



# Performance Improvement Report

Third Quarter  
SFY 06

January, February and March

David Proffitt, Superintendent

## Table of Contents

<b>Introduction</b>	page 3
<b>Management of Financial Resources</b>	page 4
<b>Management of Human Resources</b>	page 4
<b>Professional and Organizational Development</b>	page 7
<b>Infection Control</b>	page 8
<b>Medical Staff- Internal Peer Review</b>	page 9
<b>Aspect: Medical Staff Prescribing Errors</b>	page 9
<b>Aspect: Review of Medical Staff Progress Notes</b>	page 10
<b>Aspect: Appropriate use of typical anti-psychotics in psy disorders</b>	page 10
<b>Aspect: Monitoring for IV Sedation in Portland Clinic</b>	page 11
<b>Aspect: Capitol Community Clinic</b>	page 12
<b>Nursing</b>	page 12
<b>Aspect: Pain Management</b>	page 13
<b>Aspect: Chart Review</b>	page 14
<b>Aspect: Nursing Documentation</b>	page 15
<b>Program Service Directors</b>	
<b>Aspect: Comprehensive Service Plans</b>	page 16
<b>Aspect: Service Plan Reviews</b>	page 17
<b>Aspect: Integrated Summary Note</b>	page 18
<b>Aspect: Progress Note</b>	page 19
<b>Peer Specialists</b>	page 19
<b>Rehabilitation</b>	
<b>Aspect: Client Attendance at the Harbor Mall</b>	page 20
<b>Vocational Services Program</b>	page 21
<b>Health Information Services</b>	page 22

## HOSPITAL PERFORMANCE MEASURES

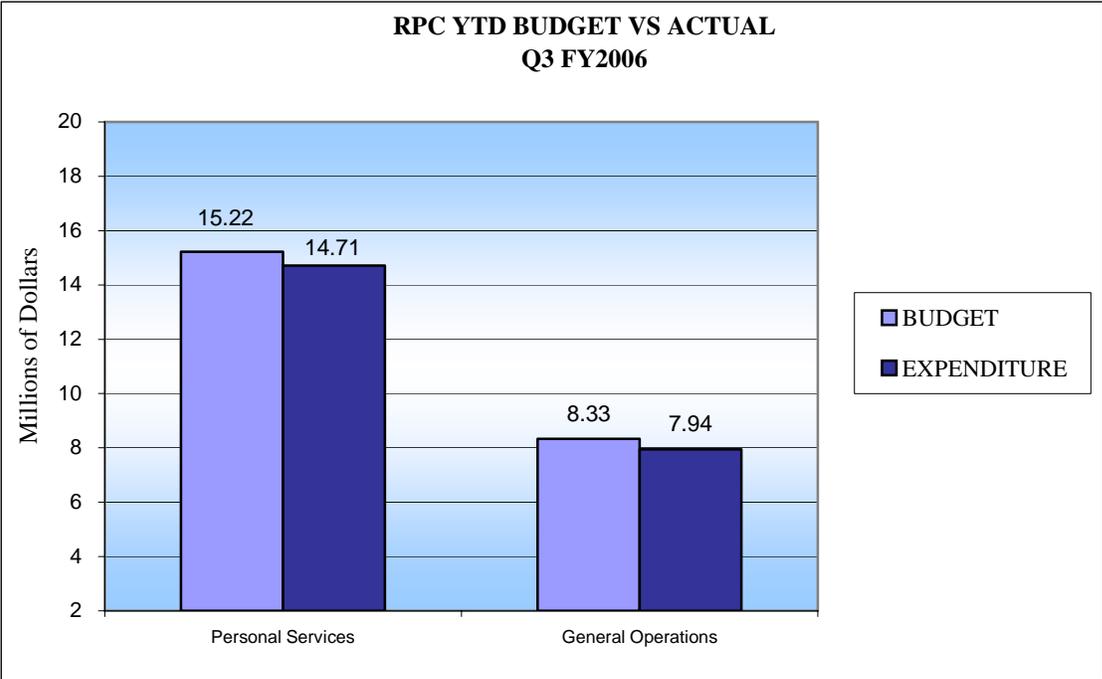
<b>Medication Error Rate-Comparisons with National Data</b>	page 24
<b>Elopement Rate-Comparisons with the National Data</b>	page 24
<b>Restraints</b>	page 25
<b>Seclusions</b>	page 28
<b>Readmissions within 30 days</b>	page 29
<b>Average Length of Stay</b>	page 30
<b>Average Post Discharge Readiness Days for Civil Clients Discharged</b>	page 31
<b>Client Injury Rate compared with National Data</b>	page 32
<b>Prevalence of Co-Occurring psychiatric and Substance Abuse Disorders - Comparisons with National Data (COPSD)</b>	page 33

## **Introduction:**

Riverview Psychiatric Center (RPC) has the **mission** to provide state of the art care to individuals with serious and persistent mental illness in Maine. RPC's **vision**, in collaboration with the community, will be a center for best practice, treatment, education and research for individuals with serious and persistent mental illness. The RPC **values** are to always treat clients with Respect and Dignity, Patients First, and Caring and Compassion.

The Riverview Process Improvement Quarterly report does consider the aims for improvement and process changes by reviewing departmental quality indicators, high risk, high volume information and national indicator information that displays how RPC compares to like facilities throughout the country. Most importantly, it describes the steps RPC intends on undertaking, to constantly improve.

# Management of Financial Resources



For the second straight year, the hospital is operating within its budget, through aggressive management of all contractual services via fiscal and programmatic accountability.

# Management of Human Resources

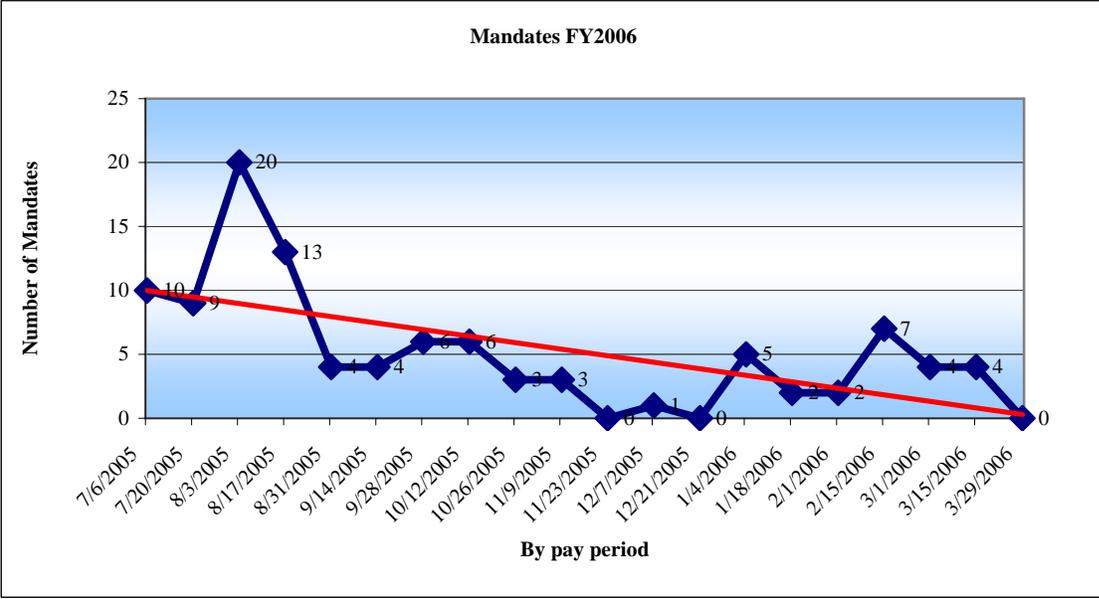
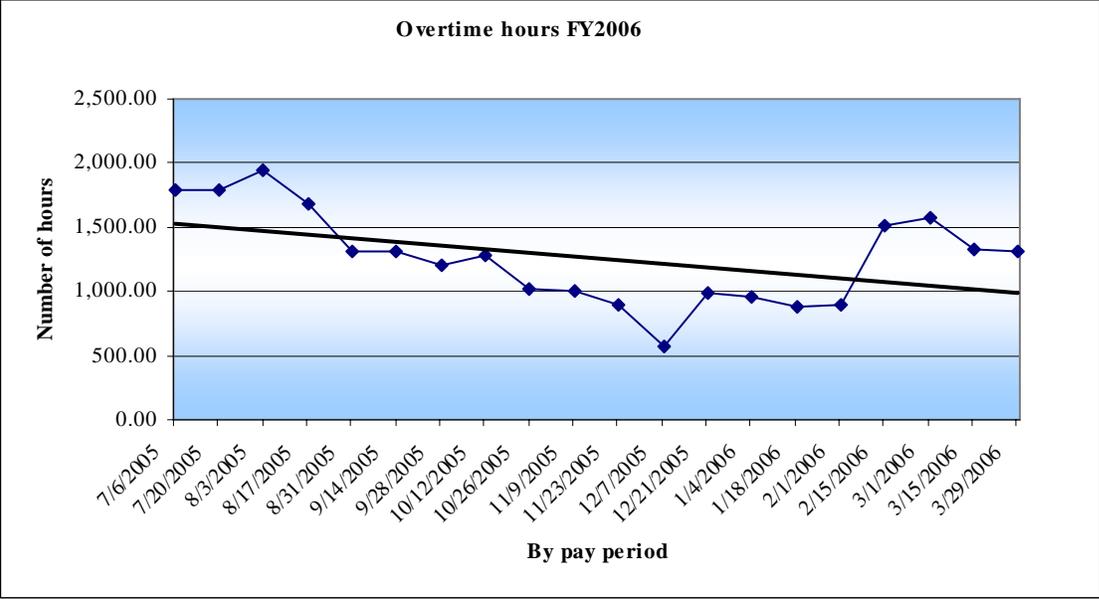
**Aspect:** Performance Evaluations

**Overall Compliance:** 52%

<u>INDICATOR</u>	<u>FINDINGS</u>		<u>TARGET PERCENTILE</u>
Employee Performance Evaluations expected to be completed within 30 days of the due date.			
Jan 2006 (November evals)	17 of 33	52%	85%
Feb 2006 (December evals)	16 of 29	55%	85%
Mar 2006 (January evals)	14 of 29	48%	85%

Human Resources will continue to monitor and report on a regular basis to Executive Leadership concerning the progress of compliance.

**Management of Human Resources**  
**Aspect: Staff Overtime and Staff Mandates**



**Findings:**

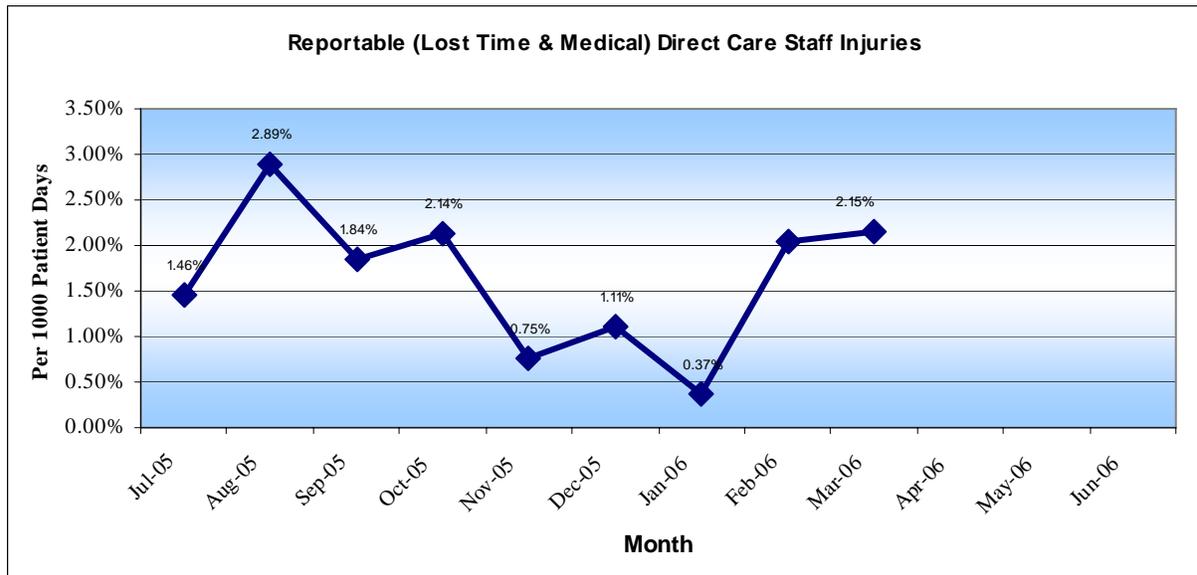
Both Staff Overtime and Mandated shifts have increased from last quarter. This is attributed primarily to having two clients transferred from MSP who required 2:1's staffing during most of this quarter. Additionally, several employees re-applied for intermittent Family Medical Leave resulting in overtime or mandates.

**Actions:**

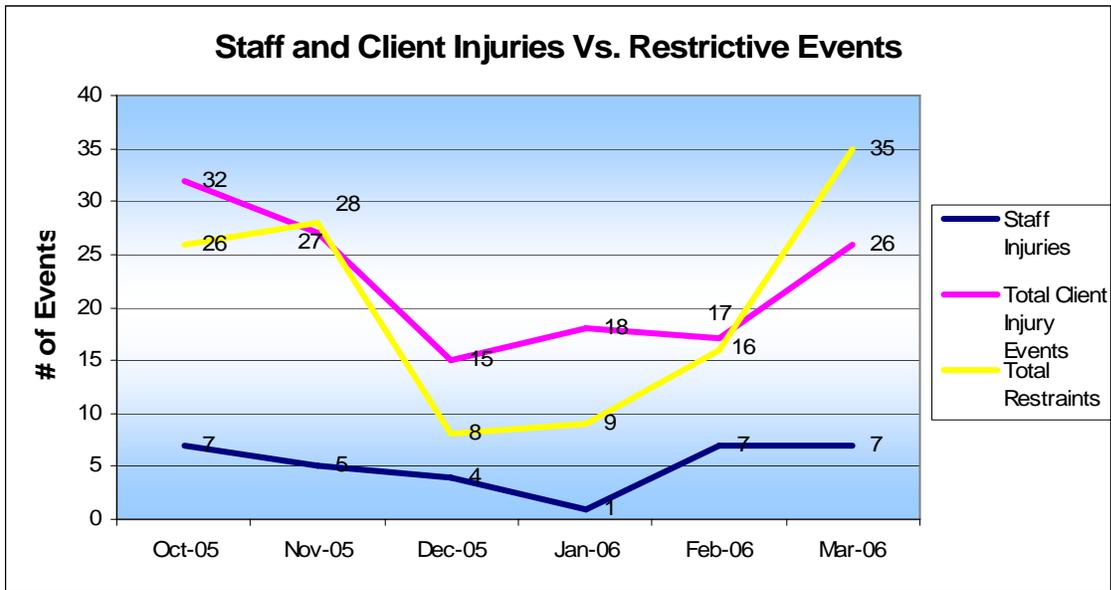
A multidisciplinary Staffing Oversight committee was formed to look at ways to improve mix of staffing on the units as well as reduce overtime utilization and decrease mandates.

## Management of Human Resources

Aspect: Direct Care Staff Injury Lost Time and Medical Care



This quarter noted an increase in direct care staff injuries from an overall of 1.33% for last quarter to 1.52% for this quarter. This percentage represents 13 direct care staff that sought medical treatment or lost time from work, as compared to 11 last quarter. Training continues for staff on new techniques and recommendations by the Behavioral Response Committee. Compared to the same time period last year (Jan 05 - Mar 05) when RPC had an average of 1.66% of direct care injuries per 1000 patient days. Staff injuries from combative clients continue to remain the single major cause of lost time and medical injuries. The Behavioral Response Leadership Committee is developing additional teaching modules to increase unit leadership during emergency situations; to increase confidence of employees in handling behavioral situations in the most therapeutic and safe manner.



The hospital continues to emphasize in its training to staff, that restraint events present the greatest risk of injury to staff and client alike. A great deal of effort by the hospital administration, Staff Development and Education, NAPPI training is directed toward alternatives to restraints, redirections, verbal engagements, and therapeutic interventions.

### Professional and Organizational Development

**Aspect:** Hospital Orientation

**Overall Compliance:** 100%

INDICATORS	COMPLIANCE		THRESHOLD
All new staff hired by Riverview Psychiatric Center will complete an Orientation to the hospital prior to assuming their duties.	12 of 12	100%	100%

**Findings:** In the 3<sup>rd</sup> quarter of 2006 Riverview Psychiatric Center hired 13 state employees. One employee resigned prior to finishing orientation.

**Actions:** Staff Development will work with Human Resources in completing Orientation.

## Infection Control

**Aspect:** Hospital Infection Control

**Overall Compliance:** Hospital average (36 months): 2.87

<b>Indicators Jan., Feb., Mar. 2006</b>	<b>Number</b>	<b>Rate</b>	<b>Threshold Rate</b>
Hospital Acquired (healthcare associated) infection rate, based on 1000 patient-days	20	2.52	2 standard deviations (5.26)

**Findings:** Infection rate is obtained by total house surveillance, accomplished by chart reviews, review of antibiotic prescribing (for infections or prophylaxis) and clinical staff reporting. According to the Maine CDC, reported cases of influenza and influenza like illness have peaked during late March throughout Maine and New England.

**Problem:** None noted.

**Status:** Hospital acquired infection rate for this period was 2.52, slightly below our 36-month average and well within the 2 standard deviation threshold of action

**Actions:** Influenza and influenza-like illnesses (ILI) among clients monitored. Staff and client education continued from last quarter through email updates and new signage. Hand hygiene and respiratory etiquette continue to be stressed to clients and staff. Information regarding general infection control information was sent to staff by the Medical Director and the Infection Control Nurse regarding general infection control and standard precaution information.

## Medical Staff

**Aspect:** Internal Peer Review of Medical Staff Documentation of Physical Exam

**Overall Compliance:** 83%

January, February, March, 2006			
Indicator	Findings	Compliance	Target%
Total documentation of physical exams reviewed will meet minimum passing requirements as detailed in the "physical exam peer review form."	18 of 21 notes met minimum requirements	86%	90%
All individual practitioner's documentation of physical exams will meet minimum passing requirements.	4 of 5 individuals met minimum requirements	80%	100%

**Findings:** The documentation of individual physical exams continues to fall below the target compliance rate of 90%. It is significantly improved from last quarter score of 72%. One after-hours practitioner fell below standard, accounting for the bulk of the variance.

**Problem:** One practitioner's performance below expectations.

**Status:** Overall compliance dropped this quarter from 86% to 83%.

**Actions:** Documentation of physical exams will be discussed at the after-hours medical staff meeting on April 11, 2006. Continue to monitor and discuss at Medical Staff meetings. The one practitioner that was below standard will be counseled by the Medical Director.

## Medical Staff

**Aspect:** Staff Prescribing Errors

**Overall Compliance:** 100%

January, February, March 2006			
Indicator	Findings	Compliance	Target %
No medical staff members will have more than two prescribing errors in any given month.	None in Jan 1 in Feb 1 in March	100%	100%

**Findings:** There were two prescribing errors by two practitioners in the 3<sup>rd</sup> quarter. Neither error resulted in significant negative client outcome.

**Problem:** None noted.

**Status:** Medical staff continues to have very low levels of prescribing errors.

**Actions:** Continue to monitor

### Medical Staff

**Aspect:** Review of Medical Staff Progress Notes

**Overall Compliance:** 98%

January, February, March, 2006			
Indicator	Findings	Compliance	Target %
Total progress notes reviewed will meet minimum passing requirements as detailed in the "progress note peer review form."	105 of 109 notes met minimum requirements	96%	90%
All individual practitioner's progress notes will meet minimum passing requirements.	11 of 11 individuals met minimum requirements	100%	100%

**Findings:** Four progress notes out of 109 reviewed in the third quarter fell below the passing threshold of 90%. Psychiatric staff is performing very well on this monitor.

**Problem:** None noted.

**Status:** The overall compliance went up from 95% to 98%

**Actions:** Continue to monitor.

### Medical Staff

**Aspect:** Appropriate use of typical antipsychotics in psychotic disorders

**Overall Compliance:** 100%

January 2006			
Indicator	Findings	Compliance	Target %
All use of typical antipsychotic monotherapy will meet agreed upon clinical indications	7 clients rec'd 7 clients met clinical criteria	100%	100%
February 2006			
All use of typical antipsychotic monotherapy will meet agreed upon clinical indications	9 clients rec'd 9 clients met clinical criteria	100%	100%
March 2006			
All use of typical antipsychotic monotherapy will meet agreed upon clinical indications	9 clients rec'd 9 clients met clinical criteria	100%	100%

**Findings:** Use of typical antipsychotic monotherapy increased slightly over the 3<sup>rd</sup> quarter.

**Problems:** No problems detected. Medical staff is prescribing typical antipsychotics appropriately.

**Medical Staff**

**Aspect:** Monitoring for IV Sedation in Portland Clinic

**Overall Compliance:** 100%

January 2006			
Indicator	Findings	Compliance	Target%
Sedation patients will have an O2 sat on room air of 92% or greater before going to recovery	13 pts sedated	100%	100%
	Lowest baseline SAT 94%		
	Lowest final SAT 94%		
February 2006			
Sedation patients will have an O2 sat on room air of 92% or greater before going to recovery	20 pts sedated	100%	100%
	Lowest baseline SAT 92%		
	Lowest final SAT 92%		
March 2006			
Sedation patients will have an O2 sat on room air of 92% or greater before going to recovery	28 pts sedated	100%	100%
	Lowest baseline SAT 93%		
	Lowest final SAT 92%		

**Findings:** 61 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 SATs both pre-op and prior to admission to recovery. Continue to report at monthly staff meeting and send quarterly report to the Medical Director. Add the time documentation to the next quarter at expectation threshold 100%.

## Medical Staff

**Aspect:** Capitol Community Clinic- Tracking Forensic Clients

**Overall Compliance:** 100%

Indicator	Compliance	Findings	Threshold
Track forensic client psychiatric appointments to ensure compliance with court	All community forensic patients will be seen as mandated by court.	98% compliance with court mandated psychiatric appointments.	100%

**Findings:** January 2006: 20 scheduled appointments with the psychiatrist: 31 scheduled appointments with the nurse practitioner; February 2006: 26 scheduled appointments with the psychiatrist: 19 appointments with the nurse practitioner; March 2006: 24 scheduled appointments with the psychiatrist: 23 scheduled appointments with the nurse practitioner;

**Status:** 98% compliance with court mandated psychiatric appointments.

**Problems:** 3 missed appointments in January due to physical illness.

**Actions:** All 3 appointments were rescheduled to February 2006.

## Nursing

**Aspect:** Seclusion and Restraint Related to Staffing Effectiveness

**Overall Compliance:** 97%

Indicators	Findings	Compliance	Threshold Percentile
Seclusion/Restraint related to staffing effectiveness:			
1. Staff mix appropriate	76 of 76	100%	100%
2. Staffing numbers within appropriate acuity level for unit	76 of 76	100%	100%
3. Debriefing completed	66 of 76	87%	100%
4. Dr. Orders	76 of 76	100%	100%

**Findings:** All staff effectiveness indicators are at 100% with the exception of debriefing at 87%. The average is 97%.

**Problem:** Staff debriefing continues to be below threshold. The problem is primarily on two of the four units. Of the ten missing debriefings, one unit had eight, and another unit had

two. This is relative to the volume of events on the respective units.

**Status:** Compliance has increased for the indicator of staff debriefing from 78% to 87 %.

**Actions:** A new debriefing protocol was developed last quarter. Each time a debriefing is not completed, the Risk Manager notifies the PSD, Nurse IV and Nurse who signed the incident report to have the debriefing sent to the Risk Manager. Next quarter a copy will be requested to be sent to the ADON as well.

## Nursing

**Aspect:** Pain Management

**Overall Compliance:** 97%

Aspect	Indicator	Findings	Compliance	Threshold
Assessment	Assessed upon admission.	105 of 106	98%	85%
	Assessed using pain scale.	46 of 47	98%	95%
Pre-administration	Assessed using pain scale	963 of 979	98%	95%
Post-administration	Assessed using pain scale	911 of 979	93%	95%

**Findings:** All admissions are assessed using the pain scale upon admission. Of the 106 charts audited upon admission, 47 identified pain as being present. Pain assessment data continues to be collected weekly from each unit for every client receiving PRN pain medication for the assessment of pre and post administration pain level. Again this quarter, only one of the audited charts assessed pain as being present upon admission, but did not use the pain scale to rate the level of pain. All aspects were above threshold with the exception of using the pain scale for post-administration of a pain medication.

**Problems:** One audited chart (client refusal) that did not rate the pain upon admission.

**Status:** Pain assessment upon admission decreased from 100% to 99% due to the one chart not in compliance. Assessment utilizing a pain scale increased from 86% to 98%.

Remaining indicators reflect the assessment and reassessment of pain pre and post administration of PRN pain medication.

**Actions:** 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.

## Nursing:

**Aspect:** Chart Review Nursing Assessment

**Overall Compliance:** 81 %

Aspect	Indicator	Findings	Compliance	Threshold Percentile
Universal Assessment	Universal Assessment completed by RN within 24 hours.	64 of 67	96%	100%
	Sections completed/deferred with documentation.	35 of 69	51%	85%
	Initial nursing care plan initiated.	68 of 68	100%	100%
	Item's triggered to integrated problem needs	41 of 67	61%	85%
	All sheets authenticated by assessing RN	66 of 69	96%	100%

**Findings:** All 67 charts had a nursing assessment initiated, however, three were incomplete. 24 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 within 24 hours due to client inability. The indicator for RN signing all sheets increased from 91% to 96%, however remains slightly below threshold.

**Problem:** While the sections on the assessment were deferred, this was not reflected in the admission note in 49% of the audited charts. Three charts universal nursing assessment were not complete in 24 hours due to client inability. All indicators are below threshold with the exception of initiating care plan. During this period, changes in nursing leadership negatively impacted training and monitoring, resulting in performance decline.

**Status:** All sections completed or deferred with documentation decreased from 63% to 51%. Overall compliance has decreased from 92 % to 81% since last quarter. The universal assessment compliance has decreased from 99 % to 96% this quarter. Initiation of a nursing care plan remains the same at 100%. Items triggered to integrated problem needs decreased from 81% to 61%. All sheets authenticated by an RN increased from 91% to 96%. The problems are a combination of performance and process.

**Actions:** The Nurse Educator will reinforce the need to document all deferred sections of the assessment in the admission note. Nursing Leadership group will meet to explore more effective methods of achieving a better understanding of documentation requirements. Documentation will be reviewed, reassessed for usefulness, and new methods of documentation will be developed by the end of June if deemed necessary.

## Nursing

**Aspect:** Nursing Documentation

**Overall Compliance:** 79%

Aspect	Indicator	Findings	Compliance	Threshold Percentile
Documentation	1. NAP notes at a minimum			
	a. Identifies STG goal/objective.	89 of 109	81%	90%
	b. Once per shift either MHW/RN	81 of 109	74%	95%
	c. Minimally Q24 hours RN.	99 of 109	91%	95%
	d. MHW notes countersigned by RN	101 of 106	95%	90%
	2. Active Treatment			
	a. Identifies Intervention	90 of 107	85%	90%
	b. Describes intervention.	30 of 70	28%	90%
	c. Assessment Completed.	102 of 108	94%	90%
	d. Plan	94 of 108	87%	90%

**Findings:** Two indicators added this quarter include “Once per shift MHW or RN” and “Minimally Q24 hours RN.” This data suggests that RN documentation occurs per RPC standard, 91% of the time. Overall MHW/RN documentation of 74% compliance is under threshold of 95%. The 20 progress notes that were audited as not identifying a short term goal listed on the treatment plan.

**Problems:** The identified short term goal is not consistent with the treatment plan short term goal on the NAP note in 19% of the cases. Some short term goals were not stated in the current treatment plan. A common short term goal stated on the NAP note was “Safety”. The writers did not reference the treatment plan prior to preparing the notes. Describing an intervention is at 28%. The narrative was observed to be written in observational terms not active treatment language.

**Status:** Overall compliance with documentation decreased from 84% to 78%.

**Actions:** The Nurse Educator will perform 20 chart audits to better identify specific needs of staff regarding documentation. The Nurse Educator will continue to reeducate staff on each unit to improve the quality of documentation. There will be individual counseling as appropriate. 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 Plans

**Overall compliance:** 93%

Indicators	Findings	Compliance	Threshold Percentile
1. Initial treatment documented within 24 hours.	52/52	100%	100%
2. Preliminary Continuity of Care meeting completed by end of 3 <sup>rd</sup> day.	47/47	100%	95%
3a. <b>Client Participation</b> in Preliminary Continuity of Care meeting.	45/47	96%	80%
3b. <b>CCM Participation</b> in Preliminary Continuity of Care meeting.	47/47	100%	80%
3c. Client's <b>Family Member Participation</b> in Preliminary Continuity of Care meeting.	42/47	89%	80%
3d. <b>Community Provider Participation</b> in Preliminary Continuity of Care meeting.	22/47	47%	80%
4. Presenting Problem in behavioral terms.	55/58	95%	85%
5. Strengths and preferences are identified.	56/58	97%	85%
6. Identifies all of client's long term goals.	43/48	90%	85%
7. Comprehensive Plan complete by the 7 <sup>th</sup> day.	56/58	97%	100%
8. Observable behavioral objectives are written.	56/58	97%	85%
10. Interventions are identified.	55/58	95%	85%
11a. Integrated Needs/Assessment Prioritized by scale at bottom of sheet.	56/58	97%	85%
11b. Integrated Needs/Assessment Contains all needs/ issues/problems.	55/58	95%	85%
12. Active medical issues addressed via Medical/ Nursing care plans.	47/50	94%	85%

**Findings:** In comparison to last quarter, there was significant improvement in all indicators monitored except for two described under problems.

**Problems:** Indicator #3d (above) regarding Community Provider Participation in Preliminary Continuity of Care meeting was below threshold. On further analysis, the majority of the true variance in performance on this indicator came from two of the service units. Indicator #7 regarding Comprehensive Service Plan completion by the 7<sup>th</sup> day was also below threshold, and all the variance came from a single service unit.

**Action:** Regarding #3d, Community Provider Participation, the long term forensic unit, will mark the indicator “not applicable” on future audits as clients served do not have community providers assigned; the short term forensic unit will develop strategies of increasing community providers attendance at these meetings, and the unit Director will proactively send letters to the jail administrators on a monthly basis to assist in the desired engagement by appropriate staff. Regarding both indicators (#3d and #7) below threshold, the Deputy Superintendent of Program Services shall guide the implementation of definable strategies prior to end of next quarter.

**Program Service Directors**

**Aspect:** Comprehensive Service Plan Reviews

**Overall Compliance:** 94%

Indicators	Findings	Compliance	Threshold Percentile
1. Completed no later than 14 days for the first 6 months and monthly thereafter.	54/56	96%	85%
2. Completed within 72 hours of a restrictive treatment.	29/29	100%	85%
3a. Review form documents <b>client</b> participated in the review	50/55	91%	85%
3b. Review form documents <b>psychiatrist</b> participated in the review	52/55	95%	85%
3c. Review form documents <b>CCM</b> participated in the review	55/55	100%	85%
3d. Review form documents <b>nurse</b> participated in the review	55/55	100%	85%
4. Review form indicates plan as having met identified goals or not.	39/55	71%	85%
5. Review form states whether client continues to meet admission criteria or not	55/55	100%	85%

**Findings:** 5 charts per month was the sample size. Program Service Directors were the reviewers. All indicators were met with one exception.

**Problems:** Indicator #4 pertains to the review form indicating the plan as having met identified goals or not, was measured at 71% this quarter, below the 85% threshold. Further analysis revealed most of the variance in this indicator came from one service unit, likely attributable to rater-reliability and interpretation of the indicator.

**Actions:** Collection tools and methods will be revised to assure information collected is reliable and valid. Deputy Superintendent of Program Services and Performance Improvement Director shall (1) collect a focused sample on all indicators, (2) review reliability of collection methods, and (3) provide education or counseling as necessary before May 20, 2006.

**Program Service Directors**

**Aspect:** Integrated Summary Note

**Overall Compliance:** 88%

Indicators	Findings	Compliance	Threshold Percentile
1. Documented in the chart on the day of the Comprehensive Service Plan Meeting.	45/46	98%	85%
2. Identifies Client Preferences.	35/46	76%	85%
3. Identifies general needs of client -- identified on completed assessment.	45/46	98%	85%
4. States whether further assessments will be needed or not.	32/46	70%	85%
5. Identifies the general goals of services.	44/46	96%	85%
6. Documents the client or guardian participation in the treatment planning process.	43/46	93%	85%

**Findings:** 4 of the 6 indicators were above threshold. 2 were below.

**Problems:** Indicator #2 pertaining to identification of client preferences improved to 100% on two service units. On the remaining two service units documentation of preferences is not reliably happening. Indicator #4 pertaining to documenting the need for further assessments continues to be problematic for all but one of the service units; the performance on this indicator dropped from 79% last quarter to 70% this quarter, below threshold.

**Actions:** Deputy Superintendent of Program Services and the Performance Improvement Director will review indicators and explore processes for addressing this by May 20, 2006.

## Program Service Directors

**Aspect:** Progress Notes

**Overall compliance:** 88%

Indicators	Findings	Compliance	Threshold Percentile
1. Review note indicates changes made in the plan to implement further progress.	45/55	82%	85%
2. Level of client participation in active treatment is documented.	52/55	95%	85%

**Findings:** 1 of the 2 indicators was above threshold.

**Problems:** Indicator #1 pertaining to changes made in the plan is below threshold. Further analysis reveals most improvement needed on both of the civil units. In short, documentation is not reflecting changes made in the plan to further client progress on these two units at an acceptable level.

**Actions:** A tool was developed to prompt nursing staff to document to reflect changes; this tool will be implemented by May 10, 2006.

## Peer Specialists

**Aspect:** Integration of into client care

**Overall Compliance:** 83%

Indicators	Compliance	Findings	Threshold Percentile
1. Attendance at Comprehensive Treatment Team meetings.	378 of 486	78%	80%
2. Grievances responded to on time.	94 of 99	95%	100%
3. Attendance at Service Integration meetings.	69 of 69	100%	100%

**Finding:** (1) Percentage of Comprehensive Treatment Team meetings attended, improved this quarter. (2) There is no change from last quarter in the percentage of late grievances. Five grievances not responded to within identified timeframe, all were responded to within 8 days. (3) All Service Integration Meetings were attended this quarter. Peer Specialists have been notified regularly of meetings this quarter.

**Actions:** Peer Specialists will continue to track Comprehensive Treatment Team Meeting attendance and reasons for not attending.

- The grievances response time will continue to be monitored.
- Peer Specialists will make additional efforts to adjust their schedules to be available for meetings.
- Peer Support Coordinator is being more active on the units in order to cover for outages and conflicts that interfere with treatment team attendance.

## Rehabilitation

**Aspect:** Client Attendance at the Harbor Mall

**Overall Compliance:** 67%

Indicators	Findings	Compliance	Threshold
Attendance by clients scheduled to attend mall groups on a daily basis	2899 of 4381	66%	70%
Attendance at morning programming	1648 of 2435	68%	70%
Attendance at afternoon programming	1251 of 1946	64%	70%

### Finding:

The sample is based on a 13-week session of the Harbor Mall from 1/1/06 to 3/31/06. For the 13-week period, the morning programming had 1648 client interactions out of a possible 2435 for a 68% total, down 4% from last report. The afternoon programming had 1251 client interactions out of 1946 for a 64% total, up 3 % from the last report. This means that for the 62 days the mall was in session we had a compliance rate of 67%. As a result of the action steps taken last quarter, there was an increase in the afternoon programming. The morning program did have a decrease and additional steps will be added for next quarter to further explore and evaluate the reason for this. We have an average daily attendance in the morning of 27 clients and 20 for the afternoon.

### Problem:

Riverview has been continuously showing an improvement and had reached threshold percentile for morning program last quarter. This quarter the afternoon program continued to show an improvement, however the morning program had a 4% decrease.

### Status:

- Rehab staff have completed approximately 80% of the Psychiatric Rehabilitation Training and have developed a new assessment tool and will look to begin using this next quarter.
- A client survey was completed to gather information and suggestions in relation to programming on the Mall. The suggestions are being implemented with the new schedule starting on April 3<sup>rd</sup>, 2006.
- Rehab. staff have all received engagement training.
- Engagement plans continue to actively evolve with those clients that have been

refusing to participate in any groups. The afternoon program continues to improve going from what once was a 55% compliance rate to what is a 64% rate to date.

**Actions:**

- Rehab. Service staff will complete training on Psychiatric Rehabilitation by the end of the FY and will implement new assessment tool and care plan.
- The Mall will begin its Spring Session programming to include the groups that were suggested by clients in the survey as well as from the Client Forum.
- Rehabilitation Services Director will monitor the attendance and will send the client’s schedule to each Recreation Therapist for review and possible change to an engagement intervention.

**Vocational Services Program**

**Aspect:** Job Coach Attendance at Comprehensive Service Plan Meetings.

**Overall Compliance:** 89%

Indicator	Findings	Compliance	Threshold Percentile
The Job Coach will attend assigned clients’ treatment plan meetings.	57 of 64	89%	80%

**Findings:** Improvement from 81% to 89% this quarter. Increase was attributed to improved communication and an addition of a job coach in January. Meetings that were missed were due to mandatory training or call outs.

**Problem:** None noted.

**Status:** Compliance rate has been met or exceeded for the recent quarters for treatment plan meeting; this will continue to be monitored.

**Actions:** Focus will change to look at those clients who are interested in working in the community. Currently have a high number of clients working at jobs here in the facility, but who have potential for community employment.

## Health Information Services

**Aspect:** Documentation and Timeliness

**Overall Compliance:** 97%

INDICATORS	COMPLIANCE	THRESHOLD PERCENTILE
1. Records will be completed within JCAHO standards, state requirements and Medical Staff bylaws timeframes.	77% -There were 23 discharges in January. Of those, 20 were completed by 30 days. 93%-There were 28 discharges in February. Of those, 25 were completed within 30 days. 84 %-There were 19 discharges in March. 16 were completed within 30 days.	All records will be completed within 30 days of discharge. The completion rate will remain at or above 80%.
2. Discharge summaries will be completed within 15 days of discharge.	100 % - 23 out of 23 were completed within 15 days in January. 96% - 27 out of 28 were completed within 15 days in February. 100% - 19 out of 19 were completed within 15 days in March.	The completion rate will remain at 100%.
3. Forms used in the medical record will be reviewed by the Medical Record Committee.	100%- 0 forms were approved/ revised in January (see minutes). 100 %- 0 forms were approved/ revised in February (see minutes). 100 %- 0 forms were approved/ revised in March (see minutes).	100%
4. Medical transcription will be timely & accurate.	100 %-no errors/issues in January. 100%-no errors/issues in February. 100 %-no errors/issues in March.	90%

**Findings:** The indicators are based on the review of all discharged records. There was 85 % compliance rate with record completion within 30 days. There was 99% compliance rate with discharge summaries. Weekly “charts needing attention” lists are distributed to all medical staff, including the Clinical Director.

**Problem:** Record completion has decreased from 84% last quarter to 78% this quarter.

**Status:** 78% compliance rate with record completion.

**Actions:** All medical staff (including the Medical Director) receives 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 with staff having patterns of deficiency being counseled.

## Health Information Services

**Aspect:** Confidentiality

**Overall Compliance:** 100% Findings:

The indicators are based on the review of all requests for information, orientation for all new employees/contracted staff and confidentiality/privacy-related incident reports .

INDICATORS	COMPLIANCE	THRESHOLD PERCENTILE
1. All client information released from the Health Information department will meet all JCAHO, State, Federal & HIPAA standards.	100 %-no issues in January. 100 %-no issues in February. 100%-no issues in March.	100%
2. New staff is receives confidentiality training during orientation.	100 % -4 new employees/contract staff in January. 100% -3 new employees/contract staff in February. 100%-7 new employees/contract staff in March.	100%
3. The Director of Health Information will track the number of confidentiality/privacy issues through incident reports.	There were 0 confidentiality/Privacy-related incident reports in January. There were 0 confidentiality/privacy related-incident reports in February. There were 0 confidentiality/privacy-related incident reports in March.	Incident reports will be monitored for privacy issues. The incident rate will remain at 0%.

**Findings:** The indicators are based on the review of all requests for information, orientation for all new employees/contracted staff and confidentiality/privacy-related incident reports. 2421 out of 2421 (100%) requests for information (2201 police checks and 220 requests for client information) were released from the Health Information department during this quarter. 14 out of 14 (100%) new employees/contract staff attended Confidentiality/HIPAA training. All indicators remained at 100 % compliance for quarter 1-FY 2006.

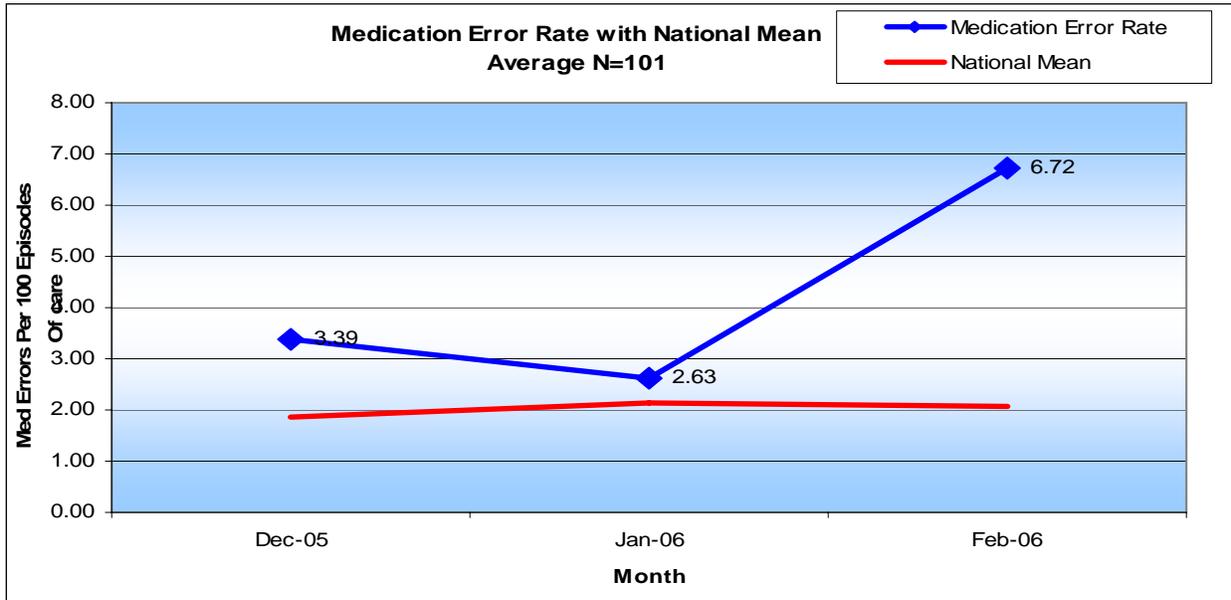
**Problem:** None found. Still, the introduction and compliance with current law and HIPAA regulations needs to be strictly adhered to, requiring training, education, and policy development at all levels.

**Status:** No issues during the third quarter. Continue to monitor

**Actions:** The above indicators will continue to be monitored.

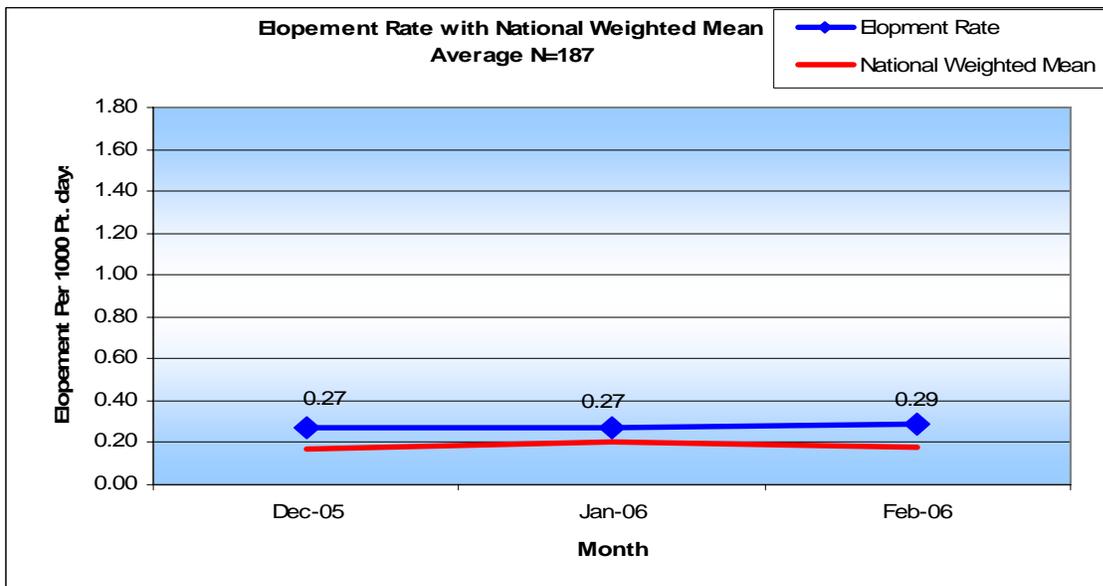
# HOSPITAL PERFORMANCE MEASURES

## Medication Error Rate-Comparisons with National Data



After a consistent decline the spike in Feb is concerning and the quarter was above the national mean. Since these med errors seem to be concentrated on new hires, the Director of Nursing has reviewed the orientation of nurses to the medication management system and has made changes in the process. Medication variances are monitored 24/7 and self reporting is an expectation; Pharmacy also notifies risk management, and nursing of concerns or any trends.

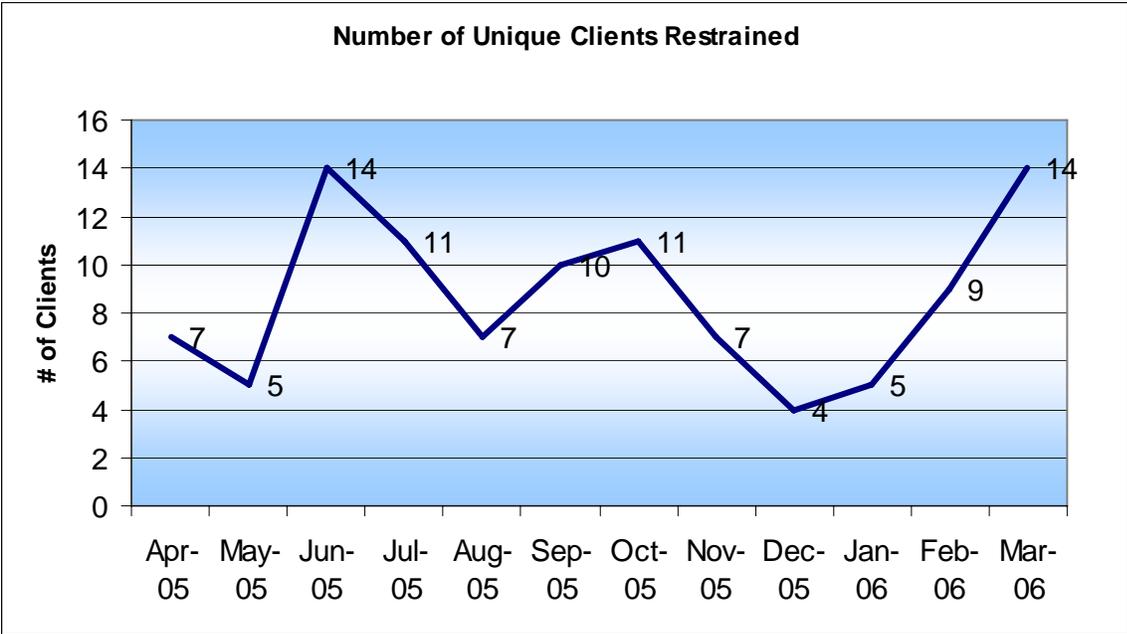
## Elopement Rate-Comparisons with the National Data



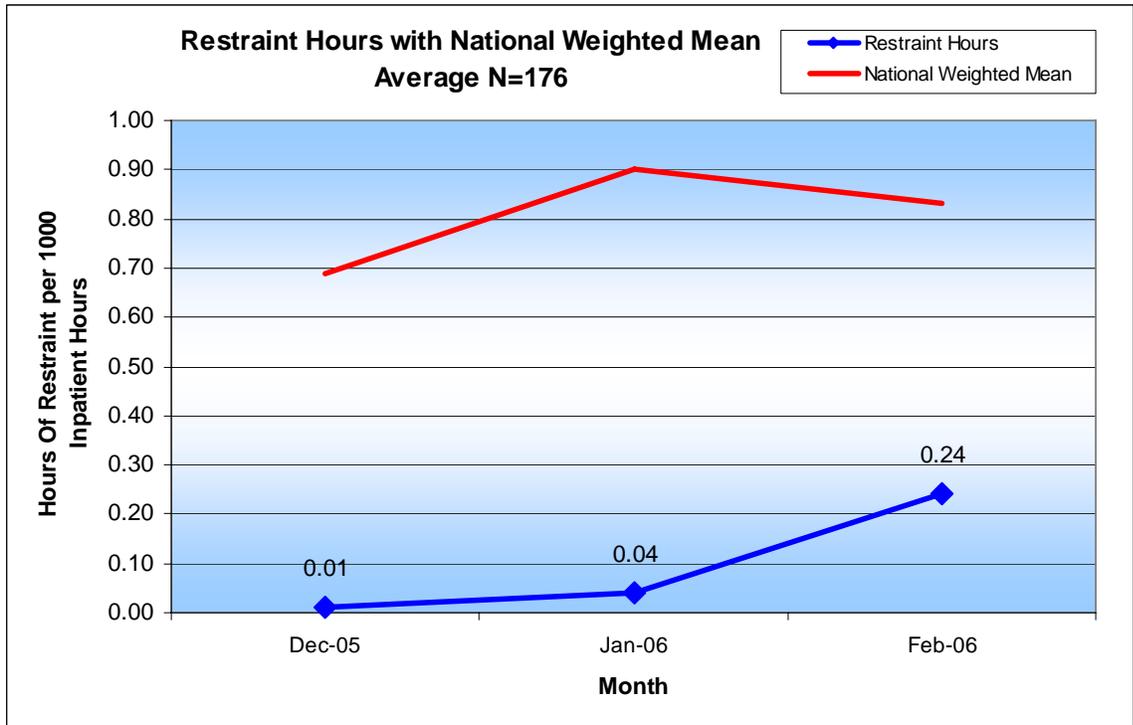
Riverview Elopement rates continue to be well in-line with the National averages

**Restraints**

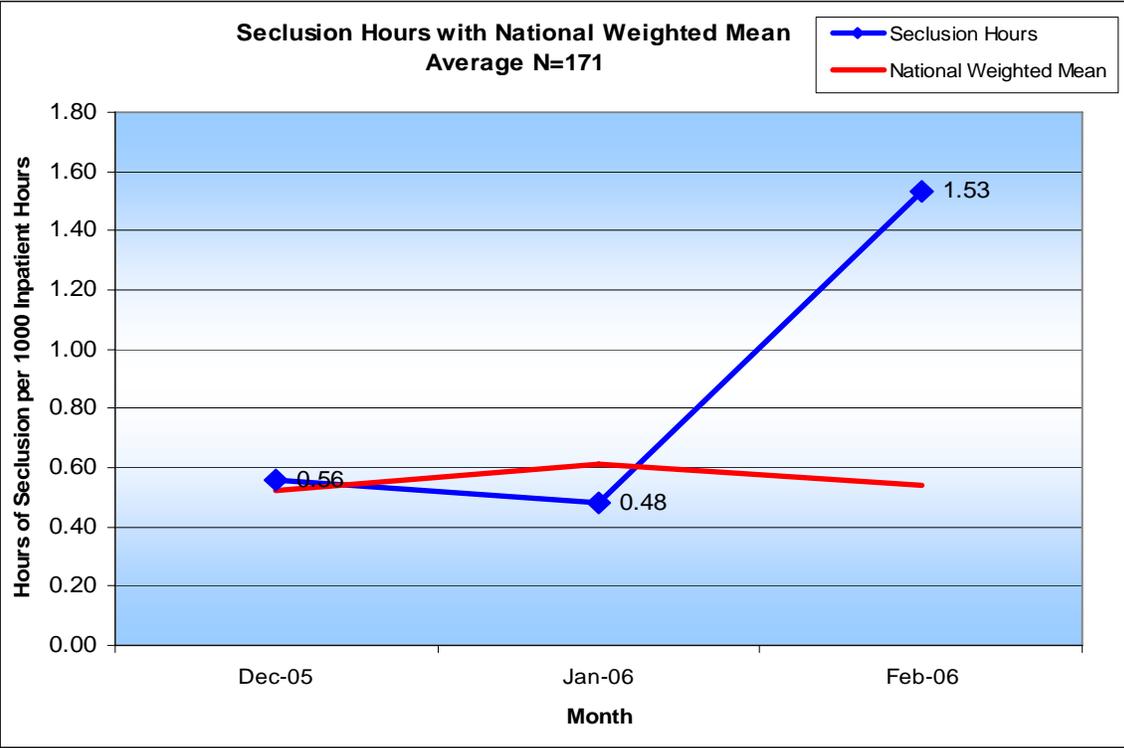
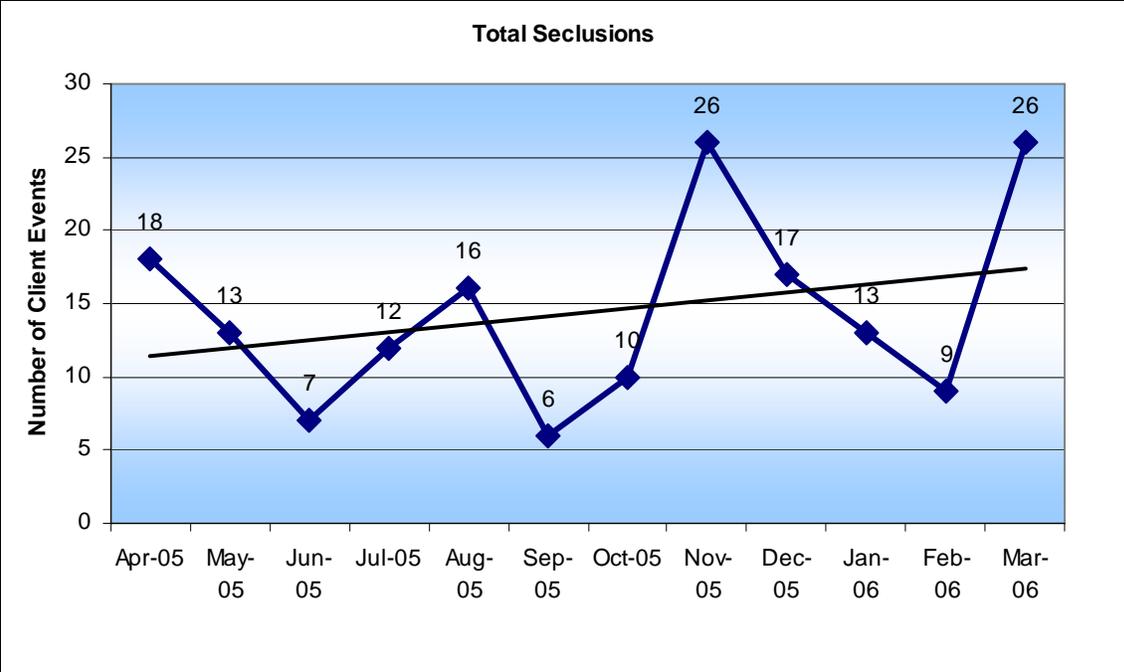
After eleven months of general decreases in restraint events, March 06 spiked in use.





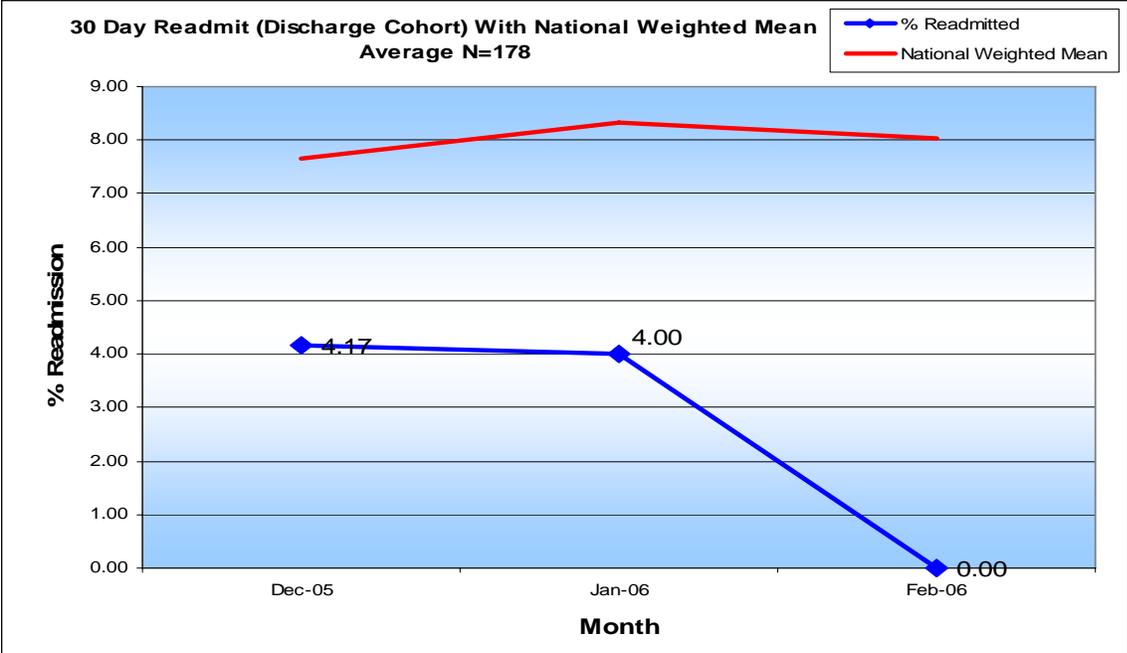


**Seclusions**



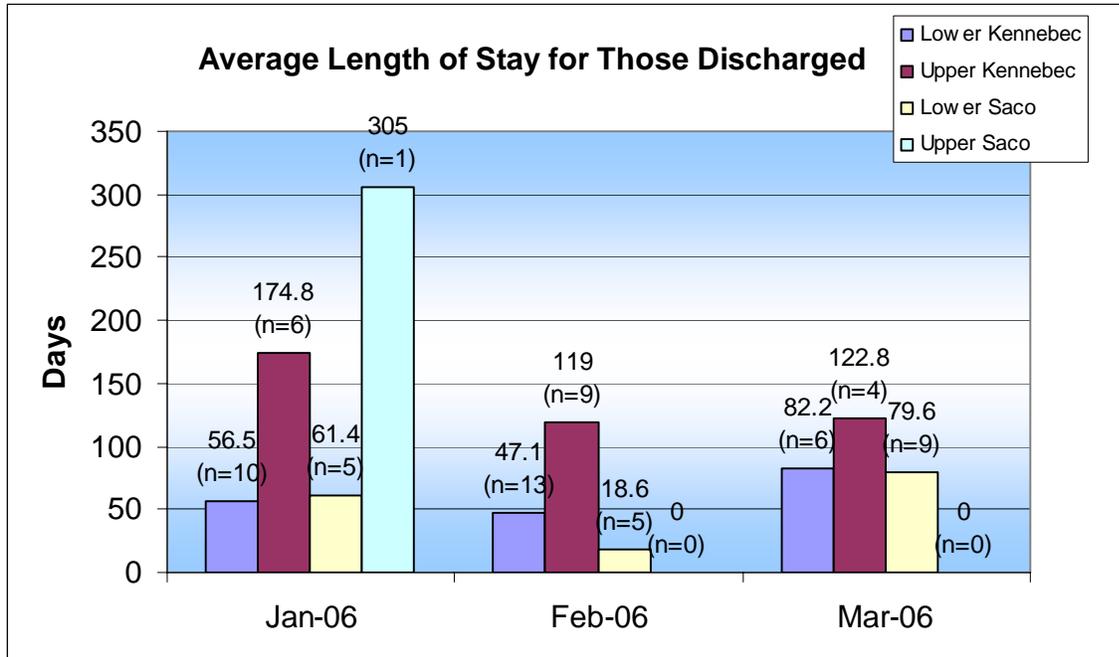
Along with restraints, the hospital has been working to decrease client seclusion events; it is a national initiative. Such events are triggers to the treatment team to review a client’s plan of care within 72 hours to help address the client’s treatment needs. Administrative Segregation was implemented during this quarter, in February.

### Readmissions within 30 days



The graph depicts the 30 day readmission rate is continually decreasing.

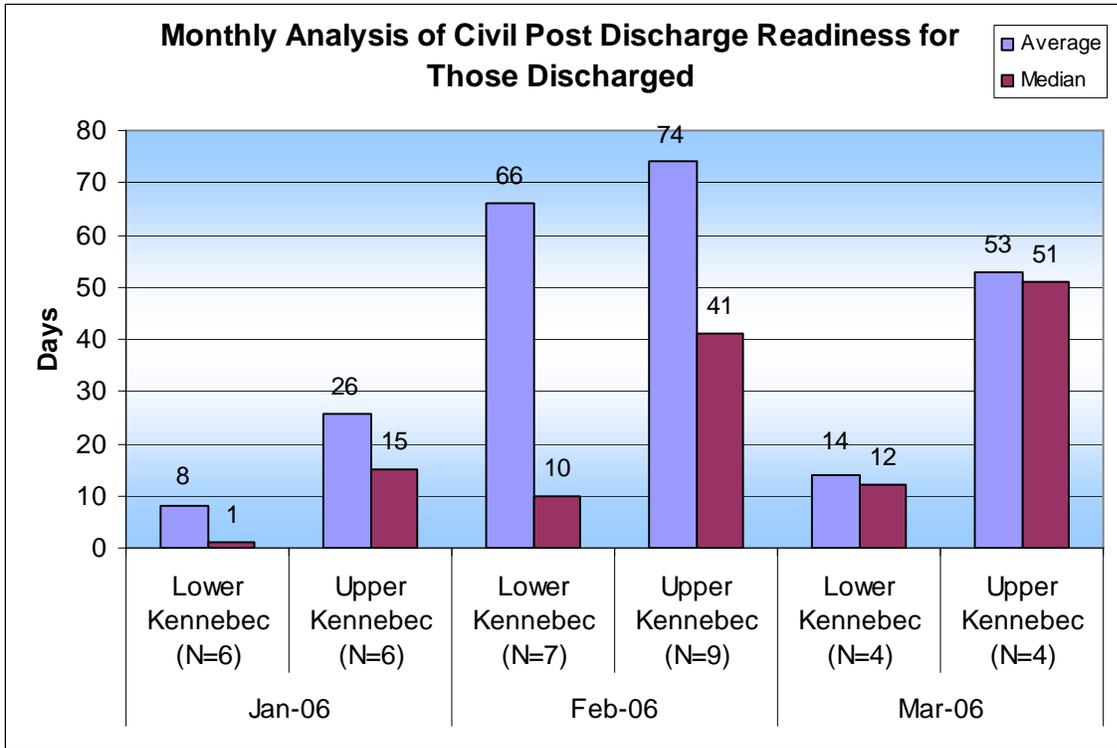
## Average Length of Stay



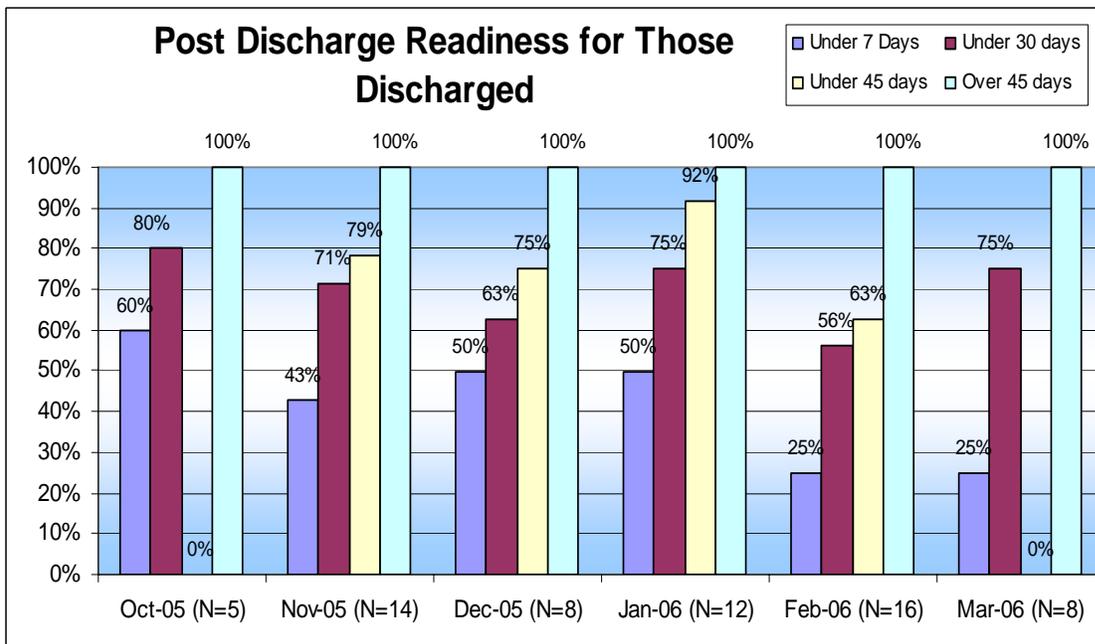
### Hospital Performance Measure Discussion:

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). Upper Kennebec serves acute and non-acute longer-term civil clients. Lower Kennebec is the admissions unit for acute civil clients.

### Average Post Discharge Readiness Days for Civil Clients Discharged

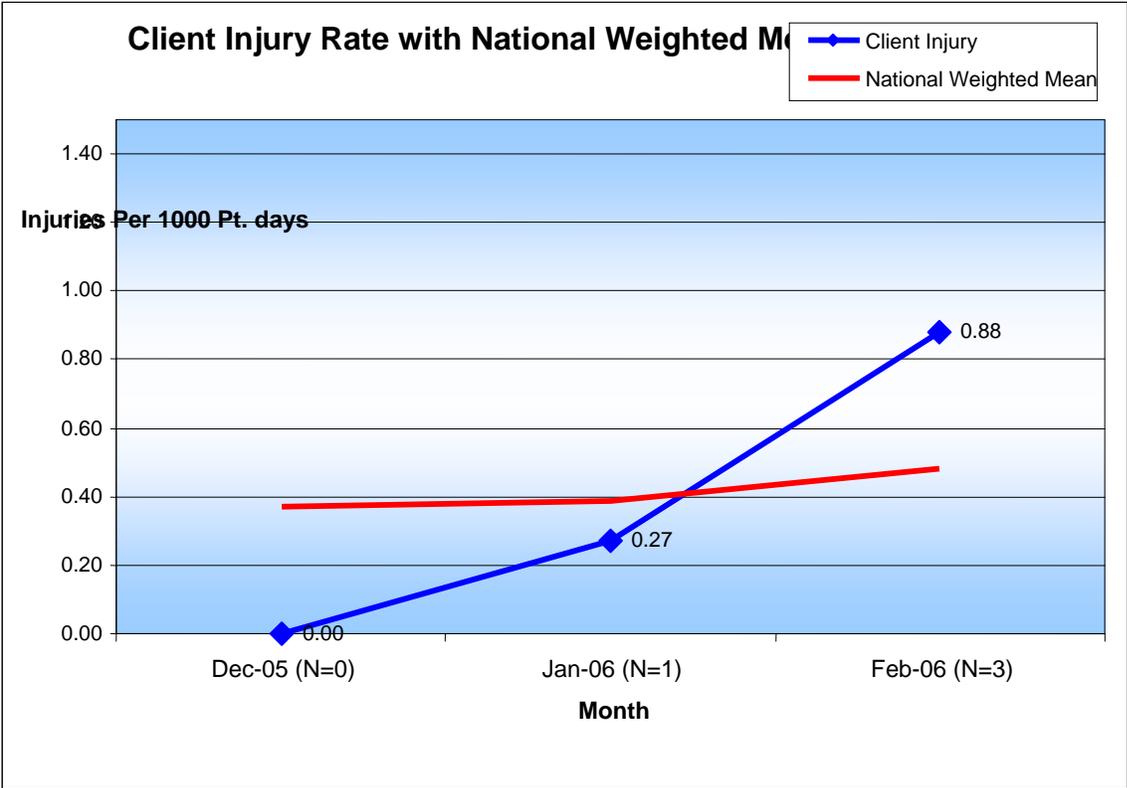


The hospital also collects data on the time a client spends in the hospital after they have been determined ready for discharge, before they are actually discharged.



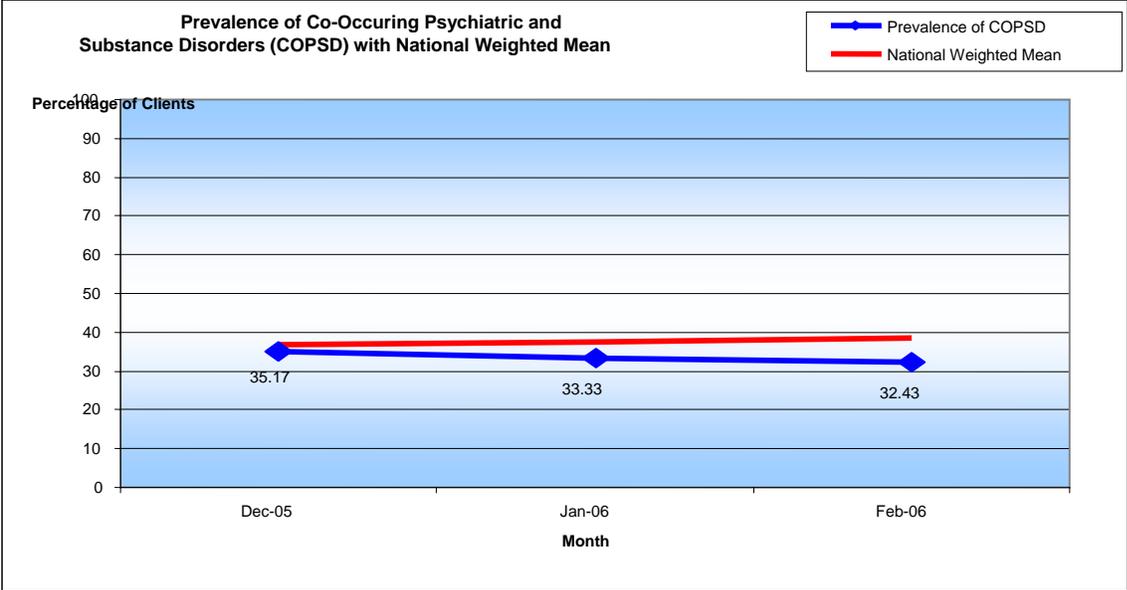
Over the past 6 months, RPC on average discharged 75% of all clients, within 45 days of a determination they are ready for discharge.

**Client Injury Rate compared with National Data.**



Client injuries increased in February as increases in client episodes of self-harm occurred. This quarter the highest category of injuries that caused injury greater than first aid were self harming injuries.

**Prevalence of Co-Occurring Psychiatric and Substance Abuse Disorders Comparisons with National Data (COPSD)**



**Hospital Performance Measure Discussion**

Currently, Riverview percentage of clients presenting with co-occurring psychiatric and mental health disorders is similar to that being experienced by other hospitals nationally. RPC clients are currently offered a limited variety of group treatment however; RPC has recently awarded an RFP for an intensive and extensive co-occurring disorder program for all of RPC. With this increased attention, RPC expects the clients identified as needing, benefiting and participating in treatment programs will increase significantly.