic. In addition to the justification, the clinical/pharmacological appropriateness is also evaluated.

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Justified Polyantipsychotic Therapy	76% (2016)	90%	90%	90%	90%	**90%**
Actual			82%	52%	40%	71%	**61%**

Data Analysis: All medication profiles in the hospital are reviewed in each month of the quarter for antipsychotic medication orders. Attending psychiatrists are required to complete a Polyantipsychotic Therapy Justification Form when a patient is prescribed more than one antipsychotic.

Action Plan: We will continue to monitor for appropriate justification of polyantipsychotic therapy. Pharmacy will continue alerting providers to provide justifications for polyantipsychotic therapy. Hopefully, these strategies will provide the necessary prompts to Medical Staff as reminders to address and provide justification for polyantipsychotic therapy.

Comments: 70% for the 4Q2017 is significantly higher than the prior quarter. The notification process to prescribers has been updated in the past six months. There has also been new communication on the importance of this measure to engage prescribers. We will be monitoring the completion of these parameters and reporting on them monthly to the Medical Staff Quality Assurance and Process Improvement Committee as well as quarterly in this report.

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

II. Measure Name: Metabolic Monitoring

Measure Description: Metabolic syndrome is a well-known side effect of second generation antipsychotics (SGAs). The majority of patients prescribed antipsychotics are prescribed an entity from the SGA sub-class. The purpose of this monitor is to ensure that we are monitoring, or attempting to monitor, SGA therapy appropriately for those patients prescribed SGAs.

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Complete/Up-to-date Metabolic Parameters	69% (FY16)	75%	75%	75%	75%	**75%**
Actual			81%	16%	27%	48%	**43%**

Data Analysis: The pharmacy completed data collection of metabolic monitoring parameters for all patients in the hospital who were receiving atypical antipsychotics during the quarter. Data elements collected on all patients included BMI (Body Mass Index) and BP (blood pressure) plus lab results including HDL cholesterol, triglycerides, fasting blood sugar, and hemoglobin A1C.

Action Plan: We will continue to monitor for metabolic syndrome in patients using SGA therapy. The patient's right to refuse assessment (weight, blood pressure and lab work) has been identified as a contributing factor to not being able to fully assess their metabolic status. The pharmacy has been updating a flow sheet for the medical service monthly to identify which patients are due for lab work to aid providers in this task.

Comments: We saw a small increase this quarter from 27% to 48%. However, it is still below our target due to prescribers and pharmacists not having readily retrievable access to labs. We are in the process of remedying this issue and will continue to monitor these parameters.

4Q2017	
# of patients with complete/up-to-date parameters	12
# of patients missing/not up-to-date parameters	11
# of patients meeting criteria for metabolic syndrome	7
# of patients without metabolic syndrome	13
# of patients unable to determine if have metabolic syndrome	3

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QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

III. Measure Name: Drug Safety Monitoring

Measure Description: The main objectives of this monitor are to provide safety monitoring recommendations that balance safety and cost-effectiveness as well as to highlight the occurrence of medication-induced side effects and the desirability of their prevention. Lastly, this monitor will serve to and facilitate the monitoring of drug safety parameters as a standard component of treatment. As referenced in the International Society for Bipolar Disorders (ISBD) guidelines, therapeutic drug level and cardiovascular risk monitoring in bipolar disorder is only completed in about half of patients according to the minimal recommendations of the US guidelines. This monitor is put into place in order to keep the facility diligent in the laboratory monitoring of drug safety parameters. Laboratory parameters are being assessed for patients utilizing lithium, valproic acid and derivatives, carbamazepine and oxcarbazepine per the table below.

Type of Measure: Quality Assurance

Laboratory Monitor	Lithium	VPA	Carbamazepine/ Oxcarbazepine
Baseline	• TSH • ECG (for patients >40 years of age) • Pregnancy test	• CBC • LFTs • Albumin • Sodium • Ammonia • Pregnancy Test	• CBC • LFTs • Albumin • Electrolytes • Pregnancy Test
Serum Levels	• At steady state • Every 3-6 months • As clinically indicated	• At steady state • As clinically indicated	• Two levels to establish dose, four weeks apart • As clinically indicated
Longitudinal Monitoring			
Every three months	• Once At 3months: ○ BUN ○ SCr ○ TSH	• Every three months for the 1st year of therapy: ○ Weight ○ CBC ○ LFTs ○ Albumin ○ Sodium	• Monthly for three months: ○ CBC ○ LFTs ○ Albumin ○ Electrolytes ○ BUN ○ SCr
Every six months	• BUN • SCr • TSH • Weight	---	---

Every 12 months	• Weight	• Weight • CBC • LFTs • Albumin • Sodium • BP* • Bone density* • FBG * • Fasting lipids*	• CBC • LFTs • Albumin • Electrolytes • BUN • SCr
***If there are clinical risk factors BP – blood pressure; BUN – blood urea nitrogen; CBC – complete blood count; ECG – echocardiogram; FBG – fasting blood glucose; FLP – fasting lipid profile; LFTs – liver function tests; SCr – serum creatinine; TSH – thyroid stimulating hormone; VPA – valproic acid and derivatives**			

	Unit	Baseline	1Q2017	2Q2017	3Q2017	4Q2017
Target	Complete/Up-to-date Laboratory Parameters	79% (FY2016)	90%	90%	90%	90%
Actual			60%	42%	47%	72%

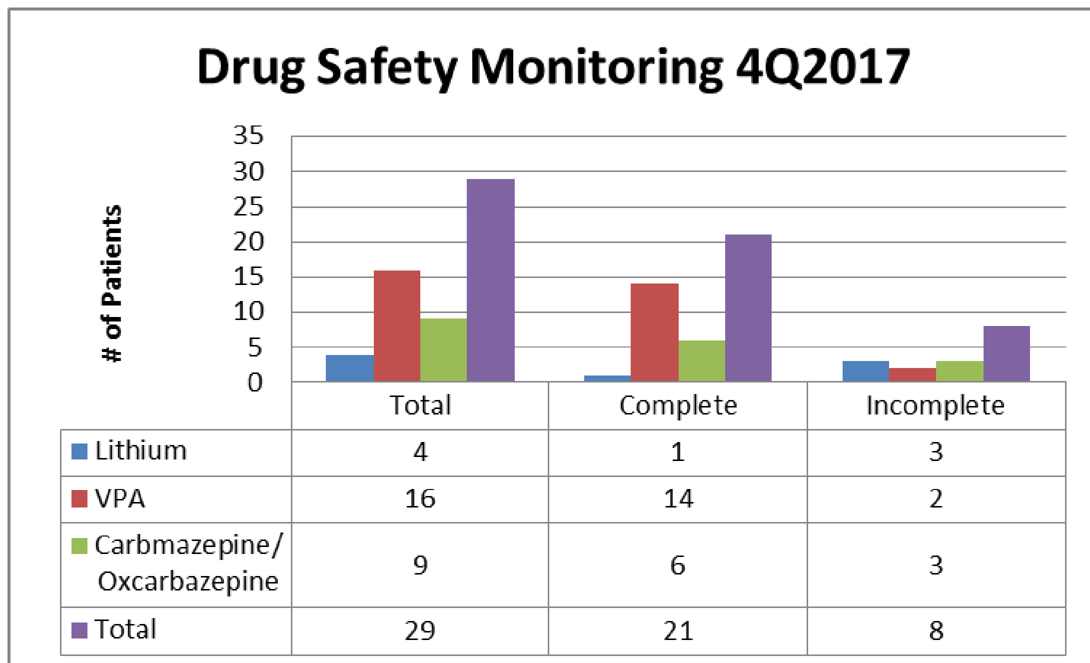
Data Analysis: We have assessed a baseline group of patients with regards to the completion of their laboratory monitoring. Each month patients using lithium, valproic acid derivatives, carbamazepine or oxcarbazepine will be evaluated for completeness of their monitoring parameters as stated in the table above and reported to the Medical Staff Quality Assurance and Process Improvement Meeting so that missing parameters may be obtained.

Action Plan: Our plan is to continue to review patients using lithium, valproic acid derivatives, carbamazepine or oxcarbazepine for completeness of monitoring parameters. Our goal is 90% of patients will have complete parameters as specified in the above table over the next quarter. An effort will be made to report the patient list and missing laboratory values monthly to aid in keeping this percentage at or above 90%.

Comments: At baseline in 4Q2017, 29 patients were utilizing lithium, valproic acid derivatives, carbamazepine or oxcarbazepine with 8 patients (28%) not having up to date laboratory parameters. We will be monitoring the completion of these parameters and reporting on them monthly to the Medical Staff Quality Assurance and Process Improvement Committee as well as quarterly in this report.

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

	Total	Complete	Incomplete
Lithium	4	1	3
VPA	16	14	2
Carbamazepine/ Oxcarbazepine	9	6	3
Total	29	21	8



QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

Nursing

Responsible Party: Renee Pfingst, RN, Director of Nursing

I. Measure Name: Mandate Occurrences

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

Type of Measure: Performance Improvement

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

Methods of monitoring: Monitoring would be performed by:

- Staffing Office Database Tracking System
- Human Resources Department Payroll System

Methods of reporting: Reporting would occur by one or all of the following methods:

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

Unit: Mandate shift occurrences

Baseline: September 2013: Nurse Mandates 14 shifts, Mental Health Worker Mandates 49 shifts

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

Mandate Occurrences: When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.

	Baseline Sept 2013	1Q2017			2Q2017			3Q2017			4Q2017			Goal
		July 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	June 2017	
Nursing Mandates	14	1	0	0	4	5	1	2	1	0	0	0	0	0
Mental Health Worker (MHW) Mandates	49	6	10	6	8	16	2	1	0	0	0	0	0	0

Nursing mandates decreased from three last quarter to zero this quarter.
MHW mandates decreased from one last quarter to zero this quarter.

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

II. Measure Name: 4Q2017 Nursing Department Chart Review Effectiveness

Lower Saco:

Indicators	Findings	Compliance
1. Encounter note written between the hours of 0700-2300.	15/15	100%
2. A shift assessment is completed each shift.	15/15	100%
3. Weekly Summary note completed.	15/15	100%
4. Observational note completed on patient who is on a higher level of observation i.e. ¼ hour checks or 1:1.	10/15 5 n/a	100%
5. Diabetes teaching checklist active/completed (if patient is diabetic).	7/15 8 n/a	100%
6. Multidisciplinary Teaching checklist active/completed.	15/15	100%
7. Dental Education Teaching checklist active/completed.	15/15	100%
8. Nursing Assessment of Suicide Risk being completed with Treatment Plan Review.	15/15	100%
9. Annual Assessment completed.	1/15 14 n/a	100%
10. Patient's Rights reviewed and signed.	11/15 4 ref.	100%
11. Informed Consent signed, dated and timed.	10/15 4 ref. 1 loc.	100%
12. Number of Telephone Orders for the month.	46/46	100%
13. Number of Telephone Orders signed by the prescriber within 24 hours.	44/46	96%

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QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

Upper Saco:

Indicators	Findings	Compliance
1. Encounter note written between the hours of 0700-2300.	9/15	60%
2. A shift assessment is completed each shift.	3/15	20%
3. Weekly Summary note completed.	15/15	100%
4. Observational note completed on patient who is on a higher level of observation i.e. ¼ hour checks or 1:1.	3/15 12 n/a	100%
5. Diabetes teaching checklist active/completed (if patient is diabetic).	14 n/a	93%
6. Multidisciplinary Teaching checklist active/completed.	13/15	87%
7. Dental Education Teaching checklist active/completed.	12/15 1 n/a	87%
8. Nursing Assessment of Suicide Risk being completed with Treatment Plan Review.	15/15	100%
9. Annual Assessment completed.	6/15 9 n/a	100%
10. Patient's Rights reviewed and signed.	13/15 1 ref. 1 loc.	100%
11. Informed Consent signed, dated and timed.	11/15 2 ref. 1 loc.	93%
12. Number of Telephone Orders for the month.	13/13	100%
13. Number of Telephone Orders signed by the prescriber within 24 hours.	12/13	92%

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

Lower Kennebec:

Indicators	Findings	Compliance
1. Encounter note written between the hours of 0700-2300.	15/15	100%
2. A shift assessment is completed each shift.	15/15	100%
3. Weekly Summary note completed.	14/15 1 n/a	100%
4. Observational note completed on patient who is on a higher level of observation i.e. ¼ hour checks or 1:1.	14/15 1 n/a	100%
5. Diabetes teaching checklist active/completed (if patient is diabetic).	1/15 14 n/a	100%
6. Multidisciplinary Teaching checklist active/completed.	15/15	100%
7. Dental Education Teaching checklist active/completed.	15/15	100%
8. Nursing Assessment of Suicide Risk being completed with Treatment Plan Review.	15/15	100%
9. Annual Assessment completed.	15 n/a	100%
10. Patient's Rights reviewed and signed.	11/15 3 ref. 1 loc.	100%
11. Informed Consent signed, dated and timed.	11/15 2 ref. 2 loc.	100%
12. Number of Telephone Orders for the month.	19/19	100%
13. Number of Telephone Orders signed by the prescriber within 24 hours.	17/19	89%

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

Upper Kennebec:

Indicators	Findings	Compliance
1. Encounter note written between the hours of 0700-2300.	14/15	93%
2. A shift assessment is completed each shift.	15/15	100%
3. Weekly Summary note completed.	15/15	100%
4. Observational note completed on patient who is on a higher level of observation i.e. ¼ hour checks or 1:1.	9/15 6 n/a	100%
5. Diabetes teaching checklist active/completed (if patient is diabetic).	2/15 13 n/a	100%
6. Multidisciplinary Teaching checklist active/completed.	15/15	100%
7. Dental Education Teaching checklist active/completed.	14/15	93%
8. Nursing Assessment of Suicide Risk being completed with Treatment Plan Review.	15/15	100%
9. Annual Assessment completed.	14/15 1 ref.	100%
10. Patient's Rights reviewed and signed.	13/15 2 loc.	100%
11. Informed Consent signed, dated and timed.	11/15 4 loc.	100%
12. Number of Telephone Orders for the month.	17/17	100%
13. Number of Telephone Orders signed by the prescriber within 24 hours.	14/17	82%

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QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

Total - All Units:

Indicators	Findings	Compliance
1. Encounter note written between the hours of 0700-2300.	53/60	88%
2. A shift assessment is completed each shift.	48/60	80%
3. Weekly Summary note completed.	59/60 1 n/a	100%
4. Observational note completed on patient who is on a higher level of observation i.e. ¼ hour checks or 1:1.	36/60 24 n/a	100%
5. Diabetes teaching checklist active/completed (if patient is diabetic).	10/60 49 n/a	98%
6. Multidisciplinary Teaching checklist active/completed.	58/60	97%
7. Dental education teaching checklist active/completed.	56/60	93%
8. Nursing Assessment of Suicide Risk being completed with Treatment Plan Review.	60/60	100%
9. Annual Assessment completed.	21/60 38 n/a 1 ref.	100%
10. Patient's rights reviewed and signed.	38/60 8 ref. 4 loc.	83%
11. Informed Consent signed, dated and timed.	43/60 8 ref. 8 loc.	98%
12. Number of Telephone Orders for the month.	95/95	100%
13. Number of Telephone Orders signed by the prescriber within 24 hours.	87/95	92%

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

Peer Support

Responsible Party: Julia Duncan, Peer Support Coordinator

I. Measure Name: Inpatient Consumer Survey Return Rate

Measure Description: There is a low number of satisfaction surveys completed and returned once offered to patients due to a number of factors.

Objective: To increase the number of surveys offered to patients, as well as increase the return rate.

Those responsible for Monitoring: Peer Support Director and Peer Support Team Leader will be responsible for developing tracking tools to monitor survey due dates and surveys that are offered, refused, and completed. Peer Support Staff will be responsible for offering surveys to patients and tracking them until the responsibility can be assigned to one person.

Methods of Monitoring:
- Biweekly supervision check-ins
- Monthly tracking sheets/reports submitted for review

Methods of Reporting:
- Patient Satisfaction Survey Tracking Sheet
- Completed surveys entered into spreadsheet/database

Unit: All patient care/residential units

Baseline: Determined from previous year's data.

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

Survey Return Rate	Unit	Target	1Q2017	2Q2017	3Q2017	4Q2017	YTD
The inpatient consumer survey is the primary tool for collecting data on how patients feel about the services they are provided at the hospital.	**LK**	50%	8% 1/13	50% 4/8	59% 10/17	92% 11/12	**52% 26/50**
	LS	50%	0% 0/12	90% 9/10	14% 2/14	44% 4/9	**30% 15/45**
	UK	50%	0% 0/18	25% 6/24	48% 13/27	52% 12/23	**33% 31/92**
	US	50%	16% 1/6	44% 7/16	60% 3/5	50% 2/4	**41% 13/31**
	Overall		**4% 2/49**	**45% 26/58**	**41% 28/68**	**60% 29/48**	**38% 85/223**

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Comments: Percentages are calculated based on the number of people eligible to receive a survey vs. the number of people who completed the surveys.

Inpatient Consumer Survey Results:

#	Indicators	1Q 2017	2Q 2017	3Q 2017	4Q 2017	YTD Average
1	I am better able to deal with crisis.	75%	70%	53%	56%	**64%**
2	My symptoms are not bothering me as much.	75%	68%	59%	59%	**65%**
3	The medications I am taking help me control symptoms that used to bother me.	38%	68%	59%	58%	**56%**
4	I do better in social situations.	63%	65%	53%	59%	**60%**
5	I deal more effectively with daily problems.	38%	69%	55%	59%	**55%**
6	I was treated with dignity and respect.	50%	68%	59%	63%	**60%**
7	Staff here believed that I could grow, change and recover.	50%	70%	63%	62%	**61%**
8	I felt comfortable asking questions about my treatment and medications.	75%	68%	63%	62%	**67%**
9	I was encouraged to use self-help/support groups.	75%	69%	67%	65%	**69%**
10	I was given information about how to manage my medication side effects.	25%	58%	61%	65%	**52%**
11	My other medical conditions were treated.	88%	63%	67%	67%	**71%**
12	I felt this hospital stay was necessary.	38%	54%	53%	65%	**52%**
13	I felt free to complain without fear of retaliation.	38%	59%	52%	62%	**53%**
14	I felt safe to refuse medication or treatment during my hospital stay.	88%	57%	47%	56%	**62%**
15	My complaints and grievances were addressed.	63%	63%	66%	61%	**63%**
16	I participated in planning my discharge.	88%	57%	63%	61%	**67%**
17	Both I and my doctor or therapists from the community were actively involved in my hospital treatment plan.	38%	54%	50%	59%	**50%**
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	50%	55%	54%	58%	**54%**
19	The surroundings and atmosphere at the hospital helped me get better.	38%	56%	63%	62%	**55%**
20	I felt I had enough privacy in the hospital.	38%	58%	63%	63%	**55%**
21	I felt safe while I was in the hospital.	75%	63%	69%	67%	**68%**
22	The hospital environment was clean and comfortable.	88%	68%	69%	69%	**73%**
23	Staff were sensitive to my cultural background.	63%	67%	64%	64%	**65%**
24	My family and/or friends were able to visit me.	25%	67%	63%	62%	**54%**
25	I had a choice of treatment options.	38%	67%	63%	60%	**57%**
26	My contact with my doctor was helpful.	88%	65%	66%	59%	**69%**

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27	My contact with nurses and therapists was helpful.	75%	71%	67%	63%	**69%**
28	If I had a choice of hospitals, I would still choose this one.	50%	59%	68%	59%	**59%**
29	Did anyone tell you about your rights?	38%	69%	68%	66%	**60%**
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	38%	61%	63%	60%	**56%**
31	Do you know someone who can help you get what you want or stand up for your rights?	88%	70%	71%	64%	**73%**
32	My pain was managed.	88%	68%	68%	65%	**72%**
	Overall Score	**59%**	**64%**	**61%**	**62%**	**62%**

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

Pharmacy Services

Responsible Party: Michael Migliore, Director of Pharmacy

I. Measure Name: Controlled Substance Loss Data

Measure Description: Daily and monthly comparison of Pyxis vs CII Safe Transaction Report.

Type of Measure: Quality Assurance

	1Q2017	2Q2017	3Q2017	4Q2017	YTD Average
Target	0	0	0	0	**0**
# of Discrepancies	13/month	14.6/month	11.6/month	4.6.month	**11/month**
Number of CS lost	0	0	0	0	**0**

Data Analysis: The average number of controlled substance discrepancies per month for the 4Q2017 was 46. This figure represents the number of discrepancies that occurred and not the number of controlled substances lost. Discrepancies typically occur from miscounts which are all investigated and reconciled.

All of the controlled substances have been accounted for, resulting in a 0% loss of controlled substances for the 4Q2017.

Action Plan: Continue to remain vigilant and educate staff on proper automated dispensing cabinet procedures to avoid the creation of discrepancies.

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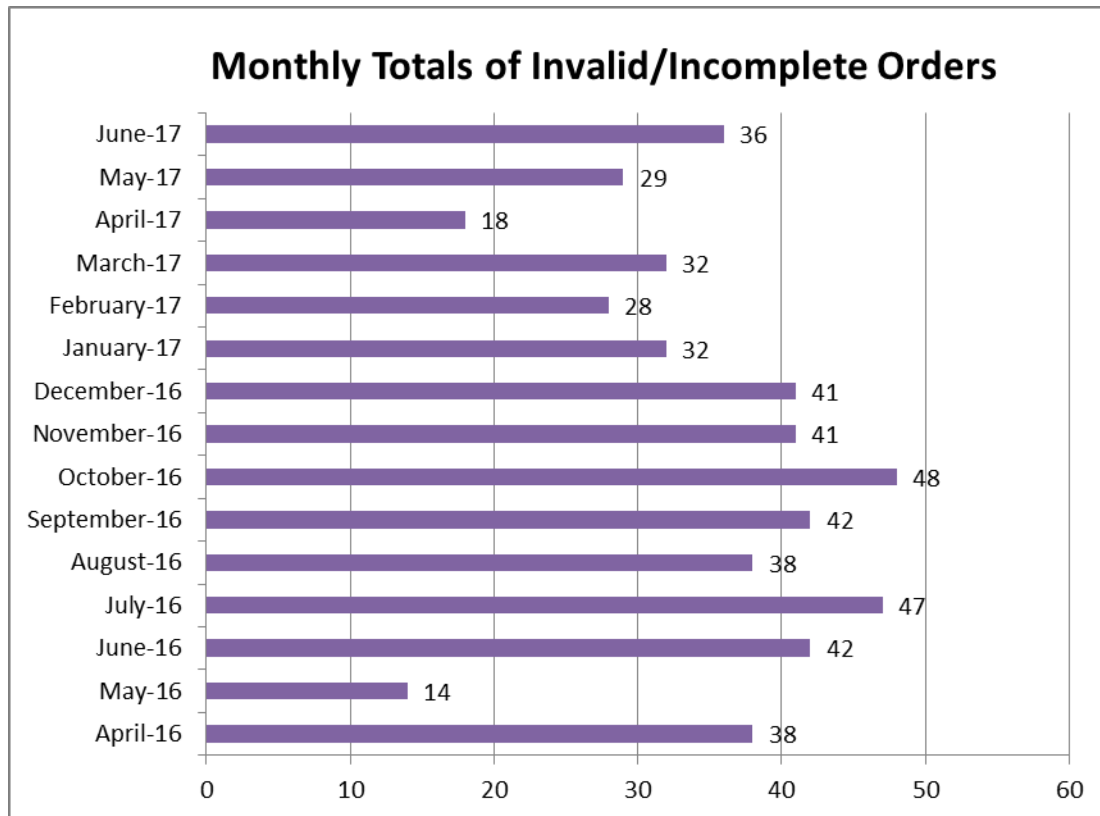
II. Measure Name: Invalid Orders

Measure Description: Incomplete/Invalid Orders.

Type of Measure: Performance Improvement



Background: With a zero tolerance policy for invalid orders, every prescribed order must contain the drug name, strength, administration route, dosing frequency, provider signature, order time and date, accurate allergy and adverse drug reaction information, and indication. Receiving an invalid order by the staff pharmacist requires documentation, copying and returning the invalid order to the prescriber for remediation, as well as contacting and informing the unit of the invalided order.

Data Analysis: For the 4Q2017, the numbers of invalid orders are significantly lower than the previous quarters. April reported 18 invalid/incomplete orders with 29 in May and 36 in June. On average, this quarter is reporting 0.91 invalid/incomplete order per day compared to 1.03 invalid/incomplete orders per day for the same quarter in FY2016. Missing indications, allergies and adverse drug reactions continue to be at the top of the list for incomplete orders. Keeping providers informed, and reporting this information at the monthly Pharmacy and Therapeutics Committee Meeting, has resulted in a decrease in invalid/incomplete orders. The Pharmacy Department will continue to monitor and educate physicians and providers through new employee orientation.

Action Plan: The Pharmacy department will continue to track incomplete orders until the implementation of the new EHR system scheduled by year end 2017. The new EHR system will contain hard stops preventing providers to proceed to initiate an order that is not complete.

III. Measure Name: Veriform Medication Room Audits

Measure Description: Comprehensive Unit Compliance Audits

Type of Measure: Quality Assurance

	Results						
	Unit	**Baseline FY2016**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	All	100%	100%	100%	100%	100%	**100%**
Actual			100%	100%	100%	100%	**100%**

Data Analysis: The Pharmacy Medication Room Audits for all units have been completed for 4Q2017 without completion deficiencies.

Action Plan: No deficiencies were noted with pharmacy's completion of the medication room audits. Pharmacy staff will continue to operate to maintain 100% completion and will continue reporting any noted deficiencies to nursing staff and administration if necessary.

Comments: Continuous monitoring of the Medication room audits and approval by the responsible individuals has again provided satisfactory results for this quarter.

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IV. Measure Name: Fiscal Accountability

Measure Description: Monthly Tracking of Dispensed Discharge Prescriptions

Type of Measure: Quality Assurance

	Results						
	Unit	**Baseline Avg. FY2016**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Actual	All	$5,479 for 361 Rx's	$6,870 for 344 Rx's	$5,503 For 311 Rx's	$5,251 For 275 Rx's	$2761 For 206 Rx's	$20,385 For 1136 Rx's

Data Analysis: Riverview Psychiatric Center's Extended Hospital Pharmacy license permits it to dispense medication to both inpatients and outpatients. The majority of the outpatient prescriptions are for a 7-day supply of discharge medications. Administrative approval is required when a greater than seven day supply is needed. Discharge prescriptions serve to cover the patient's needs until they are able to obtain medications in the community.

Action Plan: Efforts to coordinate advance discharge planning to mimic the process currently in place at Dorothea Dix Psychiatric Center will permit patients to obtain prescription coverage prior to discharge and result in decreased pharmacy expenditures as well as a reduction in the volume of outpatient prescriptions provided by the pharmacy.

	Baseline Avg. FY2016	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**	**Baseline Avg. FY2017**	**Decrease FY16/FY17**
$ spent	$5,479	$6,870	$5,503	$5,251	$2761	**$20,385**	**$5096**	**-$383**
# RX's	361	344	311	275	206	**1136**	**284**	**-77**
$ per Rx	$15.18	$19.97	$17.69	$19.67	$13.40	**$70.73**	**$17.68**	**$2.50**

Comments: The 4Q2017 reported a lower number of Rx's for discharges. The cost of a 4Q2017 prescription was $13.40, a $6.27 decrease from 3Q2017, and a $1.78 decrease from the 2016 baseline figure. The development of a new formulary and transitions of care program to minimize the dispensing of medications to patients returning to correctional facilities has proven effective in decreasing this metric.

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V: Measure Name: Dispensing Process

Measure	Unit	Baseline 2016	Goal	1Q 2017	2Q 2017	3Q 2017	4Q 2017
1. Controlled Substance Loss Data: Daily Pyxis-CII Safe Compare Report.	All	0.19%	0% Target: Actual:	0% 0%	0% 0%	0% 0%	0% 0%
2. Controlled Substance Loss Data: Monthly CII Safe Vendor Receipt Report.	Rx	0	0 Target: 0 Actual: 0	0 0	0 0	0 0	0 0
3. Controlled Substance Loss Data: Monthly Pyxis Controlled Drug Discrepancies.	All	0/mo	Target: 0 Actual: 0	0 39 (13/ mo)	0 44 (15/ mo)	0 35 (12/ mo)	0 14 (4.6/ mo)
4. Medication Management Monitoring: Measures of drug reactions, adverse drug events, and other management data.	Rx	10/year	Target: 0 Actual: 0	0 10	0 2	0 8	0 0
5. Medication Management Monitoring: Resource Documentation Reports of Clinical Interventions.	Rx	136/ quarter	100% Target: Actual:	100% 167	100% 129	100% 351	100% 330
6. Psychiatric Emergency Process: Monthly audit of all psych emergency measures against eight criteria.	All	100%	100% Target: Actual:	100% 100%	100% 96%	100% 95%	100% 100%
7. Operational Audit: Monthly audit of three operational indicators from CPS contract.	Rx	100%	100% Target: Actual:	100% 100%	100% 100%	100% 100%	100% 100%

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Psychology

Responsible Party: Arthur DiRocco, Ph.D.

I. Measure Name: Outpatient Readiness Scale (ORS)

Measure Description: The ORS will be completed for those patients who reside in the community and are receiving services through Out Patient Services (OPS). Target is 90% of outpatient services recipients will have ORS completed and updated every six months.

Type of Measure: Performance improvement

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Percent of OPS recipients evaluated with ORS	YTD FY2016 Continuing initiative 15%	75%	75%	75%	75%	**75%**
Actual			4% 2/53	26% 14/53	8% 4/53	8% 4/52	**11% 24/211**

Data Analysis: This initiative was introduced to the treatment teams meeting with patients residing in the community. Baseline was measured from FY2016. The figures above represent number of evaluations for the FY2017. Of the 53 patients classified as outpatient, 28 percent have been evaluated since the beginning of fiscal year 2016. However, attrition has reduced the overall current rate downward, resulting in a total of 11% as current. Other varying factors that affect population figures includes the addition of new patients, the movement of patients from outpatient to inpatient, the need to reassess every six months, and the release of patients from care of the commissioner.

Action Plan: Efforts to obtain completed evaluations have not been fruitful. OPS staff are still reluctant to take on the independent practice of completing ORS for the number of patients that they serve. There are a total of 52 patients requiring updated ORS. New management has indicated a willingness to address this request. The psychology staff who work with the OPS treatment team has indicated their intention to prompt the team to complete the ORS on each OPS recipient at the time of their treatment team meeting. This strategy has been employed at RPC and has resulted in a range of completion between 89% and 100%.

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II. Measure Name: Treatment Plan Improvement Initiative

Measure Description: Patient treatment plans identifying psychological interventions will contain one or more of the following criteria: clear operational definitions, baseline data (e.g., excess or deficiency), and desired, measurable outcomes. Target is within four months 90% of all treatment plans developed with psychologist input will contain key features of proposed model intervention plans.

Type of Measure: Performance improvement

4Q2017	Average of Operational Definition	Average of Desired Outcome	Average of Staff/Patient Activity	Average of Evidence of Progress
LK	0.33	0.33	1.00	0.33
LS	0.44	0.22	0.89	0.11
UK	0.83	1.00	1.00	0.50
US	1.00	0.93	1.00	0.67
Grand Total	0.76	0.70	0.97	0.45

Data Analysis: This initiative is part of a hospital wide effort to improve the delivery of mental health services to all patients. The goal is to achieve a high level of thoroughness and conformity with the standards listed above. Baseline was measured from September 2015 to February 2016. The start of this initiative was February 15, 2016. During 4Q2017 all accessible patient treatment plan records were accessed to determine whether patients with psychology goals met criteria as specified. At the close of FY2017, 83 patient files or 40% contained a psychology intervention plan. Each plan written by a psychologist was rated on the four characteristics of a model treatment plan. Overall the percentage of reviewed plans meeting acceptable criteria was rated at 76%. The table above shows that the highest ratings indicated the identification of staff patient activity to achieve the treatment goal. Identification of treatment goal in operationally defined terms was second highest rating, and the clear identification of desired outcome was third. The area in greatest need of improvement was the evidence of progress towards goals.

Action Plan: Progress is being made with psychologists in the writing of objective, operational definitions. We will continue our discussion of needed changes to achieve our goal of clear, practical behavior intervention plans.

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Rehabilitation Services

(Occupational Therapy, Therapeutic Recreation, Vocational Services, Chaplaincy, Patient Education)

Responsible Party: Janet Barrett, CTRS, Director of Rehabilitation Services

I. Measure Name: Recreational Therapy Assessment

Measure Description: Improving health outcomes/patient care. In order to receive effective treatment, all patients admitted to RPC will take part in a Recreational Therapy Assessment within seven days of admission. Each Recreation Therapist will then use this assessment to assist in the formulation of treatment interventions to assist patients in returning to a satisfying and meaningful life upon discharge. Target is to achieve and maintain an overall goal of 100% for four consecutive quarters

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Percent of Initial Rec Assessments within 7 days	85%	100%	100%	100%	100%	**100%**
Actual			88% 46/52	86% 47/56	90% 46/51	96% 49/51	**90% 188/210**

Data Analysis: Of the 51 admissions, one patient did not have their initial assessment completed within the seven day timeframe, after many attempts by multiple therapists; and 1 did not have an initial assessment completed at all.

Action Plan: Meet with the Recreation Therapists and develop a tracking system for admissions to ensure all assessments are completed in the allotted time frame and remind them to reach out to the Float RT for assistance as deadline approaches, as well as putting an assessment in the chart within timeframe noting patient's unwillingness to participate in the process.

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Safety & Security

Responsible Party: Philip Tricarico, Safety Officer

I. Measure Name: Contraband/Prohibited Items

Measure Description: Contraband/prohibited items found during front Lobby screening done by security staff of patients and visitors, to create and foster a safe environment for all staff, patients, and visitors.

"Contraband" is a term used to describe ant items that are illegal to possess / use by statute. RPC knowledge of possession / use of such item(s) on RPC property may involve law enforcement notification / intervention. Contraband as identified in statute "means any tool or other item that may be used to facilitate of section 755, a dangerous weapon or a scheduled drug as defined in section 1101, subsection 11, unless in the case of a patient at a state hospital. As used in this section, "state hospital" means the Riverview Psychiatric Center. A person is guilty of trafficking in contraband in a state hospital if:

1. That person intentionally conveys or attempts to convey a dangerous weapon to any patient at a state hospital. Violation of this paragraph is a Class C crime.
2. That person intentionally conveys or attempts to convey contraband, other than a dangerous weapon to any patient at a state hospital. Violation of this paragraph is a Class D crime.
3. Being a patient at a state hospital, that person intentionally makes, obtains or possesses contraband Violation of this paragraph is a Class D crime.

"Prohibited" is a term used to describe any items that are not illegal to possess / use. But are not permitted for entry into the secure areas in the RPC building or permitted for possession / use on RPC grounds. Unless specified otherwise by stature or hospital policy. Some prohibited items may be secured in a locked vehicle or at security.

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

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

Methods of Monitoring:

- Direct observation
- Cameras
- Front Lobby security screening of patients and visitors.

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

- Daily Activity Reports (DAR's)
- Incident Reporting System (IR's)

Unit: Hospital Wide
Baseline: -5% reduction of contraband / prohibited found each Q
Goal: Baseline – 5% each Q

Results						
	Baseline	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	3089	New Measure	3089-5% = 2935	2534-5% = 2407	2438-5% = 2316	**100%**
Actual		3089	2534	2438	2102	**100%**

4Q2017: We met our goal for this quarter. Although we are tracking 17 different categories of contraband and prohibited items, for the purpose of this indicator I am only reporting the items that pose the greatest risk/hazard to the patients and facility. Being a new CPI this is a work in progress. We may change some of the items and reporting format to better suite our needs. For instance, keys and cellphones account for a very large share of items held. However, almost every visitor has these two items so Security specifically asks for and looks for them. Therefore, the risk of them getting by Security is very minimal. Matches and lighters are easy to be missed in a screening. Therefore they will be reported for this CPI. The same goes for drugs and pens. If any of these items gets past Security it could have serious consequences for our patients and facility. We are also including known failures, incidents where an item should be held by Security but somehow got through. We are utilizing incident reports to record failures. IR's eliminate any bias or hearsay information. We had a net decrease in the four items we are tracking (weapons, drugs, lighters and chain wallets). The data also points to Wednesday being the busiest day of the week for contraband/prohibited items. This can be explained by the District Court cases heard here. We get a noticeable increase in outside visitors on this day.

Weapons: 11
Lighters: 67
Drugs (prescription and other): 9
Pens/Pencils: 29

Event	Date	Time	Location	Disposition	Comments
Prohibited item missed by Security. Item made it to the unit.	5/6/17	1610	Upper Kennebec	A Bic lighter was turned in by a patient. The patient said they were	Our current metal detector will not pick up items such as this. This was not a security staff

				able to walk through the metal detector without the lighter being detected.	failure. We are trying to upgrade our metal detector. We are still waiting for the outcome of the budget process to see if our efforts have been successful. This incident was included on this report because it was still a security/safety failure.

II. Measure Name: Grounds Safety/Security Incidents

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

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

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

Methods of Monitoring: Monitoring would be performed by;

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

Methods of Reporting: Reporting would occur by one or all of the following methods:

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

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Results						
	Baseline	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	10	2	2	2	2	**8**
Actual		2	4	0	4	**10**

The 4Q2017 target was two. Our actual number was 4. We missed our goal! We have not had any issues this quarter with state owned pickup trucks and the contraband they frequently contained. We have been working with Capitol Police, Fleet Management and the Department of Conservation (agency the trucks are assigned to). There has been significant improvement in how often we are finding contraband items in these trucks. We now have a new issue facing our safety and security. Three of our four incidents this quarter involved unlocked cars that staff use to transport patients to appointments, outings etc. We believe the sudden increase in these unlocked vehicles involves the fact that the majority of the fleet is new to Riverview. We believe staff are using the remote and accidently hitting the wrong button, unlocking the car instead of locking it. They are not familiar with the new remotes. We will continue to monitor this situation. We are pleased that in all of the events, our security staff or clinical staff had discovered/processed the event before there was a negative impact to the patients. The use of surveillance equipment plays an integral part in combating safety and security threats to people and property. Our aggressive rounds by Securitas continue to prove its worth with regard to security's presence and patrol techniques. Our security staff, along with its cohesiveness with the clinical component of the hospital, has proven to be most effective in our management practices.

Event	Date	Time	Location	Disposition	Comments
Metal cable found in parking lot	4/21/17	0935	Rear of building by gym	Placed in locked dumpster	Cable was approximately 18" long. This cable had a large plastic piece on one end. This item could be a weapon if the wrong person got a hold of it.
Unlocked state car	4/26/17	1720	Front of Building	Locked the vehicle	State vehicles have a credit card and other items that should be locked for safety.
Unlocked state car	6/13/17	1905	Front of Building	Locked the vehicle	State vehicles have a credit card and other items that should be

					locked for safety.
Unlocked state car	6/18/17	1825	Front of Building	Locked the vehicle	State vehicles have a credit card and other items that should be locked for safety.

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Staff Education

Responsible Party: Susan Bundy, Director of Staff Development

I. Measure Name: Ongoing Education and Training

Measure Description: HR.01.05.03 requires that staff will participate in ongoing education and training to increase and maintain their competency.

Type of Measure: Performance Improvement

Goal: 90% of direct support staff will attend Collaborative Pro Active Solutions training by June 2017. Attendance will be tracked by Staffing and Organizational Development. Progress will be reported quarterly.

Progress: As of June 30, 2017, 161 employees have attended Collaborative Pro-Active Solutions training.

II. Measure Name: Seclusion and Restraint Reduction

Measure Description: Because restraint and seclusion have the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of the rights of an individual served, and even death, organizations continually explore ways to prevent, reduce, and strive to eliminate restraint and seclusion through effective performance improvement initiatives.

Type of Measure: Performance Improvement

Goal: RPC will decrease the use of seclusion and restraint by 50%.

FY2017	Manual Holds	Mechanical Restraints	Locked Seclusion	Total Events Per Quarter
1Q2017	91	6	42	**139**
2Q2017	66	1	26	**93**
3Q2017	153	0	97	**250**
4Q2017	52	0	33	**85**
Total # of events	**362**	**7**	**198**	**567**

***Average # of events per month in FY201: 47**

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FY2016	Manual Holds	Mechanical Restraints	Locked Seclusion	Total Events Per Quarter
1Q2016	95	6	75	**176**
2Q2016	61	0	43	**104**
3Q2016	108	0	72	**180**
4Q2016	99	3	59	**161**
Total # of events	**363**	**9**	**249**	**621**

***Average # of events per month in FY2016: 52**

Action Plan:
Staff will receive initial and ongoing education training in the hospital approved Behavior Management Program and Recovery in Action to assist in establishing therapeutic relationships, so when a crisis begins, staff will be more influential and effective in preventing the use of seclusion and restraint.

Staff development will provide ongoing education to reinforce the organization's commitment to ensuring a caring, respectful, therapeutic environment. Data gathered through hospital performance measures will be analyzed to determine progress.