



PERFORMANCE IMPROVEMENT REPORT

**2ND QUARTER, FY 2006
OCTOBER, NOVEMBER, DECEMBER**

**DAVID PROFFITT, SUPERINTENDENT
JANUARY 2006**

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HOSPITAL PERFORMANCE IMPROVEMENT QUARTERLY REPORT October, November, December 2006

INTRODUCTION

As in previous reports, the quality indicators for the hospital continue to be analyzed, refined, and monitored to ensure they capture and reflect key hospital efforts affecting client care. Additionally, the hospital aggressively looks for ways in which these indicators are routinely incorporated into the ongoing business of hospital operations making QA a real-time, relevant management tool for improvements. Specific hospital indicators, such as seclusions, restraints, medication errors, are now collected, analyzed and looped back to the specific units as benchmarks for improvement. As units address unit specific strategies, and improvements made on a unit by unit basis, then overall hospital indicators also improve, and most importantly, are sustained. This has resulted in better client-specific indicators that have given the hospital precise monitoring data with the opportunity for performance improvement, not only by department and discipline, but also by units.

Consistent with previous reports, the quarterly report contains two sections. The first section presents the core Aspects of Quality for each discipline or topic area within the hospital. The data collected this quarter is presented for each aspect, and is compared to the indicator “threshold percentile” which reflects the quality standard the hospital uses to define when corrective actions are required. The report then describes specific findings based on the data, and the action steps planned or underway to address problem areas. The term “compliance” is used to reflect the extent to which the data shows achievement of the quality indicator in relation to the threshold. Overall compliance for each indicator shows the average degree of compliance for the indicators and time periods listed.

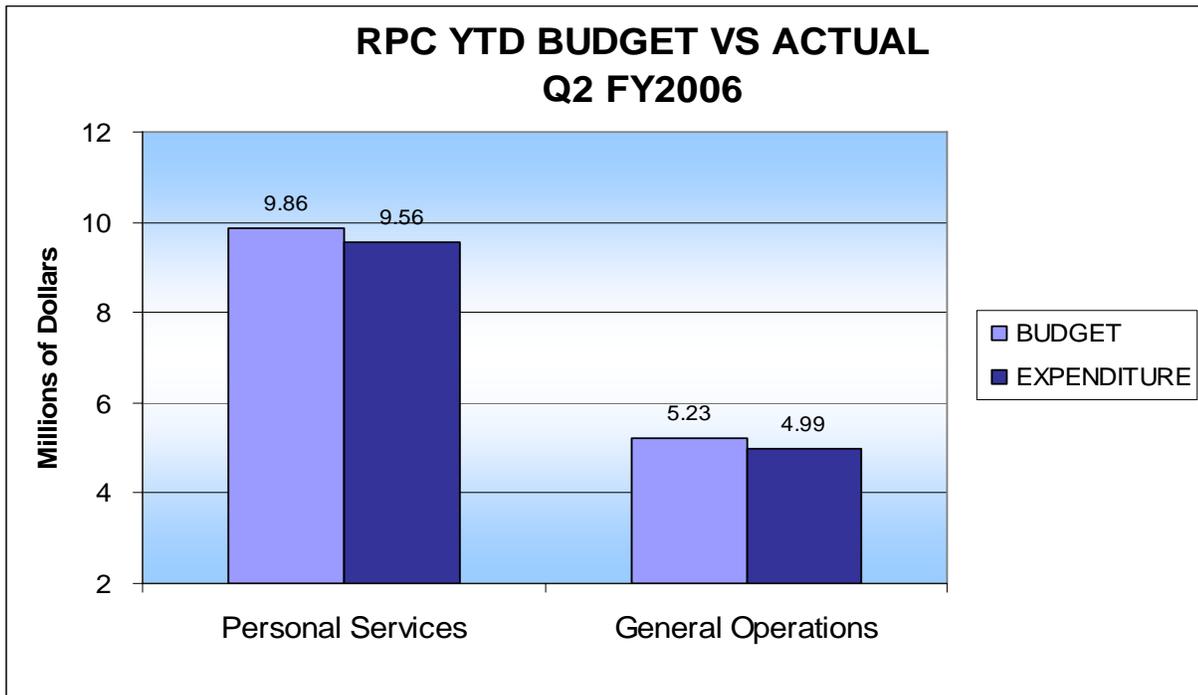
The second section presents a series of “Hospital Performance Measures” which describes occurrences of important hospital activities. These activities are routinely monitored and trended. These measured occurrences assist the hospital in identifying additional areas that may require increased surveillance, study or action.

When possible, hospital data is compared with national data. This offers a comparison of Riverview with a national standard that provides some indicator as to how the hospital measures up with like facilities throughout the country. An artifact of the national data collection system used by Riverview and virtually every other psychiatric hospital in the country is the “timing” of when the national comparative data is fed back to the participating states. Riverview submits data monthly. That data is reviewed nationally, and the formula for “National Mean” is applied. However, that month’s submitted data is not sent back to the states until the next month’s data is forwarded and reviewed. This enables the national data system to ensure consistency in data submitted and respond to states if data is extraordinary, before publishing national data results. While this process ensures that exceptional circumstances or flawed data doesn’t unduly influence national data, it delays by at least one month, the availability of national comparative data for the states. Thus, for the months October, November, and December covered by this report, December’s national data will not be available to Maine until the January data has been submitted, reviewed and approved, sometime in early February. The next quarterly report will be in April 2006.

HOSPITAL INDICATORS

FINANCIAL MANAGEMENT

ASPECT: MANAGE FINANCIAL NEEDS WITHIN EXISTING,
ALLOCATED RESOURCES



FINDINGS:

The hospital continues to operate within budget. . Overtime costs have decreased due to careful scheduling of staff.

PROBLEM:

None noted.

STATUS:

Finances are now tracked on a monthly basis and expenditures measured against YTD allocations.

ACTIONS:

- Continued monitoring and careful management of overtime and mandates.
- Continued aggressive management of contractual services via fiscal and programmatic accountability, using monthly YTD, Budget vs. Actual expenditures.
- Through aggressive fiscal management and enhanced revenues via aggressive billing and participation with the Department in Meditech, we will be able to maintain this level of financial management.

PEER SUPPORT:

ASPECT: INTEGRATION OF PEER SPECIALISTS INTO CLIENT CARE

OVERALL COMPLIANCE: 76%

Indicators	Findings	Compliance	Threshold Percentile
Attendance at Comprehensive Treatment Team meetings.	366 of 502	73%	75%
Grievances responded to on time.	73 of 77	95 %	100%
Attendance at Service Integration Meetings.	21 of 21	100%	100%

FINDINGS:

Four step 1 grievances were responded to late in Oct. There were 3 late grievances (8, 4, and 10 days late) and 1 was 3 days late.

Comprehensive Treatment Team Meetings were attended 73% of the time. Of the 136 missed meetings, 13 were due to admissions (Lower Kennebec and Lower Saco), 9 were due to other meetings/treatment mall groups, 49 were due to peer specialist being out sick, 29 were due to peer specialist being on vacation, 25 were due to the client not wanting peer support present (primarily on Upper Saco), and 11 were due to mandatory trainings.

Service Integration Meetings were attended 100% of the time for the month of December. This is a new indicator as of December 1, 2005. This was not added to the percentile average above.

PROBLEM:

Not all step 1 grievances are being responded to in a timely manner. Peer Specialists are not attending client Comprehensive Treatment Team Meetings. Peer Specialists are not always notified or available for Service Integration Meetings.

STATUS:

The percentage of grievances responded to in a timely manner has increased from 84% last quarter to 94% this quarter. On Lower Kennebec, grievances have recently been assigned to the Nurse IV to respond to, which has decreased the incidents of late grievances. All late grievances were step 1 grievances and were eventually resolved.

Attendance at client Comprehensive Treatment Team Meetings increased from 66% to 73%. Peer Specialists are attempting to rearrange their schedules to accommodate team meetings.

Peer Specialists began tracking attendance at Service Integration Meetings on December 1, 2005. The number of meetings attended for December was 21 of 21.

ACTIONS:

- The Peer Support Coordinator will continue to meet with the Risk Manager monthly and Program Service Directors as needed to address grievances that are not responded to within the time allowed.
- Peer Specialists will continue to track Comprehensive Treatment Team Meeting attendance and reasons for not attending.
- By Feb 1, 2006 Peer Specialists will develop a plan to schedule attendance at meetings where their presence is required. Peer Support coordinator and Deputy Superintendent for Clinical Services will approve the plan.
- Peer Specialists will continue to track attendance at Service Integration Meetings and work with Continuity of Care Managers and Program Service Directors to ensure all meetings are attended and notifications are made.
- Peer Specialists will notify Peer Support Coordinator when they cannot attend Service Integration Meetings and problem-solve how meetings can be attended.
- Peer Specialists will develop a communication process for meeting notification by March 1, 2006.

MULTIDISCIPLINARY

ASPECT: MEDICATION VARIANCES/ERRORS

Time Period	Complex	Prescribing	Dispensing	Administration	Totals
October 05			2	5	7
November 05				2	2
December 05	1 P and A		1	3	5

FINDINGS:

October 2005 (N=7) 2 not dispensed; 1 not administered; 3 wrong dose; 1 wrong drug November 2005 (N=2) 2 communication failure, appropriate policy not followed resulted in medication being given after discontinued, and extra dose being given.

December 2005 (N= 5) 1 complex (prescribing and administration); 1 extra medication, 1 missed dose; 1 wrong dose; 1 dispensing error

One error in December caused an adverse event (skin rash), that was treated successfully at Riverview with an antihistamine antidote.

PROBLEM:

Medication Variances do not seem to have a pattern. The complex medication error reported in December was the result of a telephone order during which a medication allergy was not identified by the nurse, nor ascertained by the medical staff member resulting in the prescription of a medication to which the client was allergic. Another issue identified in this quarter was the lack of clarity of the Clozapine protocol as to who is responsible for notifying the national Clozapine registry (physician or pharmacist), and that MD orders may be written and instituted before the required registry protocol is followed. The variances that do not reach the client are no longer reported as a part of the quarterly report; these variances assist in identifying system issues which need to be addressed to prevent errors to clients.

STATUS:

After reviewing the methodology of reviewing medication errors, changes were made in reporting. Medication variances are being presented differently this quarter. The variances being shown here are actual errors that reached the client. There are four basic types of medication errors that are reported nationally.

1. Prescribing: An incorrect selection of a drug, drug dose, dosage form, quantity, route, or from improper evaluation (e.g. known allergies) by the doctor or other licensed independent practitioner (LIP). (MD or LIP)
1. Dispensing: An incorrect drug, dose, form or quantity is formulated and delivered for use to the point of intended use (pharmacist or pharmacy tech).
2. Administration: An incorrect selection and administration of drug, drug dose, for quantity, route, concentration of a drug product ordered by the physician or other LIP. (Nurse)
3. Complex: An error that is a result of 2 or more types of distinct variances, prescribing, dispensing or administration

The total variances for the quarter were 14. Telephone orders and sensitivity to drug allergies to be addressed. Clozapine protocol has been updated. A Failure Mode and Effects Analysis (FMEA) is in process regarding medication variances that highlight system issues.

ACTIONS:

- Variances are continuously monitored. If a variance is noted, the nurse files a variance and notifies appropriate providers and supervisors so the client receives immediate attention. The nurse then places the variance in the Nurse IV (clinical supervisors) in box to be dealt with within 24 hours.
- Nursing and Medical Providers have all been made aware of the need to be vigilant about requesting and providing information regarding client allergies prior to proceeding with a telephone medication order.
- Pharmacy and Therapeutics (P&T) Committee, a multidisciplinary team, met and revised the clozapine protocol. This has clarified who was responsible for what action. At P&T it was also decided the physician's orders to begin clozapine will not be written until after the registry has been notified and the lab work has returned.
- A multidisciplinary team began the Failure Mode Effects Analysis (FMEA) process to help identify and offer solutions to issues identified by the Medication Variance process. The FMEA will be completed by the end of the next quarter.

REHABILITATION

ASPECT: CLIENT ATTENDANCE AT HARBOR MALL
OVERALL COMPLIANCE: 67%

Indicators	Findings	Compliance	Threshold Percentile
Attendance by clients scheduled to attend mall groups on a daily basis	3131 of 4685	67%	70%
Attendance at morning programming	1789 of 2491	72%	70%
Attendance at afternoon programming	1342 of 2194	61%	70%

FINDINGS:

The sample is based on a 13-week session of the Harbor Mall from 10/03/05 to 12/30/05. For the 13-week period, the morning programming had 1789 client interactions out of a possible 2491 for a 72% total, up 3% from last report. The afternoon programming had 1342 client interactions out of 2194 for a 61% total, which is also up 3 % from the last report. This means that for the 60 days the mall was in session we had a compliance rate of 67% compared to last quarter's 64%. As a result of all of the action steps we have implemented since the start of monitoring in December of 2004, we show an increase of meeting our threshold percentile from only 3 times to 37 times in the morning program and from only once in the afternoon to 14 times. We have an average daily attendance in the morning of 30 clients and 22 for the afternoon.

PROBLEM:

In the first 8 weeks of this program cycle, the morning programming only had 5 days where the expected outcome was not met. The morning program was meeting the expected outcome over 85% of the time and the 14 times that we did meet it in the afternoon were all prior to the holidays. We will continue to monitor the morning session as a result of the drop in attendance in the latter part of the session. We will be looking for any additional indicators or factors that would result in a decline of attendance of clients in prescribed treatment. Improvements have been made in the afternoon programming. However, we have yet to have the increase sustain itself over a longer period of time.

STATUS:

The Treatment Mall staff continues to work with the action steps outlined last quarter as well as putting more emphasis on helping to get clients engaged in their prescribed treatment. Units have been striving to get 100% attendance on a daily basis and providing much positive feedback to clients when this goal is achieved. Engagement plans continue to actively evolve with those clients that have been refusing to participate in any groups. The morning and afternoon programs both improved by an additional 3%. Once again the overall compliance rose slightly this quarter from 64% to 67%.

ACTIONS:

- Hospital-wide training on Psychiatric Rehabilitation and Engagement Planning has started and will continue throughout the next quarter.
- Suggested program ideas from survey results will be implemented. These groups will be Recovery with Humor, Computer Group as well as additional Peer Run Groups.
- Rehabilitation Services Director will further assess client interest in specialty-focused groups suggested in the client forum. Broader client interest will trigger creation of a group and these would be added mid-session; if only one or two individuals are interested, needs of these clients will be addressed on an individual basis.
- Rehabilitation Services Director will work with Recreation Therapist to create specific treatment interventions for those clients who continue to sporadically refuse attendance at their prescribed treatment.

HUMAN RESOURCES**ASPECT: PERFORMANCE EVALUATIONS****OVERALL COMPLIANCE: 63%**

. Indicators	Findings	Compliance	Threshold Percentile
Employee Performance Evaluations expected to be completed within 30 days of the due date			
Oct 2005 (August evals)	15 of 32	47%	85%
Nov 2005 (September evals)	21 of 28	75%	85%
Dec 2005 (October evals)	21 of 32	66%	85%

FINDINGS:

During this quarter 92 performance evaluations were sent out; 57 were received in a timely manner. Human Resources continue to stress the importance of timely submission and requested from all Department Heads to submit their evaluations for processing for timely merit increases for staff. There was an increase by the end of this rating period 63% as compared to 42% last quarter.

PROBLEMS:

Supervisors are not submitting performance evaluations in a timely basis.

STATUS:

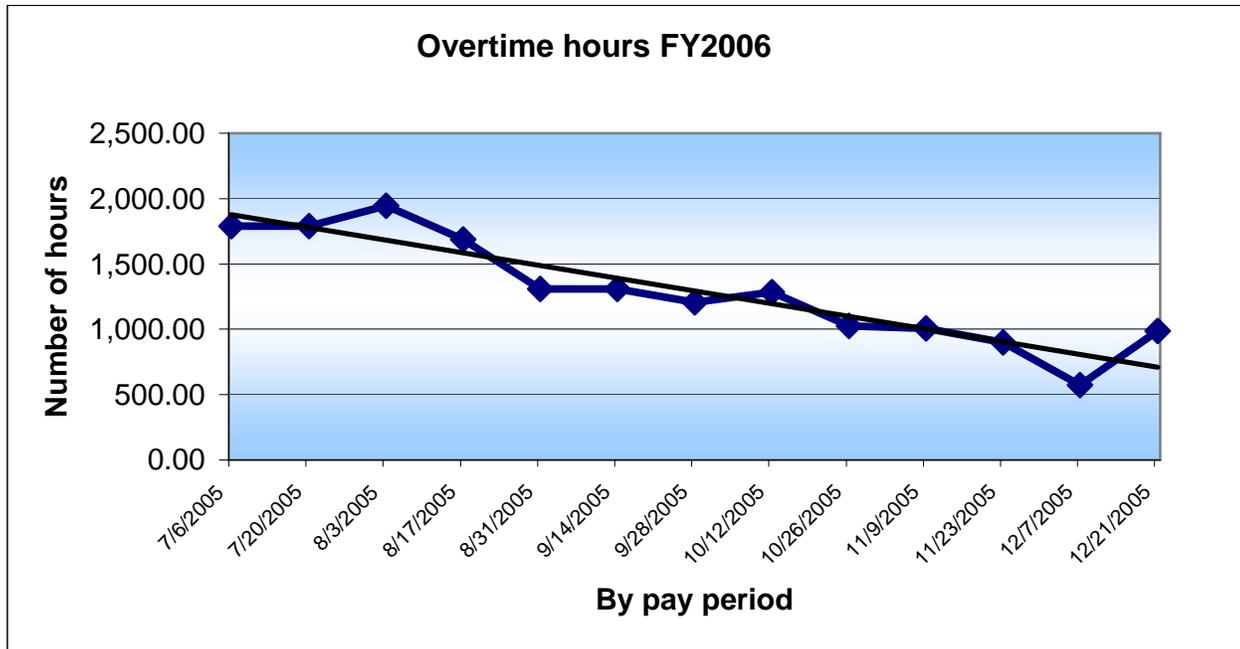
Last quarters overall compliance was at 42%. This quarters increase significantly to 63%. All managers have actively been encouraged to get their Performance Evaluations completed. As a result compliance has significantly increased by 21% this quarter.

ACTION:

- Human Resources will continue to monitor and report on a regular basis to Executive Leadership concerning the progress of compliance.
- Human Resources will continue to assess and question unit managers to follow-up on those that remain outstanding.
- Since we have accomplished a 21% increase over this three-month period, it is anticipated that we will meet our target goal of 85% by the end of the next rating period.

HUMAN RESOURCES

ASPECT: OVERTIME HOURS



FINDINGS

Overtime has continued to decrease this fiscal year (2006). We reached an all time low the first pay period in December (12/7/05). We did experience an expected increase at the end of December due to the holiday season.

PROBLEMS:

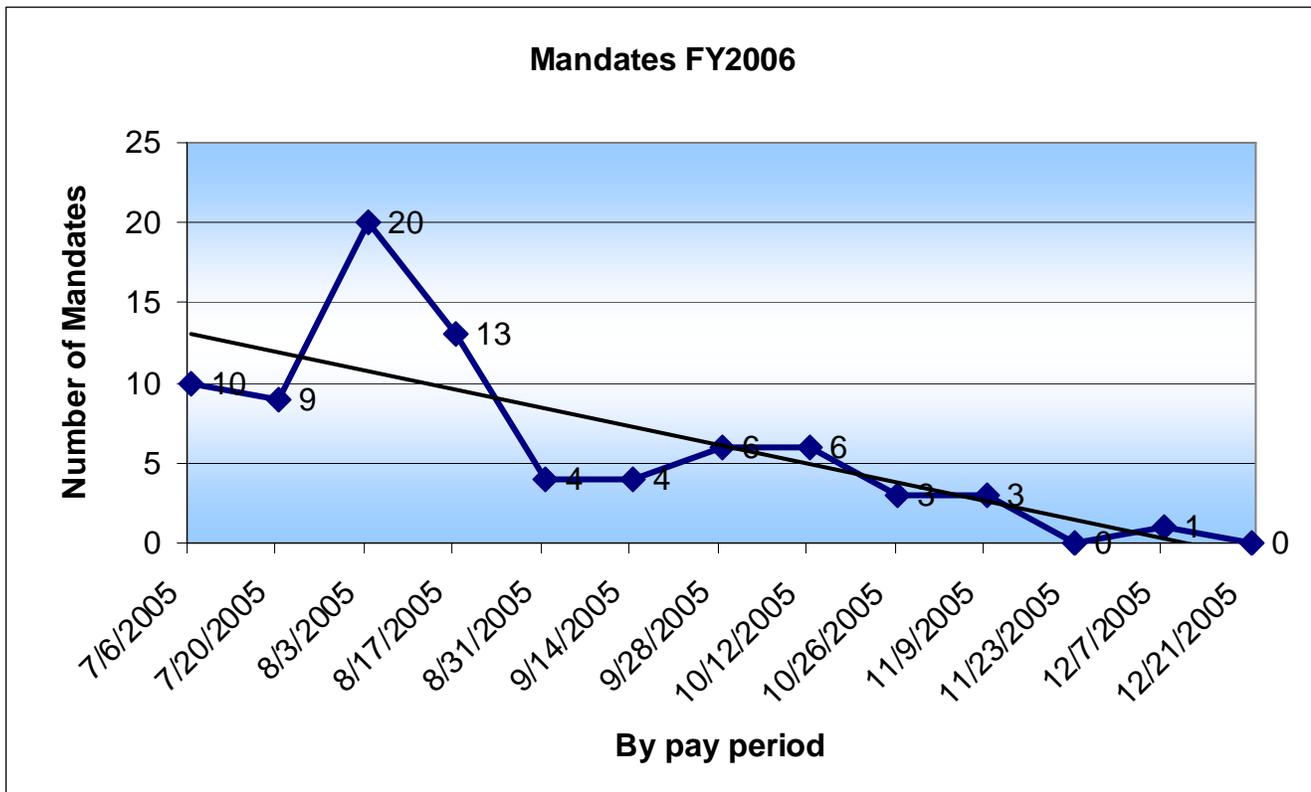
None, at this time as overtime is decreasing.

STATUS:

Since the development of two staffing coordinator positions, one for the Civil and one for the Forensic side, and overtime authorization and vacation request authorization is done by the Program Service Directors, there has been a decrease in overtime on the units. In addition, we are continuously recruiting MHW and RN positions. Also, tighter management of staff assignments for all departments has contributed to the reduction of overtime.

ACTION:

- Continue to aggressively review requests for time off.
- Adhere to acuity plan and recruit MHW and Nurses to fill existing vacancies.
- Establish a recruitment plan, by utilizing other means of recruitment including on-line recruitment through Jobs-In-ME.com and other Internet advertising companies.
- Increase recruitment in schools and promote nursing loan/tuition assistance.



FINDINGS:

Mandated shifts have been reduced from the beginning of the fiscal year (July 05 - Sept 05) from an average of 9 per pay period for last quarter to an average of 1.8 this quarter (Oct 05 - Dec 05). Two (2) of the last 3 pay periods in this quarter actually saw no mandates. This is quite an achievement for the Unit staff.

PROBLEMS:

None as mandated shifts are decreasing.

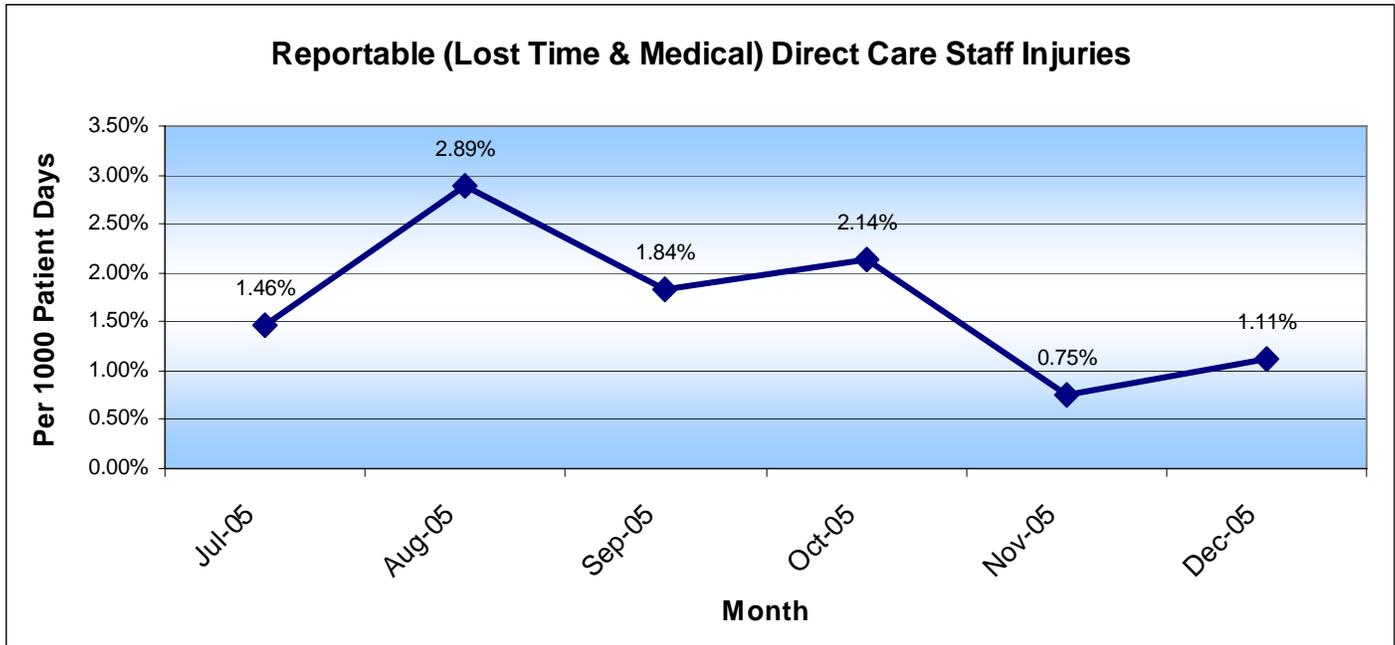
STATUS:

Adherence to staffing within acuity plan and tighter management of staff assignments and approval of time off requests on the unit level has contributed to reduction of mandates.

ACTIONS:

- Continue to aggressively review requests for time off, adherence to acuity plan and recruit MHW and nurses to fill existing vacancies.
- Establish a recruitment plan by utilizing other means of recruitment including on-line recruitment through Jobs-In-ME.com and other internet advertising companies
- Increased recruitment in schools and promote nursing loan/tuition assistance.

**HUMAN RESOURCES
ASPECT: DIRECT CARE STAFF
INJURIES**



FINDINGS:

November & December injuries remain constant at 1% as compared to October at 2%. This three-month review reveals that there is a decrease in direct care staff injuries from an overall of 2% for last quarter to 1.33% for this quarter. These numbers represent 11 direct care staff that sought medical treatment or lost time from work. We continue training staff on new techniques and recommendations by the NAPPI committee. It is worthy to note that in comparison to last year during these same months (Oct 04 - Dec 04) we had an average of 2.66% of direct care injuries per 1000 client days, we have decreased this to 1.33% over the past year. This is a 50 % decrease in 1 year.

PROBLEM:

Staff injuries from combative clients continue to remain the major cause of lost time and medical injuries.

STATUS:

The hospital has developed a 5 part strategy to address staff injuries:

- 1.Reviewing of each injury by senior administrative staff,
- 2.A hospital-wide emphasis on the importance of staff safety,
- 3.Continued emphasis on active treatment to engage clients early,
- 4.Implementation of the recovery approach identifying and developing new skill sets for clients and
- 5.Education on new NAPPI techniques to assure staff has the most current education. This has helped in decreasing staff injuries.

ACTIONS:

- Continued implementation of the above 5 steps strategy.

ENVIRONMENT OF CARE**ASPECT: STAFF INJURIES DUE TO ENVIRONMENT- CORRECTED****OVERALL COMPLIANCE: 100%**

Indicator	Findings	Compliance	Threshold Percentile
Total of staff injuries reported due to environment and corrected within 24 hours.	7 of 7	100%	100%

FINDINGS:

7 of 51 total staff injuries were reported as due to the environment this quarter. 7 of 7 were corrected within 24 hours. The injuries and actions were as follows: A dietary staff cut their hand on a sharp object in the dishwasher which was filed down by maintenance; a dietary staff injured their back using the floor machine. All dietary staff were evaluated on their use of the machine and were instructed by a Physical therapist in the correct method of using the machine. A staff member slipped on a wet floor caused by a client shower in 2 areas (1 on Upper Kennebec & 1 on Lower Kennebec). Staff mopped up the area after each incident. Staff slipped on floor in stairwell # 6 after a snow fall. Housekeeping staff installed runner carpets to absorb water from melted snow. Dietary staff burned their hand getting hot water from a coffee maker. Dietary supervisor reminded this staff of the correct procedure for removing a container of hot water from under the water nozzle. Staff slipped on ice in parking lot, which was corrected by the Security staff on duty by putting sand and salt in the area. Security staff will be doing 2 hour checks to look at surface conditions in parking lots & walkways during the winter months.

PROBLEM:

None. Environmental issues contributed to injury in 7 situations and were addressed within 24 hours.

STATUS:

All 7 incidents of staff injuries were repaired or addressed within 24 hrs. of report. Last quarters results also showed all environmental issues were repaired/addressed within 24 hours.

ACTIONS:

- Repairs and necessary changes to be made in a timely manner (within 24 hours).

HOUSEKEEPING

ASPECT: BATHROOM CLEANLINESS

OVERALL COMPLIANCE: 91%

Indicators	Findings	Compliance	Threshold Percentile
Bathrooms stocked with all paper goods	92 of 93	99%	90%
Trash Emptied.	88 of 93	95%	85%
Toilet cleaned.	85 of 93	91%	85%
Sink cleaned.	81 of 93	87%	85%
Soap containers filled/clean.	87 of 93	94%	90%
Floors cleaned.	86 of 93	92%	95%
Walls cleaned.	90 of 93	97%	90%
General appearance satisfactory.	90 of 93	97%	95%
Shower or tub cleaned.	33 of 37	89%	85%
Air vents dust free.	78 of 93	84%	90%

FINDINGS:

The indicators are based on the assessments of bathrooms inspected this quarter. 10 different criteria are to be met for acceptability. Bathrooms were reviewed randomly, 93 times this quarter. Improvement is needed in the area of floor cleaning and air vents.

PROBLEM:

2 of the 10 areas were below established thresholds.

STATUS:

Overall compliance went up by 3% compared to the last quarter.

ACTIONS:

- Some Housekeeping staff have been reassigned and will be mentored by exceptional housekeepers to learn better techniques to improve cleanliness of bathrooms.
- New tracking document will be developed and put in use by Jan 20, 2006.

DIETARY**ASPECT: UNIT KITCHEN CLEANLINESS****OVERALL COMPLIANCE: 96%**

Indicators	Findings	Compliance	Threshold Percentile
1. All surfaces clean	37 of 39	95%	90%
2. Thermometers in frig / freezers	35 of 35	100%	95%
3. Cupboards clean?	39 of 39	100%	80%
4. Refrigerator clean	35 of 35	100%	80%
5. Walls clean	39 of 39	100%	90%
6. Toasters clean	32 of 39	82%	85%
7. Microwave clean	35 of 39	90%	85%
8. Sinks clean	36 of 39	92%	90%
9. Assorted fruit fresh	35 of 35	100%	85%
10. All food dated	35 of 39	90%	95%

FINDINGS:

Unit kitchens were reviewed randomly, 39 times this quarter. Improvement is needed keeping the toasters clean and labeling and dating all foods that have been opened. Unit staff have been working with clients to clean the unit kitchen areas after every use. This has noticeably improved the cleanliness. Unit kitchens were checked both before and after 10 am to assure consistent cleanliness. Unit staff have been assisting with kitchen checks especially in the Special Care units. Unit staff were reminded of the importance of dating foods. A sign was placed on the refrigerators reminding staff to date foods.

PROBLEMS:

The unit staff do not consistently label and date food that they open. All toasters are not readily accessible to Dietary staff for cleaning.

STATUS:

The current quarter shows an 82% compliance keeping toasters clean; this is a 5% decline compared to last quarter. There is 90% compliance labeling and dating all foods that are opened; this is a 20% improvement. However, this still does not reach the 95% threshold. Threshold level was met this quarter regarding all surfaces being clean. Overall there was 96% compliance this quarter.

ACTIONS:

- The Dietetic Services Manager will monitor the Dietary staff that are cleaning the unit kitchens more closely and review findings on an individual basis with the employee responsible for the tasks.
- Toasters will be moved by the unit staff to allow Dietary staff access for cleaning.
- Signs placed on unit refrigerators to remind staff to date food
- Dietary staff will check dating of items on units daily.

PROFESSIONAL & ORGANIZATIONAL DEVELOPMENT**ASPECT: COURT COORDINATOR WILL MEET WITH CLIENTS PRIOR TO HEARINGS****OVERALL COMPLIANCE: 100%**

Indicators	Findings	Compliance	Threshold Percentile
The Court Coordinator will meet with 100% of the RPC clients awaiting a District Court Commitment hearing and explain the court process to them.	27-27	100%	95%

FINDINGS:

This indicator is based on 13 court sessions during the months of October, November and December 2005. It does not include 18 patients who had hearings at the Riverview Psychiatric Center during that same time period. These individuals were from the Maine General Medical Center and the Veterans Administration at Togus. Although the court coordinator did meet these individuals when they arrived at Riverview on the day of the hearings, he did not see them prior to that time. Meeting with them prior to the hearings was beyond the scope of his responsibilities.

PROBLEM:

The court coordinator was able to meet with all 27 individuals from Riverview prior to their commitment hearing. On a number of occasions it was necessary to make more than one visit to the Units to accomplish this task. This was because the clients were either at the treatment mall, eating, in treatment planning sessions, or sleeping.

STATUS:

Last quarters Overall Compliance was 97% with 1 client refusing a pre-court meeting.

ACTION:

- The court coordinator will answer any questions clients may have regarding the hearings and assist them with making calls to their attorney should they request assistance.
- This indicator will be replaced with another indicator in the next quarter due to monitoring revealing a stable process.

INFECTION CONTROL

ASPECT: HOSPITAL INFECTION CONTROL

OVERALL COMPLIANCE: Hospital average (36 months): 3.0

Indicators Oct., Nov., Dec. 2005	Number	Rate	Threshold Rate
Hospital Acquired (healthcare associated) infection rate, based on 1000 patient-days	16	1.96	2 standard deviations (5.8)

FINDINGS:

Infection rate is obtained by total house surveillance, the most effective method for behavioral healthcare facilities to identify trends and problems. Surveillance accomplished by chart reviews, review of antibiotic prescribing (for infections or prophylaxis) and clinical staff reporting. The Infection Control Nurse addressed concerns of unit staff and clients regarding prevention and treatment of tinea pedis (athlete’s foot).

PROBLEM:

Influenza vaccine that was ordered for this influenza season was not received in a timely manner.

STATUS:

Infection rate for this period was within the 2 standard deviation threshold of action (rate of 5.8 infections per1000 patient-days). Due to delay in receiving influenza vaccine, Riverview participated in a Maine state-sponsored influenza vaccination clinic in which approximately 100 employees were vaccinated. Full supply of vaccine was recently received. Staff desiring vaccinations are receiving them. Twenty clients were also given Influenza vaccine. Although all clients were offered the vaccine, most refused. Influenza awareness was raised by informational emails sent to staff. New informational signs were posted throughout facility encouraging respiratory etiquette. Signs also posted to encourage visitors to visit at other times if symptomatic.

ACTIONS:

- The Infection Control Nurse will work with pharmacy related to availability and ordering supply sources for the next flu vaccine season and will assure the vaccine is ordered in a timely manner.
- The Infection Control Nurse will work with Unit Staff and the Housekeeping staff to educate on shower cleaning after each use.
- The Infection Control Nurse will hold classes for the clients on appropriate foot care and footwear.
- Hand hygiene will continue to be stressed to staff and clients.
- Information will be sent out to staff regarding any pertinent topic of infection control.

CLIENT SATISFACTION ASPECT: SATISFACTION SURVEYS OVERALL COMPLIANCE 76%

Indicators	Findings	Compliance	Threshold Percentile
1. Has anyone informed you about your rights?	27 of 30	90 %	85%
2. Has anyone talked to you about the services that are available	26 of 30	87 %	85%
3. Are you informed ahead of time of changes in your privileges, appointments or daily routines?	26 of 30	87 %	85%
4. Do you know someone who can help you get what you want or stand up for your rights?	25 of 30	83%	85%
5. Has your Community Worker visited or contacted you since you have been in the hospital? (14 Patient's answered Non Applicable).	13 of 16	81 %	85%
Do you know how to get in touch with your Community Worker? (14 clients answered Non-Applicable)(14 clients answered Non-Applicable)	13 of 16	81%	85%
7. Do you have an Individualized Support Plan (ISP)?	9 of 30	30%	85%
8. I feel more confident in my ability to deal with crisis situations?	21 of 30	70%	85%
9. I am less bothered by my symptoms now?	22 of 30	73%	85%
10. I am better able to function?	24 of 30	80%	85%
11. I do better in social situations?	21 of 30	70%	85%
12. I experience less difficulty in my life	20 of 30	67%	85%
13. I am treated with dignity and respect?	25 of 30	83%	85%
14. I feel comfortable asking questions about my treatment and	27 of 30	90%	85%
15. I am encouraged to use self-help/peer support /groups after	25 of 30	83%	85%
16. My medication benefits and risks were discussed with me?	24 of 30	80%	85%
17. I am given information about how to understand and manage	23 of 30	77%	85%
18. My other medical conditions are being treated? This question has an NA answer with 9 clients responding Non-Applicable)	20 of 21	95%	85%
19. I feel free to voice complaints/suggestions?	26 of 30	87 %	85%
20. I feel my right to refuse medication or treatment is respected.	22 of 30	73%	85%
21. I participate in planning my discharge? 14 clients answered Non Applicable "Not vet"	14 of 16	88 %	85%
22. I feel I had enough privacy in the hospital?	18 of 30	60%	85%
23. I feel safe while I am in the hospital?	25 of 30	83 %	85%
24. If I had a choice of hospitals, I would still choose this one?	22 of 30	73%	85%

FINDINGS:

A Peer Survey Representative collects client satisfaction information in several areas. The opportunity to respond is provided to every client scheduled for discharge, as well as other clients randomly chosen to complete the survey after they have been in the hospital at least 2 weeks. A quarterly report is developed and reported to the Executive Leadership Committee, the Quality Improvement Council (QIC) and the Advisory Board. The hospital feels that selecting 7 areas, (identified in white) may allow a more focused effort for improvement.

PROBLEM:

The sample size is much smaller than in other quarters due to the unavailability of the survey collector due to illness. The survey demonstrates substantial need for continued improvement in many areas.

STATUS:

Fewer clients have been interviewed for this survey but the percentage of compliance has increased from 71% in the last quarter to 76% during this quarter.

ACTIONS:

- The next quarter, the unit staff will work on areas that have fallen more than 15% below the desired threshold.
- The admissions office will track the presence and availability of a client's ISP upon admission and the presence of this plan will be discussed with the client.
- Privacy will be discussed with clients on admission and reinforced during their hospital stay. Peer support staff will be used to check on privacy issues on a regular basis.
- Nursing & Mental Health workers will have Privacy training with discussions of ways to enhance privacy. Education sessions will be completed to all unit staff by March 1, 2006. Competencies will be developed for staff education.
- A survey will be done with clients by the Nurse Educator to determine what functional areas they have difficulty with. This will be completed by April 1, 2006.
- Nursing staff on each unit will continue to offer medication education opportunities for clients during the daily medication administration on each unit and document those sessions in the menu driven NAP note (which contains a specific note for medication education. Their right to refuse medication will be discussed with them during these sessions.
- Superintendent will continue to hold quarterly "Client Forums" to discuss client concerns.
- Peer Specialists have developed performance indicators for clients and will continue tracking.
- Information concerning the client's illness will be discussed with them as part of their Treatment Plan.

MEDICAL STAFF-INTERNAL PEER REVIEW

ASPECT: REVIEW OF MEDICAL STAFF DOCUMENTATION OF PHYSICAL EXAMS

OVERALL COMPLIANCE: 86%

Random selections of 8 physical exams are chosen each month for peer review. Medical staff rate the quality of each other's exams based on a rating scale of 1 to 5 for each of the following elements: 1) If the physical exam was incomplete upon admission, was a reason given (e.g. patient refused or was uncooperative) 2) Were vital signs recorded upon admission on the physical exam form? 3) Is each page of the exam signed, dated, and timed? 4) Is a medical problem list generated immediately after the form is completed? 5) Are medication and food allergies recorded on the physical exam form? For each form completed a minimum passing grade is 22 of a maximum 25 points.

Each individual practitioner's total scores for exams reviewed are aggregated and averaged to determine the practitioner overall rating.

Indicator	Findings	Compliance	Threshold Percentile
All physical exams reviewed will meet minimum passing requirements as detailed in the "physical exam peer review form."	13 of 18 notes met	72 %	90%
All individual practitioners' documentation of physical exams will meet minimum passing requirements.	3 of 3 individuals met	100%	100%

FINDINGS:

In October, November, and December the overall quality of the notes improved slightly from the prior quarter. Within the quarter the rates of compliance varied between 50% in October, 100% in November, and 83% in December. Negative issues primarily revolved around dating and signing of every page of the physical exam. On a positive note, in the aggregate all three practitioners reviewed were within the passing range.

PROBLEM:

Compliance although it has come up still remains at 86 %.

STATUS:

The overall compliance (86%) improved this quarter compared to last quarter (59%). Specific individual was counseled and improvement in his documentation has been noted.

ACTIONS:

- Continue to monitor.
- Individuals counseled about substandard documentation if indicated.
- Discussed at medical staff peer review committee.

MEDICAL STAFF

ASPECT: MEDICAL STAFF PRESCRIBING ERRORS

OVERALL COMPLIANCE: 97%

Prescribing errors, including the use of unapproved abbreviations, are determined by review of medication variance reports by the Pharmacy and Therapeutics Committee. This occurs on a monthly basis and are aggregated and compiled by the Medical Director.

Indicator	Findings	Compliance	Threshold Percentile
Med staff members will have no prescribing errors.	33 Med staff, one error	97%	90%

FINDINGS:

October, November, and December: one prescribing error by one medical staff member

PROBLEM:

One prescriber ordered a medication for which there was a listed allergy. Although the client was allergic to the medication, there was no adverse event.

STATUS:

There was one prescribing error in 3 months. While generally above threshold, these types of errors are potentially serious and will need constant diligence. Prescriber was counseled

ACTIONS:

- Continue to monitor. A medication use failure mode and effects analysis (FMEA) has been started to review the medication use process with special attention to medication allergies and preventing drug incompatibilities.

MEDICAL STAFF INTERNAL PEER REVIEW

ASPECT: REVIEW OF MEDICAL STAFF PROGRESS NOTES

OVERALL COMPLIANCE: 95%

On a random basis a minimum of 40 progress notes per month are peer reviewed by all psychiatric medical staff and rated based on a 25 point rating scale created by the Medical Director. Each of 5 data elements are assigned a rating of from 1 to 5, with 5 the maximum score possible.

The data elements rated are:

- A progress note is written for each significant patient contact.
- The progress note documents medical necessity criteria for continued stay or lack thereof.
- The progress note documents the delivery of active treatment to address the problems leading to admission.
- The progress note documents progress toward stated goals and achievement of discharge criteria.
- The progress note is legible. For each rated note the minimum passing score is 22 of a maximum 25 possible points.
- The total notes for a given practitioner are aggregated and averaged to determine the practitioner's overall score.

Indicator	Findings	Compliance	Threshold Percentile
Total progress notes reviewed will meet requirements in the “progress note peer review form.”	81 of 82 notes met	99%	90%
All individual practitioners’ progress notes will meet minimum passing requirements.	9 of 10 individuals met	90%	100%

FINDINGS

Progress note requirements have generally been met very well throughout the quarter with only one note out of 82 reviewed not meeting passing requirements. Unfortunately this one note represented the only note reviewed for a particular practitioner, resulting in 1 of 10 practitioners being below threshold.

PROBLEM:

Notes from current quarter are well done except for one practitioner. The trend remains within threshold and generally in line with the previous quarter and much better than quarter before last.

STATUS:

After counseling, discussion and education, physicians and practitioners have improved in this area, and indeed have maintained a high level for 6 months. One practitioner, who because of the randomness of how charts are chosen for review, had only one note reviewed. This note was substandard. All the other practitioners were well within standards. December: One individual counseled September through December: discussion and reeducation at medical staff meetings

ACTIONS:

- This will be a continued focus area for the next quarter,

MEDICAL STAFF

ASPECT: APPROPRIATE USE OF TYPICAL ANTIPSYCHOTICS IN PSYCHIATRIC DISORDERS

OVERALL COMPLIANCE: 100 %

The medical staff have agreed upon the following medical necessity criteria to judge when typical antipsychotic drugs can, or should, be prescribed.

The presence of one or more of the following criteria would be necessary:

- Diagnosis of Tourette’s syndrome.
- The need for depot neuroleptics when the client can not tolerate Risperdal Consta.
- The client has been well controlled on a typical agent for years.
- The client has failed to respond to multiple atypical antipsychotic agents.
- There are drug allergies or other bona fide medical contraindications to atypical agents.
- The client refuses to take atypicals and using them would cause a strong potential for noncompliance.
- The prescriber decides that an atypical would pose a physical risk of exacerbating a pre-existing medical condition (e.g. diabetes).All cases where typical agent monotherapy is used will be reviewed on a monthly basis to ascertain whether, or not, at least one medical necessity criteria pertains to warrant this treatment regimen.

October 2005			
Indicator	Findings	Compliance	Threshold Percentile
All use of typical antipsychotic monotherapy will meet agreed upon medical necessity criteria	14 clients rec'd 14 clients met clinical criteria	100%	100%
November 2005			
All use of typical antipsychotic monotherapy will meet agreed upon medical necessity criteria	13 clients rec'd 13 clients met clinical criteria	100%	100%

FINDINGS

For the reporting quarter, all clients who received only typical antipsychotics (and no atypicals) met preapproved clinical criteria.

PROBLEM:

No problems detected. Medical staff is prescribing typical antipsychotics appropriately.

STATUS:

Because the database used for the basis of this indicator is the National pharmacology data set, December findings could not be reported at this time and will be in the next quarterly report.

ACTIONS:

None needed; continue to monitor.

MEDICAL STAFF

ASPECT: USE OF BRAIN IMAGING FOR DIAGNOSTIC PURPOSES

OVERALL COMPLIANCE: 100 %

The medical staff have discussed and agreed upon the following medical necessity criteria which would warrant the ordering of a brain imaging study:

- New onset seizure.
- Progressive dementia, especially if associated with gait disturbance or incontinence.
- Focal neurological signs.
- Delirious state without obvious cause or sudden change in mental status.
- Sudden onset of severe headache without history of migraine.
- Recent traumatic brain injury, especially if associated with unconsciousness.
- Pre-Electro-convulsive therapy (ECT) workup.
- Abnormal neuropsychological testing suggesting a dementing or localizing process

All brain imaging studies ordered in the quarter were reviewed to ascertain if at least one of the agreed upon medical necessity criteria were present in the medical record.

October 2005			
Indicator	Findings	Compliance	Threshold Percentile
All brain imaging studies will meet agreed upon clinical indications	1 study ordered 1 study met indications	100%	100%
November 2005			
All brain imaging studies will meet agreed upon clinical indications	No studies ordered	100%	100%
December 2005			
All brain imaging studies will meet agreed upon clinical indications	1 study ordered 1 study met indications	100%	100%

FINDINGS:

There were two brain-imaging studies ordered in the quarter. Both met pre-approved criteria for medical necessity. The overall utilization of brain imaging appears to be decreased from prior quarters.

PROBLEM:

No problem detected.

STATUS:

All clients requiring brain-imaging studies met medical necessity criteria.

ACTIONS:

- None needed; continue to monitor.

MEDICAL STAFF

ASPECT: MONITORING FOR IV SEDATION IN PORTLAND CLINIC

OVERALL COMPLIANCE: 100%

IV sedation for dental clients in the Portland Clinic is a relatively high- risk procedure. There is the possibility of respiratory depression caused by the use of sedating medications. To insure that the risk of sub-optimal oxygen perfusion is minimized, care is taken that the client has adequate blood oxygen saturation levels on room air prior to leaving the immediate supervision of the anesthetist. This saturation level is monitored electronically and must reach a minimum of 92% prior to the client leaving the operating suite and being moved to the recovery room.

October 2005			
Indicator	Findings	Compliance	Threshold Percentile
Sedation patients will have an O2 saturation on room air of 92% or greater before going to recovery	23 pts sedated Lowest baseline saturation 94 Lowest final saturation 92	100%	100%
November 2005			
Sedation patients will have an O2 saturation on room air of 92% or greater before going to recovery	17 pts sedated Lowest baseline saturation 96 Lowest final saturation 94	100%	100%
December 2005			
Sedation patients will have an O2 saturation on room air of 92% or greater before going to recovery	17 pts sedated Lowest baseline saturation 92 Lowest final saturation 97	100%	100%

FINDINGS:

57 clients received sedation services in the quarter. All clients had their oxygen saturations (SAT) at or above the threshold prior to going to the Recovery Room.

PROBLEM:

No problem detected.

STATUS:

All clients receiving IV sedation had adequate oxygenation prior to leaving operatory for the Recovery Room.

ACTIONS:

- Continue to monitor O2 saturations both pre-op and prior to admission to Recovery.
- Continue to report at monthly staff meeting and send quarterly report to the Medical Director.

CAPITOL COMMUNITY CLINIC

ASPECT: NEED FOR PHYSICAL EXAM

OVERALL COMPLIANCE: 100%

GUIDELINES:

Healthy and without symptoms of disease or illness. Age 18-25 years/every 5 years, Age 26-39 years/every 5 years, Age 40-49 years/every 2-3 years, Age 50-65 years/every 1-2 years, Chronic physical illness: Annual physical exam recommended. Chronic, long-term psychiatric illness: Annual physical exam recommended.

Indicator	Findings	Compliance	Threshold Percentile
Capitol Community Clinic will assess client need for a physical exam during the intake process and will encourage each patient to have a physical exam.	76 unique patients were seen in the clinic and 76 were assessed as to the need for a physical exam	100%	100%

FINDINGS:

Of the 76 clients seen this quarter, 100% were assessed as to need for a physical. 74% are within the established guidelines for physical exam. All patients are still screened for chronic medical problems, including chronic pain. All clients are advised of the necessity of having annual physical exams. Age 18-25: 9 clients with 2 noncompliant; Age 26-39: 25 clients with 3 noncompliant; Age 40-49: 23 clients with 7 noncompliant; Age 50-65: 17 clients with 6 noncompliant.

PROBLEMS:

Many clients refuse for various reasons. They may be without insurance or income and not be able to afford medical; or they do not see the need for a physical exam. Some can afford care but choose not to.

STATUS:

If a client has a Clinical Social Worker (CSW), the CSW notes the need in the clients Individual Service Plan (ISP) and follow-up for the exam.

ACTION:

- Continue to screen at the time of intake for medical history and need for physical exam. A large part of the screening is education.
- Continue to work with case management to coordinate medical services for patients who are waiting on insurance and are in good health. Anyone who is on medicines or is initiating psychiatric treatment is encouraged to have an annual physical exam.
- Continue to work with case management to assist clients with referrals, and entitlements.
- Get an immediate referral for those who present with an acute medical problem at time of intake. A referral with Dr. Davis, our hospital medical physician, will be initiated if necessary.

NURSING**ASPECT: SECLUSION & RESTRAINT RELATED TO STAFFING EFFECTIVENESS**

OVERALL COMPLIANCE: 95%

Indicators	Findings	Compliance	Threshold Percentile
Seclusion/Restraint related to staffing effectiveness:			
1. Staff mix appropriate	80 of 80	100%	100%
2. Staffing numbers within appropriate acuity level for unit	80 of 80	100%	100%
3. Debriefing completed	62 of 80	78%	100%
4. Dr. Orders	80 of 80	100%	100%

FINDINGS:

All staff effectiveness indicators are at 100% with the exception of debriefing at 78%. The average is 95%.

PROBLEM:

Staff debriefing continues to be below threshold. The problem is across shifts and units. There is no correlation to the staff numbers on the units.

STATUS:

Compliance has decreased for the indicator of staff debriefing from 89% to 78%. The indicator of medication errors related to staff effectiveness was dropped this quarter due to significant compliance.

ACTIONS:

- A new debriefing protocol was developed. All Program Service Directors, Nurse IV's and Nursing Supervisors (NODs) were trained in the process. The new protocol is under pilot until 2-1-06.
- Each time a debriefing is not completed, the Nurse Executive will follow up. This will be coordinated with the Risk Manager.
- The Seclusion and Restraint policy is being updated to reflect JCAHO standards. This will be completed by Feb 1, 2006.

NURSING**ASPECT: CODE CART & REDLINING****OVERALL COMPLIANCE: CODE CART 98%; REDLINING 98%**

Indicators-Redlining	Findings	Compliance	Threshold Percentile
Lower Kennebec	276 of 276	100%	100%
Upper Kennebec	271 of 276	98%	100%
Lower Saco	524 of 552	95%	100%
Upper Saco	272 of 276	99%	100%

Indicators-Code Cart Sign Off	Findings	Compliance	Threshold Percentile
1) Lower Kennebec	271 of 276	98%	100%
2) Upper Kennebec	271 of 276	98%	100%
3) Lower Saco	269 of 276	97%	100%
4) Upper Saco	268 of 276	97%	100%
5) NOD Building Control	275 of 276	99.6%	100%
6) NOD Staff Room I 580	275 of 276	99.6%	100%

FINDINGS:

Compliance with both redlining and Code Cart sign offs are running at 98%. This quarter represent more stability than last quarter. The variance from 100% represents one or two shifts the RN did not check the Code Cart or perform the redlining function for that shift.

PROBLEM:

All of the units' Code Carts are still not at 100%.

STATUS:

These two indicators are unchanged from last quarter but have been consistently increasing.

ACTION:

- Each individual identified not completing either function has received and will receive individual counseling and quality assurance alert.

NURSING**ASPECT: PAIN MANAGEMENT****OVERALL COMPLIANCE 95%**

Aspect	Indicator	Findings	Compliance	Threshold
Assessment	Assessed upon admission.	128 of 128	100%	85%
	Assessed using pain scale.	31 of 36	86%	95%
Preadministration	Assessed using pain scale	1207 of 1210	99.7	95%
Post administration	Assessed using pain scale	1159 of 1210	96%	95%

FINDINGS:

Beginning in November, all new admissions were audited. Sample size for assessment using the pain scale upon admission was decreased this quarter due to fewer clients admitted with an active complaint of pain. Of the 128 charts audited upon admission, only 36 identified pain as being present. In order to increase sample size, pain assessment data was collected weekly from each unit for every client receiving PRN pain medication for the assessment of pre and post administration pain level. Five of the audited charts assessed pain as being present upon admission, but did not use the pain scale to rate the level of pain. 3 of these incidents were due to the clients refusal to use the scale, one was descriptive in nature i.e. "not too bad" and one was not rated. All aspects were above threshold with the exception of using the pain scale for pain identified upon admission.

PROBLEMS:

There was only one audited chart that did not rate the pain upon admission. A small sample size contributed to 5 charts creating a large variance. Client refusal accounted for the majority of the five audited charts found not in compliance.

STATUS:

Pain assessment upon admission increased from 97% to 100%. Assessment utilizing a pain scale decreased from 91% to 86%. Remaining indicators were changed to reflect the assessment and re-assessment of pain pre and post administration of PRN pain medication. Data collection was changed to capture a larger sample size and decrease variance. In order to increase sample size, pain assessment data was collected weekly from each unit for every client receiving PRN pain medication for the assessment of pre and post administration pain level. Pain scales were added to all PRN stickers to prompt the documentation of the assessment using the pain scale. A competency based training on the assessment and reassessment of pain to include utilization of the pain questionnaire was done with all RNs by the Nurse IV or Nurse Educator. These indicators were above threshold at 99.7% and 96%.

ACTIONS:

- Educational reinforcement will be provided for RNs doing admissions to clearly document patient refusal to participate.
- The one nurse that did not rate the pain will receive individual counseling.
- Patient refusal will not be counted as “not rated” in the next quarterly data.

NURSING:**ASPECT: CHART REVIEW****OVERALL COMPLIANCE 92 %**

	Indicator	Findings	Compliance	Threshold Percentile
Universal Assessment	Universal Assessment completed by RN within 24 hours.	100 of 101	99%	100%
	Sections completed/deferred with documentation.	64 of 101	63%	85%
	Initial nursing care plan initiated.	101 of 101	100%	100%
	Item's triggered to integrated problem needs list.	82 of 101	81%	85%
	All sheets authenticated by assessing RN	92 of 101	91%	100%

FINDINGS:

One chart did not indicate an assessment within 24 hours, the client was uncooperative upon admission and the audit was performed within 48 hours of admission. At the time of the audit the assessment was incomplete. 37 charts had sections on the assessment that the client did not participate in due to their condition upon admission. These sections were not identified as deferred with supporting documentation. 19 charts were found to not consistently asterisk (*) the problems to the identified problem needs list. The problems were assessed and identified on the problem needs list but were not identified on the assessment with an asterisk (*). All admissions were audited within 1 working day of admission to ensure initiation of treatment occurred at time of admission. It is also necessary to ensure completeness of the medical record for a more immediate response and corrective action related to initiation of treatment. The staff responsible for each individual discrepancy was counseled. The expectation was set that the admitting RN will complete the admission assessment prior to leaving duty for that shift. The indicator for RN signing all sheets was below threshold at 91% In 6 charts the auditor counted ALL pages of the assessment for signature when only three pages required an RN signature. This occurred in audits prior to clarification of the expectation of which pages required a signature. In three charts there was an isolated signature missing.

PROBLEM:

While the sections on the assessment were deferred, this was not reflected in the admission note in 37% of the audited charts. Using an asterisk (*) to identify identified problems to be included on the problem list is still below threshold. The identified problems were included on the problem list but not identified on the assessment with an asterisk (*) in 19% of the charts audited. While the RNs signed all sheets requiring a RN signature, all sheets were not authenticated in 9% of the charts.

STATUS:

All sections completed or deferred with documentation increased from 55% to 63%. The compliance has increased from 78 % to 92% since last quarter. The universal assessment has increased from 97 % completion in the 1st quarter 06 to 99 % in this quarter. Initiation of a nursing care plan has increased from 93% to 100%. Items triggered with an asterisk (*) increased from 67% to 81%. All sections completed or deferred increased from 55% to 63%.

ACTIONS:

- The Nurse Educator will reinforce the need to document all deferred sections of the assessment in the admission note and the need to identify with an asterisk the identified problems on the problem/needs list.
- A nursing committee has been formed to streamline the admission process and address the two indicators listed above that are below threshold.

NURSING

ASPECT: NURSING DOCUMENTATION

OVERALL COMPLIANCE 84%

Aspect	Indicator	Findings	Compliance	Threshold
Documentation	1. NAP notes at a minimum			
	a. Identifies STG goal/objective.	99 of 135	73%	90%
	b. Once per shift either MHW/RN	Unacceptable data collection methodology	No Data	95%
	c. Minimally Q24 hours RN.	Unacceptable data collection methodology	No Data	95%
	d. MHW notes countersigned by RN	121 of 135	90%	90%
	2. Active Treatment			
	a. Identifies Intervention	122 of 135	90%	90%
	b. Describes intervention.	92 of 135	68%	90%
	c. Assessment Completed.	122 of 135	90%	90%
	d. Plan	122 of 135	90%	90%

FINDINGS

Two categories had an unacceptable data collection methodology that made it impossible to aggregate the data. The 36 charts that were audited as not identifying a short term goal actually did identify a short term goal that was not part of the current treatment plan.

The description of the intervention is being written in goal format 73 % of the time. The indicator for a NAP note was changed to include observational notes as appropriate based on client activity. The threshold for these indicators was adjusted from 100% to account for normal expected variances.

In the charts where the MHW note was not countersigned, there was also not an assessment or plan. The numbers of deficiencies were all consistently in the same chart audits. This indicator just met threshold.

PROBLEMS

The identified short term goal is not consistent with the treatment plan short term goal on the NAP note in 27% of the cases. The short term goals were stated under the problem list and not as short term goals. There also were short term goals that did not become part of the current treatment plan. The writers did not reference the treatment plans prior to writing the notes.

Describing an intervention is at 68%. The narrative is being written in observational terms not active treatment language. Instead of using a regular note format, the observational notes are being written on NAP notes, thus falling outside compliance for the requirements of a NAP note.

STATUS

Although the documentation by MHW and Nurses during the last quarter was at 80% and 90%, the methodology of collecting the data was changed this quarter and was not usable. The Nurse Educator has developed and is delivering a comprehensive training on the different types of notes, goal of each note, and components of each type of note to each unit. This material is available on the intranet for use with those staff unable to attend the scheduled trainings.

The Director of Professional & Organizational Development and the Director of Nursing have not yet completed a “Competency Assessment”, which will identify levels of staff competency. Additional training is also needed unit by unit for staff to fully comply with NAP, Active Treatment, and Comprehensive Service Plan documentation and implementation.

Overall compliance with documentation decreased from 88% to 84%. Identification of the short term goals decreased from 92% to 73%. MHW notes countersigned by RN decreased from 92% to 90%. Active treatment documentation increased from 68% to 85%. Identification of intervention increased from 68% to 90%. Description of the intervention decreased from 78% to 68%. RN completing assessment of MHW intervention increased from 88% to 90%. Identification of new plan increased from 88% to 90%.

ACTIONS:

- The way the data is collected and calculated will include the number of entries being audited, not just the number of charts. If one chart is missing one entry out of 42, the compliance for that chart indicator should be calculated as 93% complete, not zero.
- The Nurse Educator will reeducate staff on each unit to improve the quality of documentation.
- There will be individual counseling as appropriate.
- The documentation training has been developed and placed on the intranet for use with off shift and individual employees needed extra education and support in the area of documentation.
- The Nurse Educator will develop a Competency Assessment, which will identify levels of staff competency, but more importantly, additional training needed unit by unit for staff to fully comply with NAP and Active Treatment documentation.
- Information gathered from the routine chart reviews will trigger a specific staff “competency assessment,” which in turn will be used to develop specific staff skills training.

PROGRAM SERVICE DIRECTORS
ASPECT: COMPREHENSIVE SERVICE PLAN

This indicator tracks the compliance with aspects of the comprehensive service plan documentation with samples from all units of the hospital.

OVERALL COMPLIANCE 84%

Indicators	Findings	Compliance	Threshold Percentile
1. Initial treatment documented within 24 hours.	57 of 58	98%	100%
2. Preliminary Continuity of Care meeting completed by end of 3 rd day.	45 of 48	94%	95%
3a. Client Participation in Preliminary Continuity of Care meeting.	41 of 48	85%	80%
3b. CCM Participation in Preliminary Continuity of Care meeting.	46 of 48	96%	80%
3c. Client's Family Member Participation in Preliminary Continuity of Care meeting.	42 of 48	88%	80%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	22 of 48	46%	80%
4. Presenting Problem in behavioral terms.	57 of 58	98%	85%
5. Strengths and preferences are identified.	58 of 58	100%	85%
6. Identifies all of client's long term goals.	48 of 58	83%	85%
7. Comprehensive Plan complete by the 7 th day.	57 of 58	98%	100%
8. Observable behavioral goals/objectives are written.	40 of 58	69%	85%
9. Interventions are identified.	33 of 58	57%	85%
10a. Integrated Needs/Assessment Prioritized by scale at bottom of sheet.	51 of 58	88%	85%
10b. Integrated Needs/Assessment Contains all needs/ issues/problems.	52 of 58	90%	85%
11. Active medical issues addressed via Medical/ Nursing care plans.	32 of 51	63%	85%

FINDINGS:

5 charts per unit per month (15 per unit for the quarter) was the desired sample size. 15 charts were reviewed on each civil unit, Upper Kennebec and Lower Kennebec. On Lower Saco, 13 charts were reviewed as there were only 3 admissions in the month of October. On Upper Saco many clients have been in this setting long before the inception of this process. As a result, of the 15 charts sampled, the indicators pertaining to Preliminary Continuity of Care Meetings only applied to 5 clients this quarter. The clients served on Upper Saco represent a unique population at Riverview given their lengthy stay, initial needs assessments and plans being purged from the record. The 48 hour meetings do not typically occur on the unit as most clients have been transferred from Lower Saco. Overall, there was an improvement of 6% in overall compliance for this aspect. In comparison to last quarter, improvements were made on the following aspects: documentation of initial treatment (up 13%); completion of continuity of care meeting within timeframe (up 9%; now 1% below threshold); client participation (up 3%; above threshold again); CCM participation (up 8%; above threshold again); family member participation (up 6%; above threshold again); community provider participation (up 3%; still below threshold); presenting problem in behavioral terms (up 5%; above threshold); strengths and preferences identified (up 7%; above threshold); identification of client's long term goals (up 28%; now 2% short of threshold); completion of comprehensive plan within above threshold); integrated needs assessment complete (up 12%; now above threshold).

There were also some declines on variables also below established thresholds in the last report: observable goals/objectives written (down 1%); interventions identified (down 22%); active medical issues addressed in care plan (down 4%).

Some factors that likely contribute to variability in the data include: some nursing staff covering duties on a different unit from their usual assignment, reallocation of professional nurses resulting in reduced consistency in care providers on the unit, wide variability in treatment plan writing skills in unit staff with relatively few highly skilled writers, inconsistency in forms used, revision of some care plans needed, revisions of the auditing tools, and differences in raters.

Issues seem to cluster in three general categories around (a) meeting timelines for care planning meetings, (b) nursing assessment tools and documentation, and (c) quality of treatment planning.

PROBLEMS:

There were 8 indicators on this aspect below desired thresholds: initial treatment documented within 24 hours, preliminary continuity of care meeting completed by the end of the 3rd day, participation in preliminary continuity of care meeting by community providers, identification of client's long term goals, completion of the comprehensive plan by the 7th day, observable behavioral goals/objectives written, interventions identified, and active medical issues addressed via medical/nursing care plans. Please refer to Corrective Actions section below regarding plans to address each of these.

STATUS:

There were 10 indicators on this aspect below desired thresholds last report. In the current report period there are only 8; both indicators associated with the Integrated Needs Assessment are now above threshold. As detailed in the findings section, improvements were made in a large number of indicators. Factors associated with the improvements over the review period include: ongoing chart review and management to objectives by Program Service Directors, additional chart review by Nurse On Duty, increased education sessions by Nurse Educator, addition of Deputy Superintendent of Clinical Services to provide additional support and oversight. The focal declines are attributable to (a) planned actions not yet executed including the competency assessment tool for treatment planning described in the last report is still in development and the Medical/Nursing Care Plan format continues to be in need of improvement/revision; and (b) earlier discontinuation of Program Service Directors monitoring these indicators/aspects on a monthly basis at the unit level. The initial treatment documentation within 24 hours will be tracked under nursing.

ACTIONS:

- Problems with documentation of initial treatment within 24 hours will be addressed by the nurse educator, who will review all charts within one work day of each client's admission.
- Completion of the continuity of care meeting by the end of the 3rd day and completion of the comprehensive plan by the 7th day are both approaching respective thresholds. The action will be PSDs will directly monitor these indicators on a monthly basis and manage to this objective. Health Information Management will also be proactively flagging charts in danger of missing these deadlines.
- Participation in preliminary continuity of care meeting by community providers will be addressed by (1) continuing to encourage and develop ways to facilitate community workers' involvement in treatment team meetings including the use of video conferencing or audio attendance, (2) Continuity of Care Managers (CCMs) will attempt to contact and document all attempts to contact community providers in advance of the meeting, and (3) by Feb. 1, 2006 Director of Performance Improvement and CCMs will develop a means to sample the above activity as a separate performance improvement aspect with at least two indicators.
- By April 1, 2006, the Director of Professional & Organizational Development and the Director of Nursing will develop a "Competency Assessment," which will identify levels of staff competency. They also will identify additional training needed, unit by unit, for staff, to fully comply with the Comprehensive Service Plan documentation. These actions are designed to target improvements in identification of client's long term goals, writing observable behavioral goals/objectives, and identification of interventions.
- By April 1, 2006 Director of Nursing and the Nurse Educator will revise the Medical/Nursing Care Plan format and develop the Annual Nursing Assessment for long-term clients in keeping with recommendations from the units, and provide training as needed to effectively and consistently develop medical/nursing care plans for identified issues.

**PROGRAM SERVICE DIRECTORS
ASPECT: SERVICE PLAN REVIEWS**

This indicator tracks the compliance with aspects of the service plan review documentation with samples from all units of the hospital.

OVERALL COMPLIANCE 98%

Indicators	Findings	Compliance	Threshold Percentile
1. Completed no later than 14 days for the first 6 months and monthly thereafter.	52 of 54	96%	85%
2. Completed within 48 hours of a restrictive treatment?	58 of 58	100%	85%
3a. Review form documents client participated in the review.	54 of 54	100%	85%
3b. Review form documents psychiatrist participated in the review.	54 of 54	100%	85%
3c. Review form documents CCM participated in the review.	52 of 54	96%	85%
3d. Review form documents nurse participated in the review.	53 of 54	98%	85%
4. Review form indicates plan as having met identified goals or not.	50 of 54	93%	85%
5. Review form states whether client continues to meet admission criteria or not.	53 of 54	98%	85%

FINDINGS:

5 charts per unit per month (15 for the quarter) was the desired sample size. 15 charts were reviewed on Upper Saco, Upper Kennebec and Lower Kennebec; Lower Saco reviewed 13. Reviewers were Program Service Directors. As the above chart presents, all indicators are above threshold on this aspect.

PROBLEMS:

None identified.

STATUS:

Program Service Directors re-instituted chart audits on this aspect and have continued to actively assist in the training of nursing staff and managing this objective.

ACTIONS:

- The corrective actions identified pertaining to treatment planning in the Comprehensive Service Plan section, along with the Program Service Directors' active support of that training and education, will also serve to enhance this aspect of care.

**PROGRAM SERVICE DIRECTORS
ASPECT: INTEGRATED SUMMARY NOTE**

This indicator tracks compliance with aspects of the integrated summary note documentation with samples from all units of the hospital.

OVERALL COMPLIANCE 84%

Indicators	Findings	Compliance	Threshold Percentile
1. Documented in the chart on the day of the Comprehensive Service Plan Meeting.	43 of 48	90%	95%
2. Identifies Client Preferences.	35 of 48	73%	85%
3. Identifies general needs of client -- identified on completed assessment.	43 of 48	90%	100%
4. States whether further assessments will be needed or not.	38 of 48	79%	85%
5. Identifies the general goals of services.	42 of 48	88%	85%
6. Documents the client or guardian participation in the treatment planning process.	42 of 48	88%	100%

FINDINGS:

5 charts per unit per month (15 for the quarter) was the desired sample size. 15 charts each were reviewed on Upper Kennebec and Lower Kennebec. Lower Saco reviewed 13 for reasons detailed above. Upper Saco reviewed 15. However, Upper Saco serves many clients who have been in this setting long before the inception of this process; as a result the 15 charts only applied to 5 clients this quarter. The clients served on Upper Saco represent a unique population at Riverview given their lengthy stay, earlier needs assessments and plans being purged from the record long ago and 10 clients of the 15 sampled were admitted prior to the 48 hour meeting and resulting integrated summary note. All reviewers were Program Service Directors. As the above chart presents, 4 of the 6 indicators are above thresholds on this aspect.

PROBLEMS:

Indicators below thresholds were: (1) identification of client preferences, falling short of threshold by 7% and (2) indication of need for further assessment which was short of the threshold by 6%. Continuing education, guidance and management of these objectives will be necessary by Program Service Directors.

STATUS:

Program Service Directors re-instituted chart audits on this aspect and are at 84% compliance. This was not tracked in the last quarter. They have continued to actively assist in training of nursing staff on this objective. The Nurse Educator has been offering training relevant to this aspect. A template was developed to prompt the note writers to include required information and nurses have been bringing the template to the meeting and writing their notes in keeping with that template.

ACTIONS:

- The corrective actions identified pertaining to treatment planning in the Comprehensive Service Plan section, along with the Program Service Directors' active support of that training and education, will also serve to enhance this aspect of care. Eventually, having a fully dedicated Nurse IV on Lower Saco will also help support these objectives in the day-to-day operation of that unit.
- Information gathered at the routine chart audits will assist in identifying continued areas of needed enhancement.

PROGRAM SERVICE DIRECTORS

ASPECT: TREATMENT PLAN DOCUMENTATION REVIEW

This indicator tracks compliance with aspects of progress note documentation with samples from all units of the hospital.

OVERALL COMPLIANCE 90%

Indicators	Findings	Compliance	Threshold Percentile
1. Review note indicates changes made in the plan to implement further progress.	44 of 54	81%	95%
2. Level of client participation in active treatment is documented.	53 of 54	98%	95%

FINDINGS:

5 charts per unit per month (15 for the quarter) was the desired sample size. 15 charts each were reviewed on Upper Saco and Upper Kennebec. Lower Saco reviewed 13. Lower Kennebec reviewed 15 but 4 were not yet due at the time of the audit. 1 of the 2 indicators for this aspect was found above threshold.

PROBLEMS:

Insuring that the review note indicates changes made in the plan to implement further progress is below threshold by 4%. This is seen as a training/education issue, similar to that described in sections above. At closer review, most improvement is needed on Upper Saco on this aspect. Other units have used a template to guide progress notation with favorable results, and Upper Saco is just starting this process.

STATUS:

Program Service Directors re-instituted chart audits on this aspect and have achieved 90 % compliance. This was not tracked in the last quarter. They have continued to actively assist in training of nursing staff and managing of this objective. Nurse Educator has been offering training relevant to this aspect. A template was developed to prompt the note writers to include required information and, except on Upper Saco, nurses have been bringing the template to the meeting and writing their notes in keeping with that template.

ACTIONS:

- The corrective actions identified pertaining to treatment planning in the Comprehensive Service Plan section, along with the Program Service Directors’ active support of that training and education, will also serve to enhance this aspect of care. Eventually having a fully dedicated Nurse IV on Lower Saco will also help support these objectives in the day-to-day operation of that unit.
- Information gathered at the routine chart audits will assist in identifying continued areas of needed enhancement.
- All units will use the template developed to prompt note writers to include required information and nurses will be educated to write their notes in keeping with that template.

VOCATIONAL SERVICES PROGRAM

ASPECT: JOB COACH ATTENDANCE AT COMPREHENSIVE TREATMENT PLAN MEETING

OVERALL COMPLIANCE: 81 %

Indicator	Findings	Compliance	Threshold Percentile
The Job Coach will attend assigned clients’ treatment plan meetings.	59 of 73	81%	75%

FINDINGS:

The 14 meetings that were missed by job coaches were primarily due to the fact that a job coach was out due to sick leave or vacation. The other coaches would cover the clients that required supervision but would not be able to cover the team meetings. The one employee that was out on leave has returned.

PROBLEM:

Compliance is now above the threshold.

STATUS:

Of the 73 team meetings held this past quarter, job coaches attended 59 of them resulting in an overall compliance rate this quarter of 81%. This improved effort is due to improved communications and teamwork by the job coaches, thus helping us to increase our compliance this last quarter by 12% over last and meeting our threshold.

ACTIONS:

- There will be 2 more positions added to the department, one starting on January 8th and the second within the next two months. This will allow for more coverage when someone is out on vacation or sick.
- We will continue to implement the changes made last quarter. If the current threshold continues to be met, it will be raised further to help achieve an even higher standard of practice.

HEALTH INFORMATION SERVICES

ASPECT: CONFIDENTIALITY

OVERALL COMPLIANCE: 100%

Indicators	Findings	Compliance	Threshold Percentile
All client information released from the Health Information department will meet all JCAHO, State, Federal & HIPAA standards.	All requests met standards.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	4 new staff in Oct/Nov. 3 new staff/contract in	100%	100%
The Director of Health Information will track the number of confidentiality/privacy issues through incident reports.	0 for Oct., 0 for November, and 0 for December	100%	100%

FINDINGS:

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. 2110 out of 2110 (100%) requests for information (1905 police checks and 205 requests for client information) were released from the Health Information department during this quarter. 23 out of 23 (100%) new employees/contract staff attended Confidentiality/HIPAA training. All indicators remained at 100% compliance for quarter 2, FY 2006.

PROBLEMS:

None found.

STATUS:

No issues during quarter 2. Continue to monitor.

ACTIONS:

- The above indicators will continue to be monitored.

HEALTH INFORMATION SERVICES ASPECT: DOCUMENTATION & TIMELINESS
OVERALL COMPLIANCE: 95%

Indicators	Findings	Compliance	Threshold Percentile
Records will be completed within JCAHO standards, state requirements and Medical Staff bylaws timeframes.	There were 11 discharges in Oct. Of those, 10 were completed by 30 days.	91%	80%.
	There were 27 discharges in Nov. Of those 24 were completed within 30 days.	89%	80%.
	There were 25 discharges in December. Of those 21 were completed within 30 days.	84%	80%
Discharge summaries will be completed within 15 days of discharge.	11 out of 11 were completed within 15 days in October.	100%	100%.
	26 out of 27 were completed within 15 days in November.	96%	100%
	25 out of 25 were completed within 15 days in December.	100%	100%
Forms used in the medical record will be reviewed by the Medical Record Committee.	0 forms were approved/revised in Oct.	100%	100%
	0 forms were approved/revised in Nov.	100%	100%
	0 forms were approved/revised in December.	100%	100%
Medical transcription will be timely & accurate.	no errors/issues in Oct.	100%	90%
	no errors/issues in Nov.	100%	90%
	no errors/issues in Dec.	100%	90%

FINDINGS:

The indicators are based on the review of all discharged records. There was 88% compliance with record completion within 30 days. There was 100% compliance with discharge summaries. Weekly “charts needing attention” lists are distributed to all medical staff, including the Medical Director.

PROBLEM:

Discharge summary completion remains a problem, but improved this quarter (previous quarter 89% compliance).

STATUS:

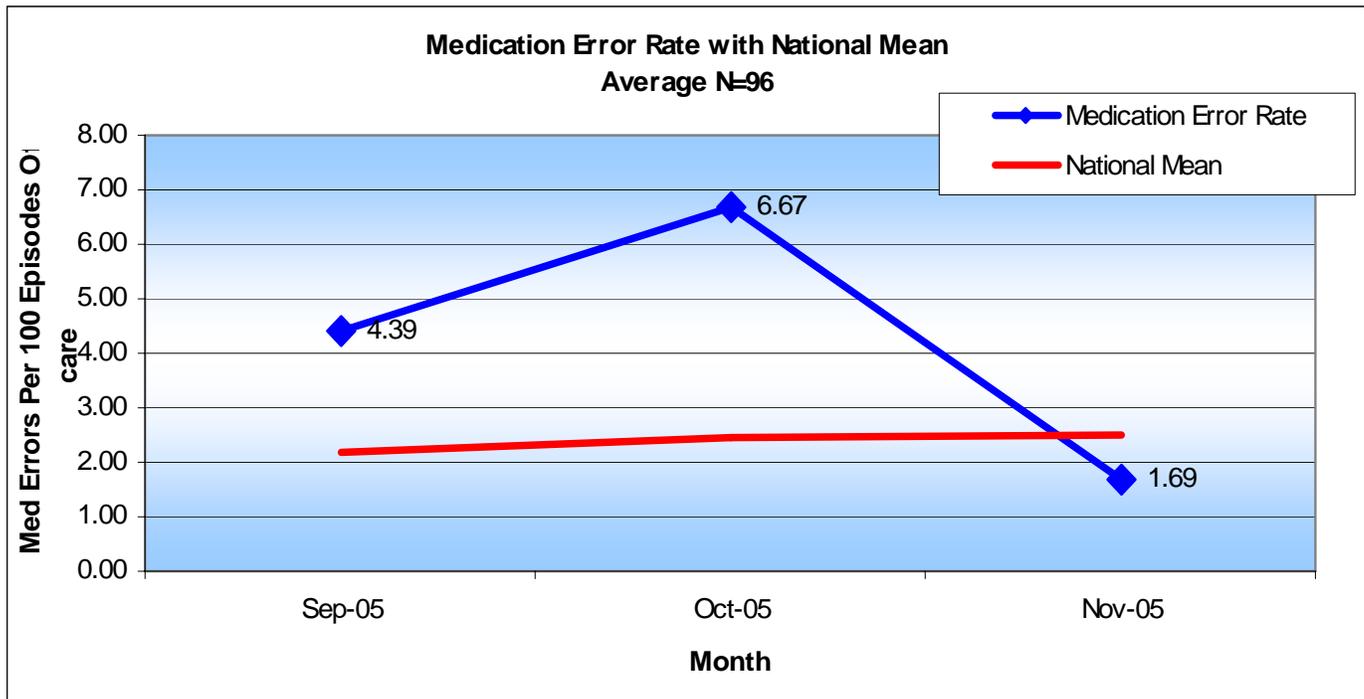
100% compliance rate with discharge summary completion.

ACTIONS:

- All Medical Staff receive weekly notification regarding charts needing attention. Medical Staff are notified via telephone call and or e-mail regarding any discharge summaries that need to be completed prior to deficiency. The above indicators will continue to be monitored.

HOSPITAL PERFORMANCE MEASURES

MEDICATION ERROR RATE-COMPARISONS WITH NATIONAL DATA

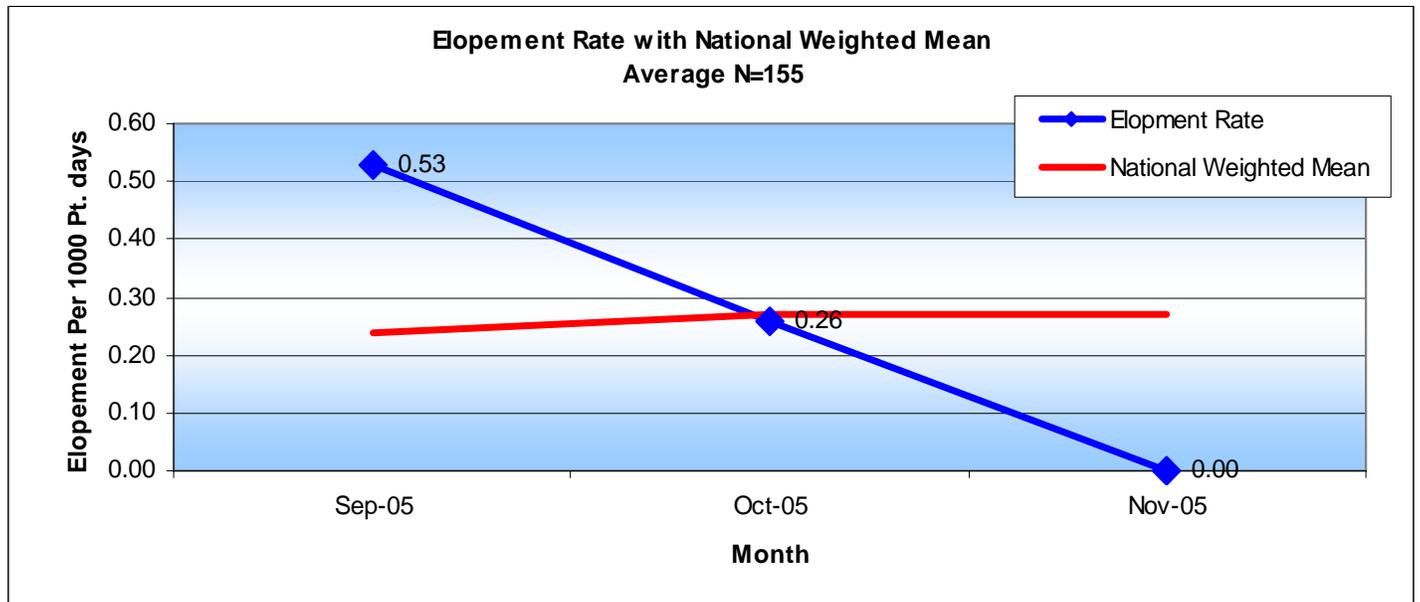


HOSPITAL PERFORMANCE MEASURES DISCUSSION

The hospital medication error rate continues to fluctuate. Riverview nursing leadership, P&T and Risk Management are working collaboratively to improve reporting by allowing anonymous reporting, and will continue to work on more strategies to improve the process of recognizing the importance of reporting all variances to allow the opportunity to fix system issues before they become medication variances that cause harm to clients.

There is a multidisciplinary Failure Mode and Effects Analysis (FMEA) currently in progress on identifying process issues.

ELOPEMENT RATE-COMPARISONS WITH NATIONAL DATA



HOSPITAL PERFORMANCE MEASURES DISCUSSION

ELOPEMENT

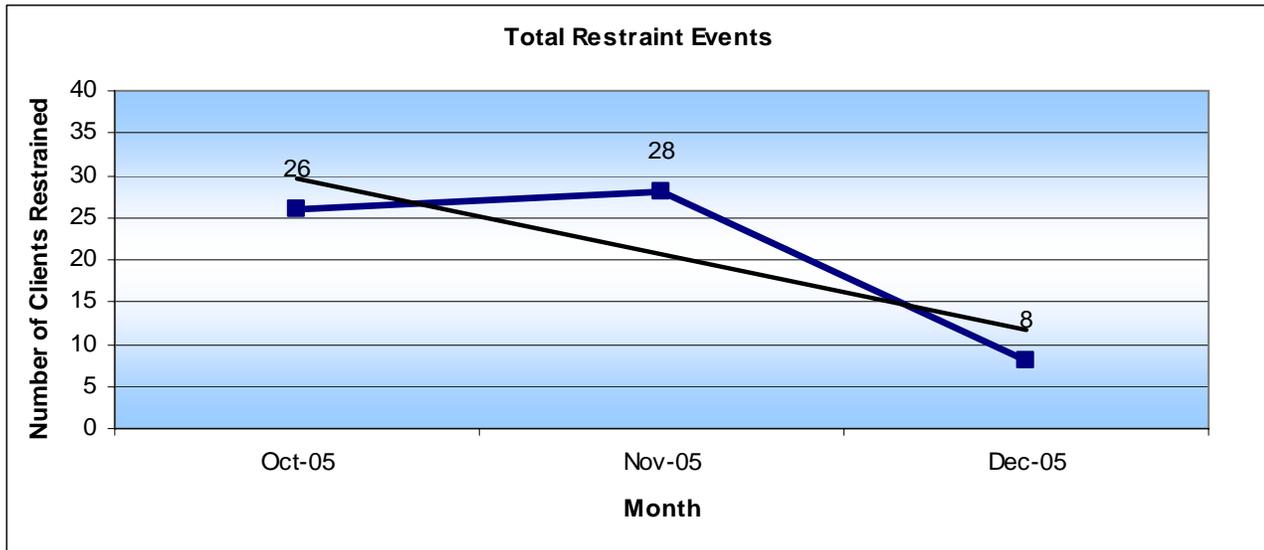
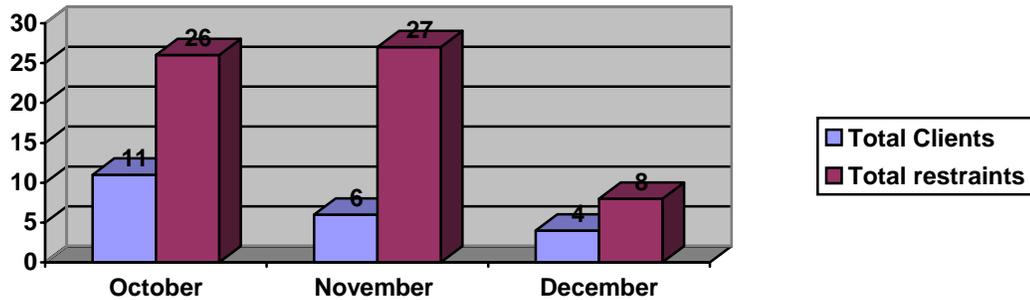
Eloperments are defined as any time a clients is absent without authorization, or fails to return when scheduled. There was a spike in September, which caused the development of a PIT or multidisciplinary Performance Improvement Team which developed recommendations and recently submitted them to the senior leadership for consideration.

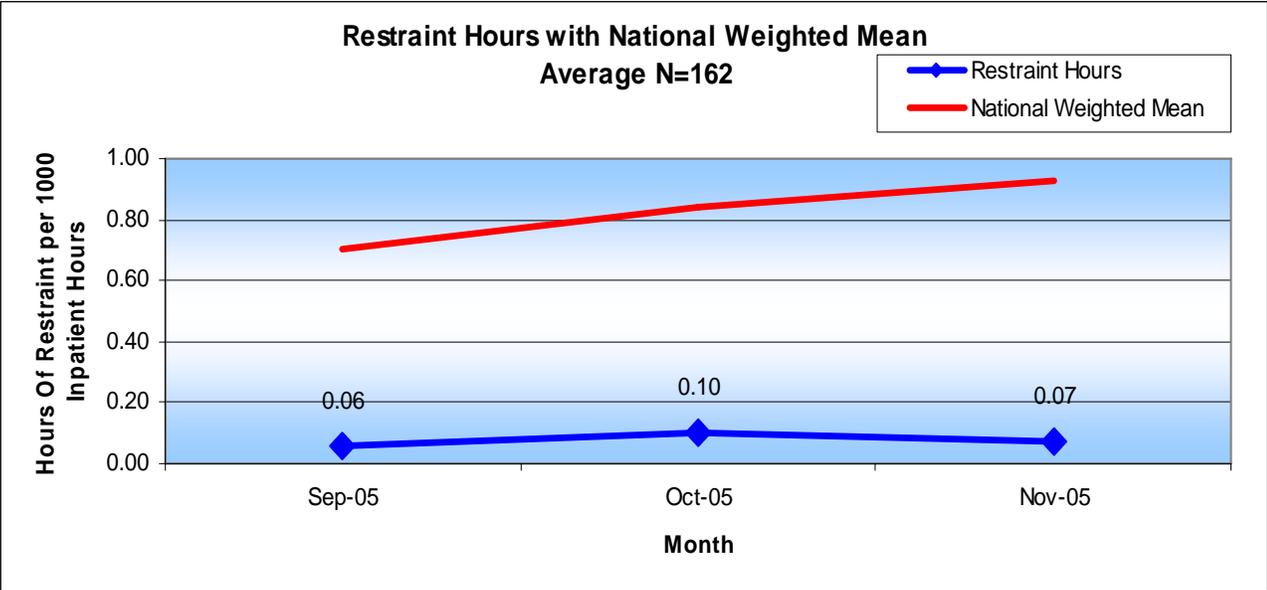
HOSPITAL PERFORMANCE MEASURES

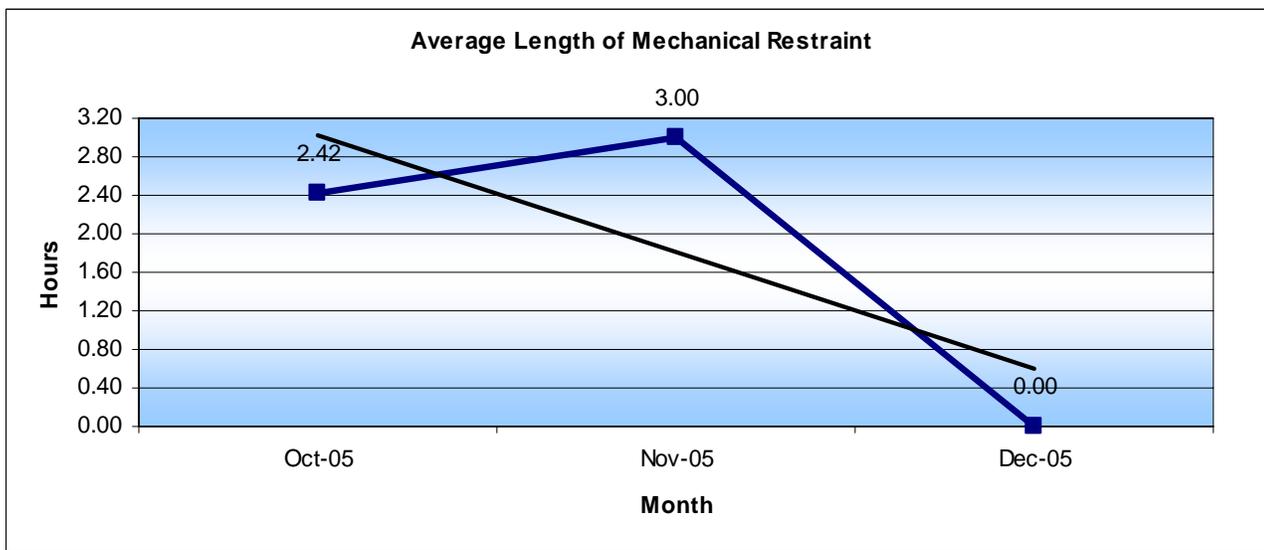
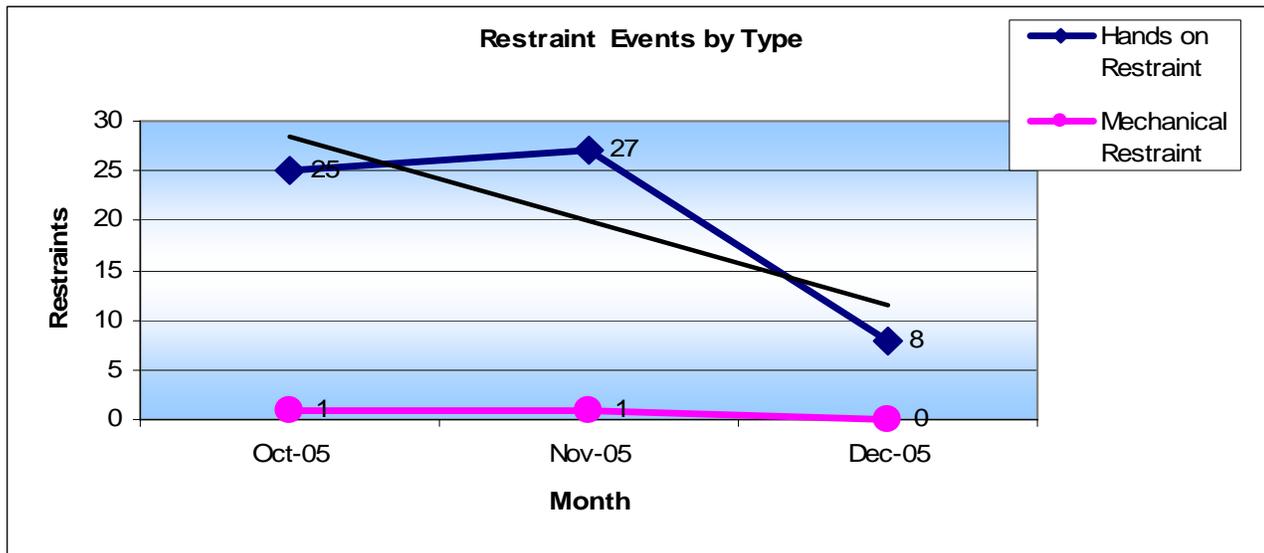
RESTRAINTS

The hospital celebrates a new first this quarter. There were no mechanical restraint events in the entire facility for the last six weeks of the quarter. The entire hospital has been working diligently to reduce seclusion and restraint. We have succeeded in markedly reducing the most restrictive type of restraint. The total numbers of hands on restraint events were up in October and November but dropped dramatically in December.

Hands on Restraint Events 2nd Quarter SFY06





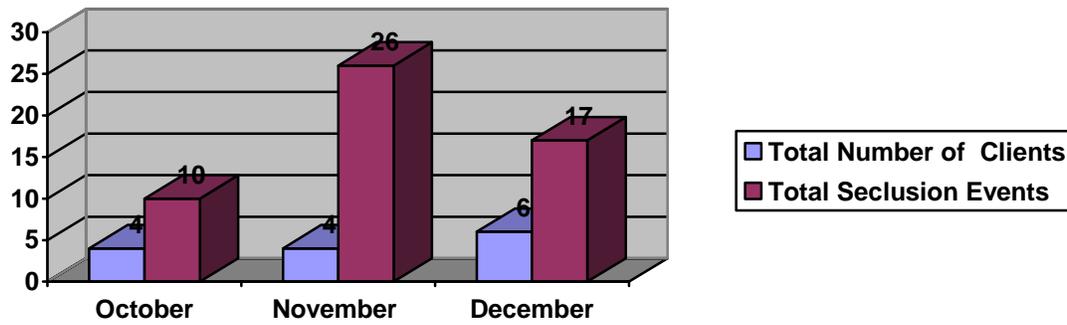


HOSPITAL PERFORMANCE MEASURES SECLUSIONS

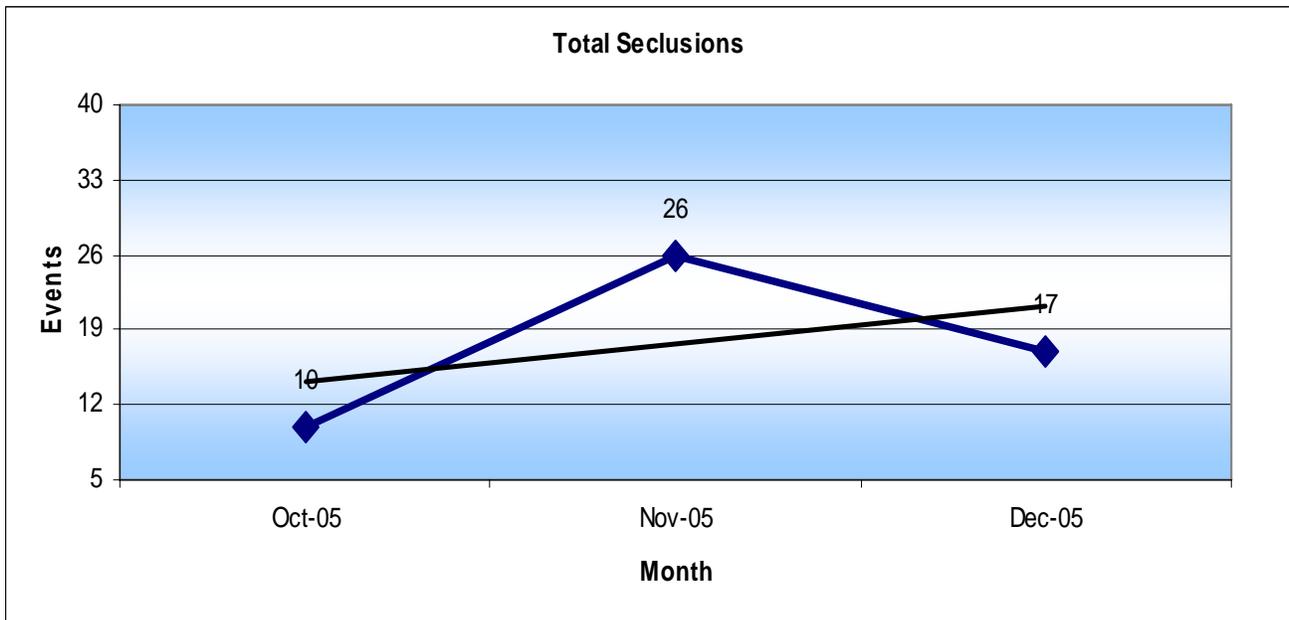
Along with restraints, the hospital has been working to decrease client seclusion events; it is a national initiative we endorse. Restraint and Seclusion are considered “treatment failures.” Such events are triggers to the treatment team to review a client’s plan of care within 72 hours to help address the client’s treatment needs.

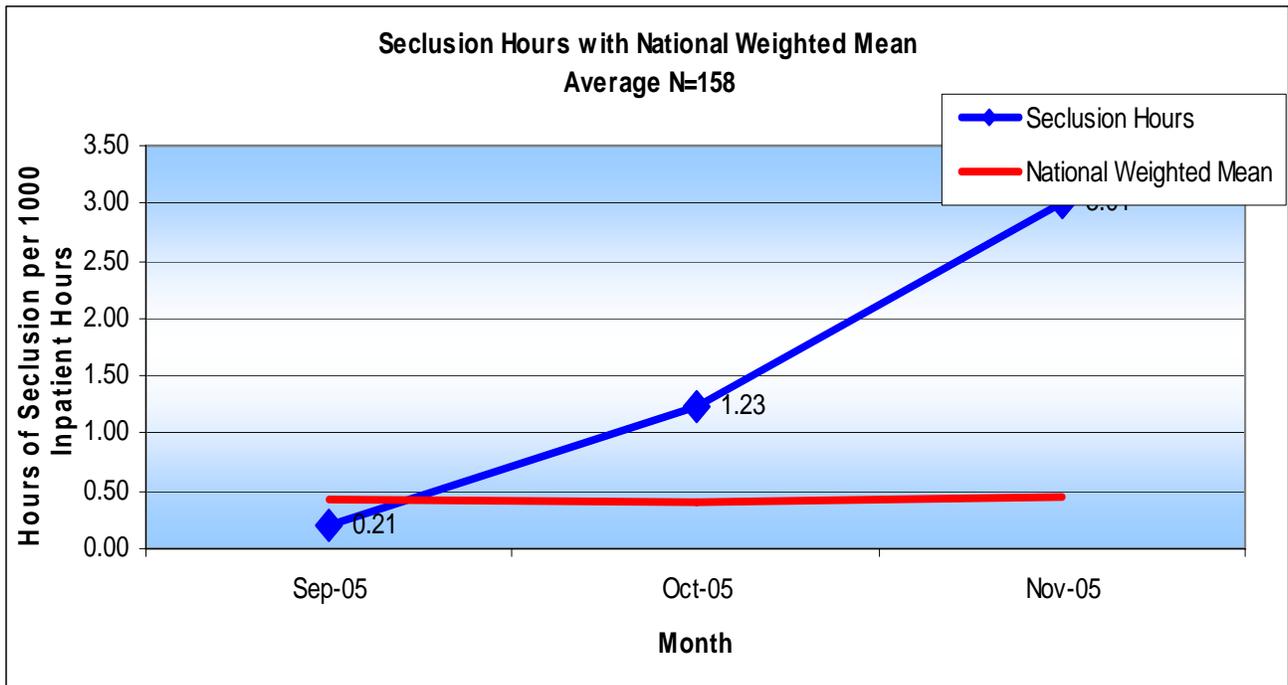
In August, October and November a spike in the total number of seclusion events occurred.

Seclusion 2nd Quarter SFY06



A select number of clients account for the total seclusion events.

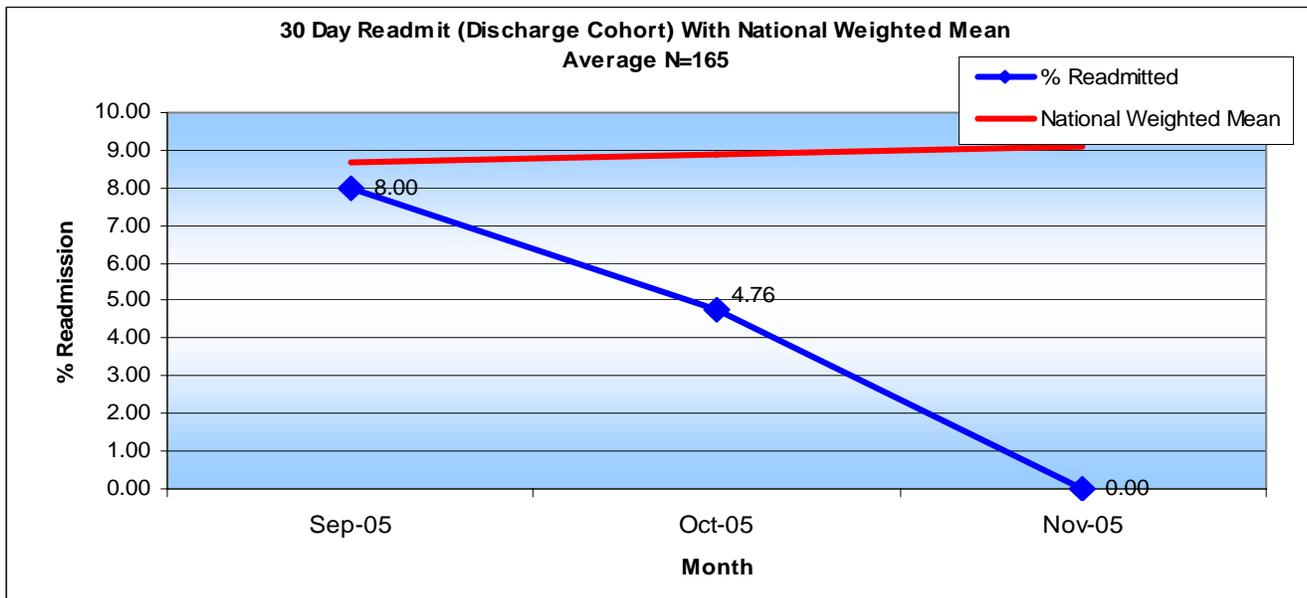




The plan to address increasing seclusion time is to restrict the physician's order to one hour and assess the client every 15 minutes.

HOSPITAL PERFORMANCE IMPROVEMENT

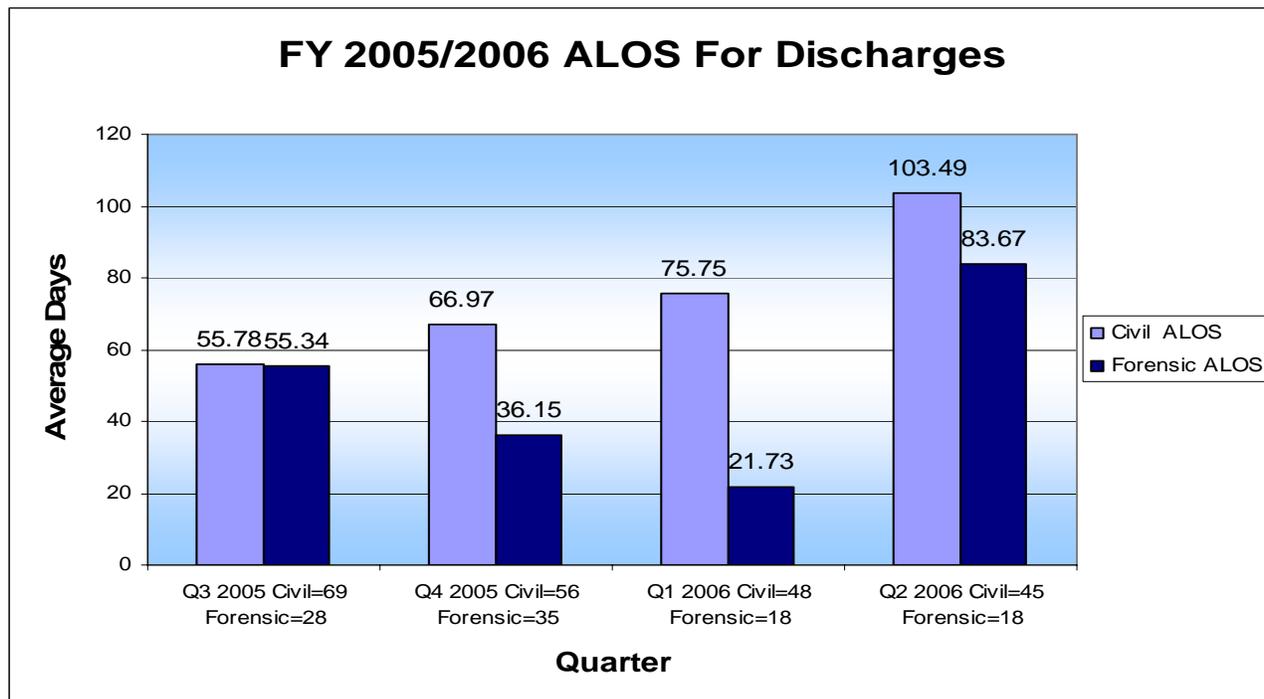
READMISSIONS



HOSPITAL PERFORMANCE MEASURES DISCUSSION

The graphs depicting the 30-day readmission rate show mixed results with a continued decrease for the measurement period.

AVERAGE LENGTH OF STAY FOR CLIENTS DISCHARGED FROM RIVERVIEW



HOSPITAL PERFORMANCE MEASURES DISCUSSION

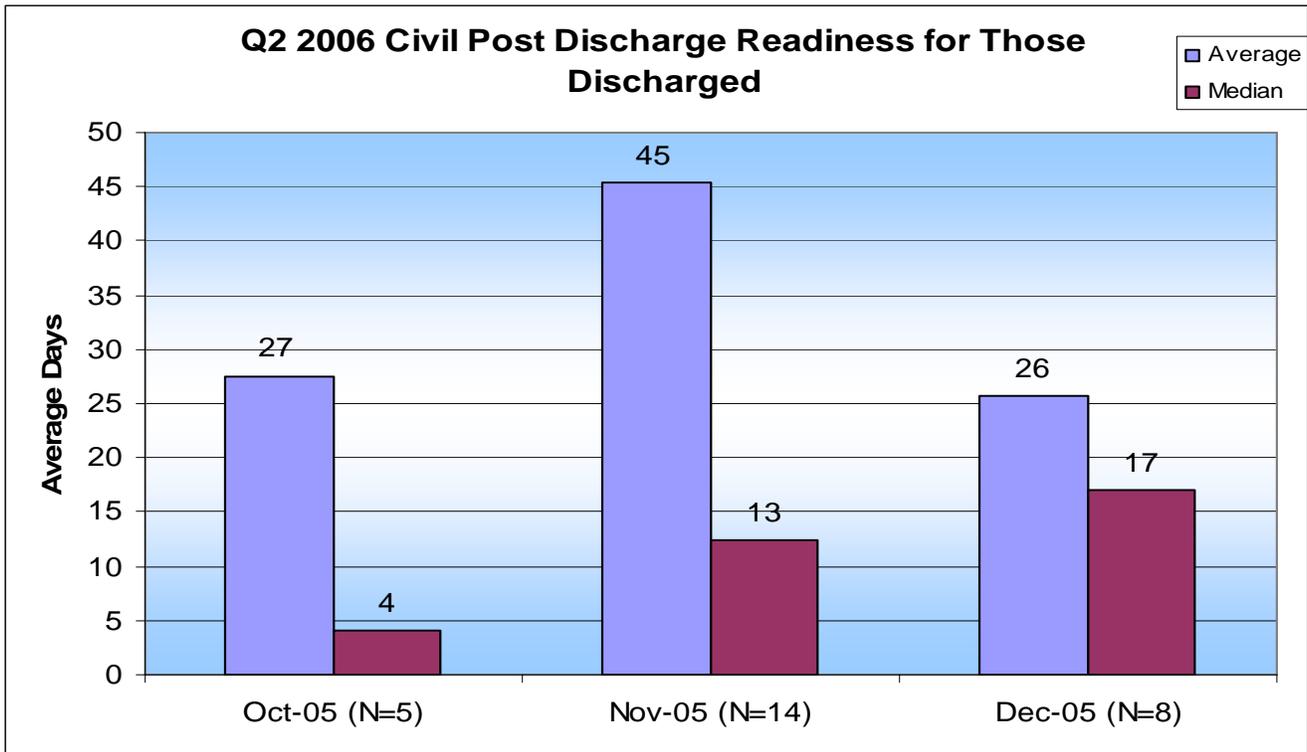
The hospital operates two distinct units for both the civil and the forensic population. The forensic units are Upper Saco and Lower Saco. Riverview's Upper Saco unit houses the long stay clients who have been adjudicated as "Not Criminally Responsible" (NCR) by the court. Given this population, there are typically very few clients discharged from that unit in any given quarter. The Lower Saco unit serves a forensic population that includes the short-term jail transfers, clients undergoing Stage III evaluations regarding competency to stand trial, and clients determined to be "Incompetent to Stand Trial" (IST) in the judgment of the court and where the unit is working to restore competency to do so. Upper Kennebec serves non-acute, longer-term civil clients. Lower Kennebec is the admissions unit for civil clients.

The average length of stay for the civil clients continues to increase over the past 4 quarters. Upon examination of the data in this quarter, there were 10 clients (22% of the population) with stays longer than 100 days who were finally discharged. Specifically there were 5 clients (11% of the whole) in the group with stays between 100-150 days, 4 clients (9% of the whole) with stays between 150-200 days, 4 clients (9% of the whole) with stays between 200 and 300 days, and 1 client (2% of the whole) with a stay of 686 days. This characteristic of the population significantly contributes to the "spike" in this quarter's measured average length of stay for civil clients discharged.

The average length of stay for the forensic clients had been decreasing over the same time frame until the dramatic increase this quarter. Similar to the sample of civil clients, there were also a number of forensic clients with long stays who were finally discharged. Specifically there were 4 clients (22% of the population) in the group with stays between 100-444 days. In short, the spike in ALOS for clients discharged this quarter represents success in making appropriate discharge arrangements for a number of clients with a long length of stay. The Department continues to conduct regular discharge meetings with community personnel to

facilitate placements, and the hospital provides a weekly report on all clients deemed ready for discharge to the Central and Regional Office.

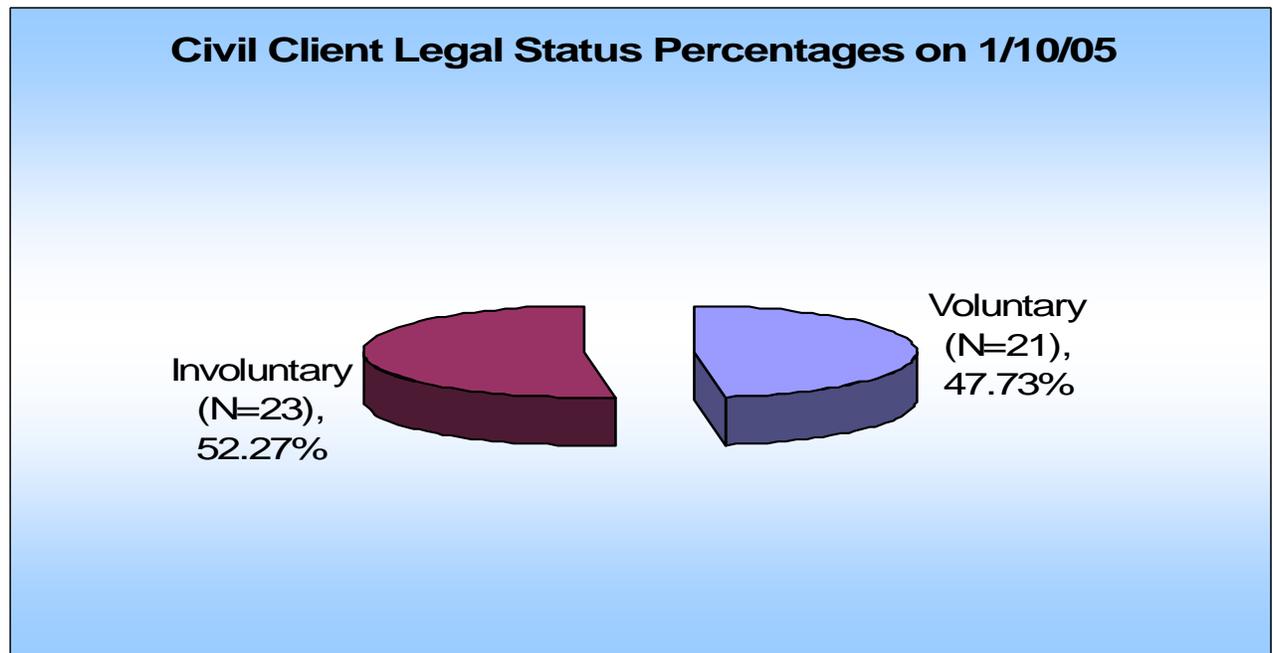
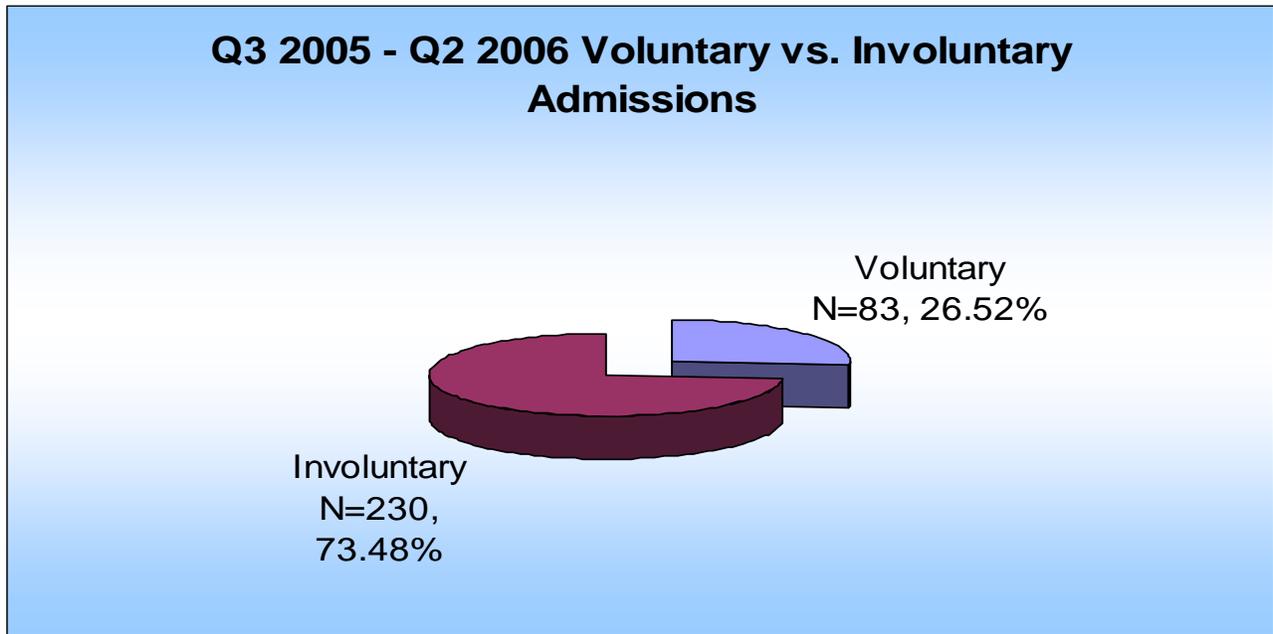
AVERAGE POST-DISCHARGE READINESS DAYS FOR CIVIL CLIENTS DISCHARGED



HOSPITAL PERFORMANCE MEASURE DISCUSSION

The hospital also collects data on the time that a client spends in the hospital after they have been determined ready for discharge, before they are actually discharged in “Post-Discharge Readiness” days. For civil clients the average time in October was 27 days (n=5), November 45 days (n=14), and December 26 days (n=8).

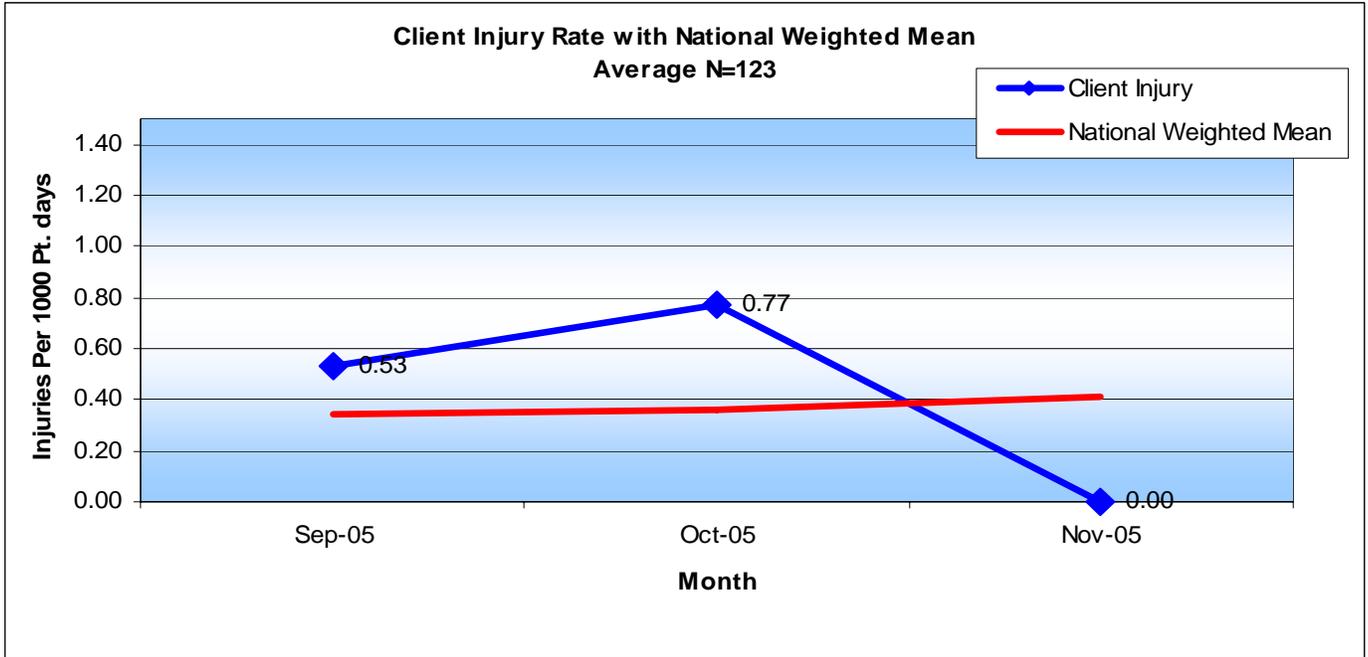
VOLUNTARY VS. INVOLUNTARY STATUS AT ADMISSION



HOSPITAL PERFORMANCE MEASURE DISCUSSION

The proportion of voluntary admissions to involuntary admissions has not appreciably changed over the past 4 quarters.

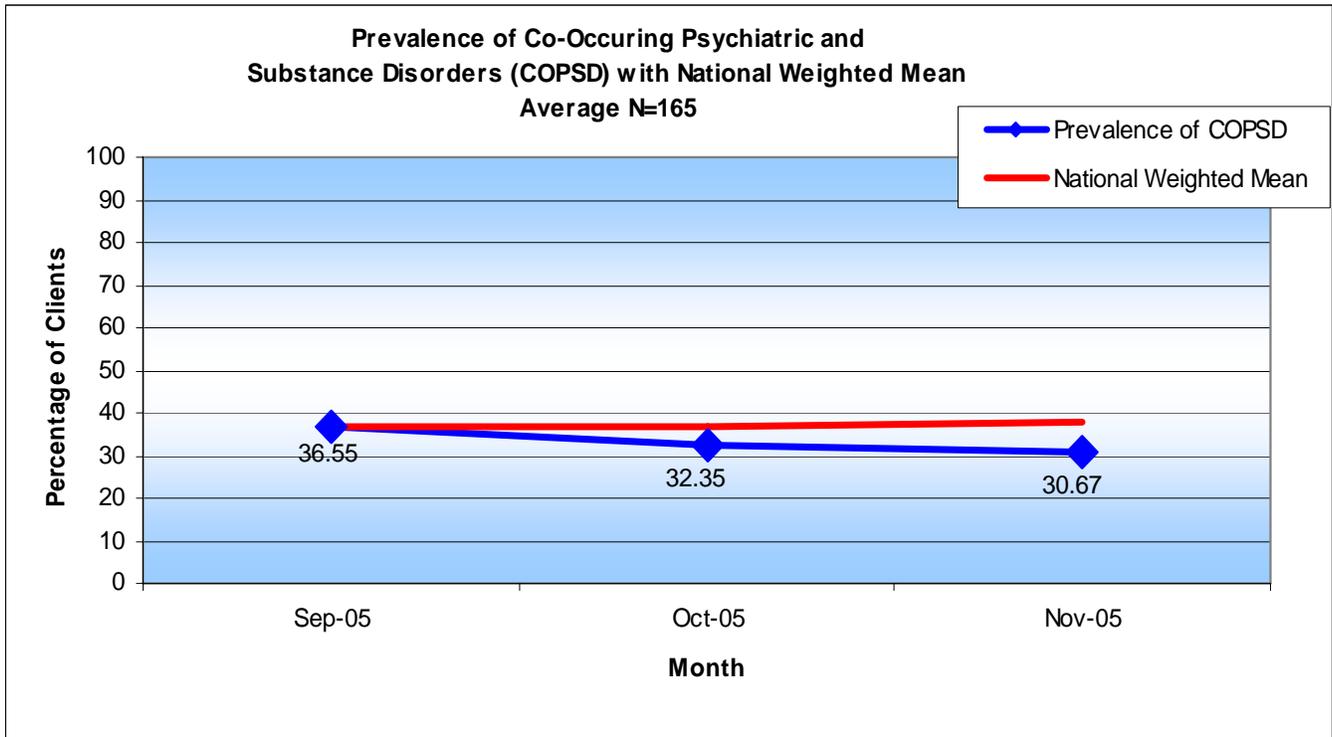
CLIENT INJURY RATE - COMPARISONS NATIONAL DATA



HOSPITAL PERFORMANCE MEASURE DISCUSSION

Client injuries have decreased as the facility has experienced less self-harm episodes. Client falls are now the largest category for this quarter. Nursing has addressed this with a fall reduction plan.

PREVALENCE OF CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS (COPSD)- COMPARISONS WITH NATIONAL DATA



HOSPITAL PERFORMANCE MEASURE DISCUSSION

Co-Occurring Disorders

Riverview serves a client population similar to the reported National Mean with respect to percentage of clients presenting with co-occurring psychiatric and mental health disorders. Identified clients are offered a variety of groups according to their level of engagement and these interventions are reflected in the client's treatment plan.

Riverview's Department of Psychology in a six-month pilot project through a chart review process of all civil client admissions independently estimated the percentage of clients presenting with co-occurring psychiatric and mental health disorders at about 60%. These chart reviews (and at times brief follow-up assessments) were done after the physician's initial admission diagnosis was formulated, generally within 48 hours of admission. During this pilot study it was also noted that the number of subsequent referrals and the degree to which clients were referred to the appropriate level of group improved.

The psychology department contracted personnel who conducted the pilot project (Crisis & Counseling Inc.) have discontinued their contract with Riverview and the review and brief assessment process which served to quickly identify clients for whom services would be appropriate was discontinued. .

ACTIONS:

- Psychology staff members, a licensed social worker, and a nurse have been identified as personnel qualified and willing to continue to offer co-occurring disorders groups once covered by contracted personnel. On the treatment mall these groups include: “Pathways to Recovery” a pre-contemplative group; Dual Diagnosis group; and Hollywood and Addiction. “Radical Acceptance” is offered weekly on one of the units and AA/NA is peer lead and also offered weekly on the treatment mall. In addition there are two peer lead community self-help groups offered in our building each week, Alcoholics Anonymous and Narcotics Anonymous. These groups will all continue to be offered this quarter.
- Develop a new contract for co-occurring services and pursue aggressively.
- Explore options with Maine Medical Center and Spring Harbor Hospital for utilization of COSIG funds (State Incentive Grant for Treatment of Persons with Co-occurring Substance Related and Mental Health Disorders) to obtain consultation services. An initial meeting was held on 1-4-06.
- Consult with the Riverview Medical Director and medical staff regarding pilot study findings of under diagnosis of co-occurring disorders. Develop follow-up training as needed.
- The Director of Psychology and the Director of Nursing will review admissions assessment process, research alternative assessment tools, and make recommendations as to changes needed to better facilitate assessment of co-occurring disorders upon admissions.
- Develop a core group of trained staff to champion co-occurring disorders treatment and to provide motivational enhancement. (Note: Fourteen staff members recently received training in Motivational Interviewing techniques.)