

Riverview

PSYCHIATRIC CENTER



PERFORMANCE IMPROVEMENT REPORT

THIRD QUARTER
SFY 07
JANUARY, FEBUARY AND MARCH 2007

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Introduction:

The quarterly report is presented in four different sections. Section I focuses on various departmental quality assessment and process improvement indicators. Each department has identified indicators, established thresholds, and concurrently collects data and assesses the data to help make the improvement actions be data driven and measurable. Implementation and evaluation of all departmental improvement actions is ongoing, and is intended to help each department to continuously improve the services they offer to clients at Riverview Psychiatric Center. This quarter you may notice that some of the Departments are reporting in different three month segments, Section II includes budget and Human resources data with trends unique to Riverview. Section III focuses on Performance Measurement trend information comparing Riverview Psychiatric Center to the National Norms for similar Psychiatric facilities. Sections IV pertains to committee-driven or otherwise authorized Process Improvement Team Activities.

Section I: Departmental Quality Assessment & Performance Improvement

MEDICAL STAFF

Aspect: Review of Medical Staff Documentation of Physical Exams for Dec/Jan/Feb Quarter FY07

Overall compliance: 98.6%

December, January, February 2006-07			
Indicator	Findings	Compliance	Target%
1. The physical exam was complete upon admission, or it was documented why not done. (Client refused or was uncooperative)	26 out of 26	100%	100%
2. Vital signs recorded upon admission on the physical exam form.	26 out of 26	100%	100%
3. When clinically indicated, a complete neurological exam was performed.	26 out of 26	100%	100%
4. A medical problem list was generated immediately after the physical exam.	26 out of 26	100%	100%
5. Medication and food allergies are recorded on the physical exam form	24 out of 26	92%	100%
6. The physical exam was completed within the first 24 hours of admission.	26 out of 26	100%	100%

Findings:

Overall the medical staff were at or close to the threshold of 100% in the documentation of quality of physical exams, exceeding any quarter in the prior 21 months at 98.2% for the quarter overall. One element, food and drug allergies, was at 92%..

Problem:

Identification of medication and food allergies is the physician's responsibility. 2 of 26 review records did not have allergies listed on the PE form because the medical staff failed to record it there. It was noted that the two physicals in question were performed by medical staff who do not frequently perform physicals. We have agreed that the primary place to record allergies upon admission will be the medical staff order sheet, not the physical exam form and will be the responsibility of the admitting psychiatrist, and not the physician performing the physical exam.

Actions:

Overall the quality of physical exams exceeded expectations and we will discontinue the monitor. During the monitoring process, however, we discovered some difficulties in always recording food and drug allergies in the physical exam sheet. Consequently the medical staff decided that the primary place medication allergies are to be reviewed and documented will be on the medical staff order sheets at admission. This will ensure one, consistent place to record allergies. The order sheet is to be faxed to the Pharmacy to alert the pharmacist of any allergies prior to the initial dispensing of any medications. This will be a new indicator under medication safety to ensure that medication allergies are noted and entered into the pharmacy system.

MEDICAL STAFF PEER REVIEW

Aspect: Review of Medical Staff Seclusion & Restraint Documentation
December/January/February Quarter FY07

Overall compliance: 98.6%

December/January/February 2006-2007			
Indicator	Findings	Compliance	Target %
1. The form "Physician Restraint and Seclusion Progress Note" is present for each Seclusion and Restraint ordered, filled out, signed, dated and timed.	45 out of 45	100%	100%
2. If the Seclusion lasts greater than 2 hours, the client is assessed by LIP, and new order completed as in 1 above.	45 out of 45	100%	100%
3. A medical staff order for is present for each event; it is completed, signed, timed and dated.	44 out of 45	98%	100%
4. There is a documented client debriefing within 24 hours of the event.	45 out of 45	100%	100%
5. The restraint/seclusion event was clinically justified.	43 out of 45	96%	100%
6. The LIP assesses the client no less than every 2 hours.	43 out of 45	96%	100%
7. Behavioral criteria for release from SRC is clearly documented.	45 out of 45	100%	100%

Findings: Indicators 1, 2, 4 and 7 at 100% compliance. Indicator 3 at 98% and Indicators 5 & 6 at 96%.

Problems: 2 out of 25 records did not have sufficient documentation for the physician reviewer to rate the clinical appropriateness of the events, or that the provider had assessed the client in the two hour requirement. Clearly this was a deficiency in the two records. The two medical staff in question will require education of their deficiencies in these cases.

Status: Remains consistent in the 95+% range for 6 months and we will discontinue the monitor going forward.

Actions: This completes two quarters of monitoring this indicator and the medical staff feels we have satisfactorily demonstrated compliance. We will discontinue the monitor. The medical director has counseled the two medical staff with the only deficient records noted in this quarter.

MEDICAL STAFF

Aspect: of Medical Staff Psychiatric Emergency Documentation
December/January/February Quarter FY07

Overall compliance: 96.6%

December, January, February 2006-2007			
Indicator	Findings	Compliance	Target %
1. The form "Notification of Psychiatric Emergency" is present for each Psych Emergency ordered, and is completed, signed, timed and dated.	9 of 10	90%	100%
2. Progress note justifying the rationale for the psych emergency is noted in the medical record.	9 of 10	90%	100%
3. A medical staff order is present for the psych emergency and contains appropriate medication orders.	10 of 10	100%	100%
4. The psych emergency is clinically justified in documentation.	10 of 10	100%	100%
5. Least restrictive methods were attempted and failed to control the client's dangerousness and are documented.	10 of 10	100%	100%
6. If consecutive psych emergency, initiation of administrative hearing took place.	10 of 10	100%	100%

Findings: Indicator 1 and 2 at 90% and Threshold is 100%. Indicators 3-6 are at 100%.

Problems: One record did not have the appropriate form, or a progress note available to the peer review group.

Status: New monitor.

Actions: The new monitor was successfully integrated into the medical staff peer review process.

Feedback was given to individuals about their performance. The Medical Director had several discussions with the Medical Records Dept. and the CPI Director about obtaining adequate numbers and types of records for meaningful review. We also tweaked the rating scale to make it more congruent with JCAHO and DHHS licensure standards for psych emergencies.

NURSING

ASPECT: Seclusion and Restraint Related to Staffing Effectiveness

COMPLIANCE: 100%

Nursing's quarter is November, December and January			
Indicators	Findings	Compliance	Threshold Percentile
1. Staff mix appropriate	61 of 61	100%	100%
2. Staffing numbers within appropriate acuity level for unit	61 of 61	100%	100%
3. Staff debriefing completed	61 of 61	100%	100%

4. Dr. Orders	61 of 61	100%	100%
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Findings: There were 61 incidents of seclusion, and restraint this quarter.

Problem: No problem noted.

Status: This indicator has increased in compliance so all monitored aspects are at 100%

Actions: Continue monitoring to assure continued compliance.

NURSING

ASPECT: Code Cart / Redlining

COMPLIANCE: REDLINING 95% CODE CART 96%

Indicators-Redlining	Findings	Compliance	Threshold Percentile
Lower Kennebec	266 of 276	96%	100%
Upper Kennebec	269 of 276	97%	100%
Lower Saco	240 of 276	87%	100%
Upper Saco	270 of 276	98%	100%

Indicators-Code Cart Sign Off	Findings	Compliance	Threshold Percentile
1) Lower Kennebec	249 of 276	90%	100%
2) Upper Kennebec	270 of 276	98%	100%
3) Lower Saco	272 of 276	99%	100%
4) Upper Saco	260 of 276	94%	100%
5) NOD Building Control	267 of 276	97%	100%
6) NOD Staff Room I 580	267 of 276	97%	100%

Findings: Redlining is at 95% and remains short of the 100% expectation. Lower Saco has completed redlining 87% of the time. Change in staff may be the reason the redlining checks have not been done consistently.

Code cart checking has not yet met the 100% compliance requirement. It continues to be below, with it being at 96% this quarter up from 95% last quarter. The unit staff sometimes forgets to check the cart.

Problem: Code carts are not being checked 100% of the time. Redlining is not being done 100% of the time on all units.

Status: Code cart checking is a critical check issue on all code carts. These are used in emergency situations and must be complete and ready to use. This is not being done and becomes a major safety issue.

Redlining is the method of checking all medication orders to confirm the accuracy. This also is a critical issue and is not being done consistently.

Action: The nurse educator will assure the Redlining procedure has been reviewed, and signed off by each nurse by the end of March 2007. This will also include the day and evening shift nurse reviewing the procedure for reviewing the charts to assure physician order are checked at the beginning of each shift. The night NOD will check with the charge nurse on each unit and report on the progress of the redlining procedure on each unit on the daily reports to the superintendent. Code cart checking will need to be reviewed with the nurse who is responsible for narcotic count and key change during each shift change. The on coming Nursing Supervisor and NOD's will check Room I-580 to make it a part of their shift report. The NOD/ Nursing supervisor will be report each shift on the daily report to the superintendent, on all six sites of the code cart.

**NURSING
ASPECT: PAIN MANAGEMENT
COMPLIANCE: 97%**

Indicator	Findings	Compliance	Threshold.
1. Pain is assessed using pain scale prior to pain medication administration.	587 of 587	100%	100%
2. Client re-assessed for pain using pain scale after pain medication delivered.	548 of 587	93%	95%

Findings: The indicator for assessing pain using pain scale pre medication administration is at 100%. The indicator for assessing pain post administration is only at 93%. This continues to be a problem as nurses are not consistently returning to assess post pain.

Problems: Nurses have not been consistently assessing post administration of pain meds. Pre and post assessments are done by the Registered Nurse and the pain medication is often given by the LPN. A more consistent process will be developed.

Status: The pre-administration has improved 1 %. The post administration has improved from 89% to 93%. This is a valid improvement .that shows the increasing awareness of completing the process..

Actions: Will continue to monitor. Nurses will be reeducated concerning the need to reassess. Pain sticker documentation forms will be changed again to improve the ease of reporting this and improve the process.

**NURSING:
ASPECT: NURSING DOCUMENTATION**

OVERALL COMPLIANCE 63%

Indicator	Findings	Compliance	Threshold
1.NAP notes at a minimum			
a. Identifies STG objective	37 of 69	54%	90%
b. Once per shift either MHW/RN	37 of 69	54%	95%
c. Minimally Q24 hours RN after first 72 hrs.	35 of 69	51%	95%
d. MHW notes countersigned by RN	41 of 69	59%	90%
2. Active Treatment			
a. Identifies Intervention	60 of 69	87%	90%
b. Describes intervention.	20 of 69	36%	90%
c. Assessment Completed.	55 of 69	79%	90%
d. Plan	59 of 69	86%	90%

Findings: There were 69 charts audited from all 4 Nursing units for nursing documentation in this quarter. Overall this group of indicators has improved from 58% compliance to 63% compliance. NAP notes once per shift by MHW or RN is up from 49% to 54%; Minimal every 24 hours is up from 47 % to 51%; MHW notes countersigned by RN is up from 57% to 59%; Describes intervention is up from 27% to 36%; Assessment completed is up from 57% to 79%; Areas that decreased were Identifies intervention from 92% to 87%; That there was a plan from 89% to 86%. This indicates an overall increase in compliance of 5%.

Problems: There remains a large problem in the consistency of these aspects of documentation. The problems are across units and shifts and indicate the need to redesign many aspects of the documentation process. The documentation issues are due to RN inconsistency.

Status: Compared to the last quarter of SFY06 the indicator "identifying STG" has decreased by 3%; "RN/MHW documenting once per shift" has increased from 49% to 54%; the indicator "documenting minimally q 24 hours by RN" increased from 47% to 51 %; the indicator "signing of MHW notes by RN" has increased by 2 %; the indicator "describing intervention" is down 9%; the "Assessment completed"

is down 22 %. The documentation remains a great concern. A PIT was begun and has been working on the Comprehensive Service Plan and documentation. The anticipated changes will improve the documentation process.

Actions: A documentation PIT is underway with a variety of recommendations to be implemented by the end of March. Some of the changes and recommendations will be: The Comprehensive Service Plan will change; the method and kind of notes will change. The documentation will be done in a continuous document with no gaps in the paperwork. The method of documenting will change from menu driven NAP notes to GAP notes without a menu. This will serve to allow documentation to be more concise and connect in a user-friendly method to the Treatment Plan. Documentation expectations for MHW and Nurses will change regarding frequency and quality and purpose. It will become a chart that is used and current. Indicators may change slightly as the process evolves. PIT charter and minutes available.

NURSING:

ASPECT: NURSING DOCUMENTATION/Comprehensive Service Plans

COMPLIANCE: 81%

Indicators	Findings	Compliance	Threshold
1. Initial care plan documented within 24 hrs	27 of 27	100%	100%
2. Presenting Problem in behavioral terms.	19 of 27	70%	85%
3. Strengths are identified	26 of 26	100%	80%
4. Client LTG is observable and Measurable	19 of 24	79%	85%
5. Comprehensive service plan is completed by the 7 th day	25 of 26	96%	100%
6. STG objectives are written, dated and numbered.	25 of 26	96%	85%
7. Interventions are identified.	25 of 25	100%	85%
8. a. Integrated Needs Assessment prioritized by scale at the bottom of the sheet.	13 of 26	50%	85%
b. Integrated needs assessment contains all needs, issues, problems found in assessments, evaluations since admission.	13 of 25	52%	85%
9. Active medical issues addressed in medical nursing care plan	15 of 22	68%	85%

Findings: The sample size was 27 records. 50 percent of the indicators, 1., 3., 5., 6., and 7. met or exceeded the threshold. The rest of the indicators fell below the threshold. This is a new area for Nursing data collection and shows the greatest area for improvement in; " Integrated Needs assessment prioritized by scale at the bottom of the sheet is at 50%; "Integrated needs assessment contains all needs, issues etc is only at 52% compliance. Other concerns are " Presenting problem in behavioral terms at 70%; Active medical problems at 68%.

Problems: Remaining Comprehensive Treatment Plan indicators are below the threshold some very greatly below.

Status: Some are new indicators that Nursing has taken over from the PSD's. During this quarter 1 Nurse collected this data. During the next quarter this will be absorbed under PSD data collection and some Nursing documentation. This data continues to indicate problems in documentation and in our Comprehensive Service Plan.

Actions: A documentation PIT is underway with a variety of recommendations to be implemented by the end of March. Some of the changes and recommendations will be: The Comprehensive Service Plan will change The Comprehensive Service Plan will become a current "living" document that will be used all of the time and updated on a regular basis. The expectation will be that using the GAP format for charting G=goal, A=assessment. And P=plan, each event of documentation will tie directly to a goal on the Comprehensive Service Plan. It will become a chart that is used and current. Indicators for the next quarter may change slightly as the process evolves. Also some of the indicators are being collected by PSD's. These will be reviewed to prevent duplication. PIT charter and minutes available. A documentation PIT is underway which will change many of the ways that documentation is done. This will be changed with new indicators and documentation in place by the beginning of March.

NURSING:

**ASPECT: NURSING DOCUMENTATION/ Integrated Summary Note
COMPLIANCE; 86%**

Indicators	Findings	Compliance	Threshold
1. Documented in the chart on the day of the Comprehensive Service Plan meeting.	24 of 25	96%	85%
2. Identifies client preferences at Service Integration meeting.	21 of 25	84%	85%
3. States whether further assessments will be needed or not per MD, PA or psychiatrist.	16 of 25	64%	85%
4. Identifies the unmet current goals of services.	21 of 25	84%	85%
5. Documents the client or guardian participation in the treatment planning process.	25 of 25	100 %	85%

Findings: The sample size was 25 records. 1and 5 exceeded the threshold; Indicators 2 and 4 were 1% below the threshold. Indicator 2 fell substantially below the threshold.

Problems: The indicator # 3 that asks that nursing identify whether further assessments are needed falls significantly below the threshold.

Status: This indicator will be a focus during the education for new documentation as a plan is devised to capture the need for further assessments.

Actions: Build a methodology to easily document the need for further assessment into the new documentation process and continue to monitor all aspects of this indicator.

PSD Comprehensive Treatment Plan

The Comprehensive Treatment Plan indicators are being revised to better demonstrate active treatment. The next quarterly report will report on the new indicators.

PEER SUPPORT

ASPECT: Integration of Peer Specialist into client care
 Overall compliance: 90%

Indicators	Compliance	Findings	Threshold
1. Attendance at Comprehensive Treatment Team meetings.	457 of 527	86%	80%
2. Grievances responded to by RPC on time.	106 of 109	97%	100%
3. Attendance at Service Integration meetings.	61 of 65	94%	100%
4. Contact during admission.	73 of 73	100%	100%
5. Grievances responded to by peer support on time.	109 of 109	100%	100%
6. Client satisfaction survey completed.	33 of 46	72%	80%

FINDINGS:

Overall compliance is down 2% this quarter from last quarter.

(1) Peer Specialists attended 86% of client treatment team meetings this quarter. Of the 70 meetings that were not attended, 11 were due to attendance at admissions, 4 were due to attending other meetings, 15 due to mandatory training, 28 due to peer specialist being out sick, 4 were due to no peer specialist being available, 6 due to client not wanting peer support present, 1 due to peer specialist not being notified of a meeting change, and 1 due to peer specialist forgetting the meeting.

(2) RPC responded to all but 3 grievances on time. All 3 grievances were on Upper Saco and were 1-2 days late.

(3) Peer Specialists attended 61 of 65 Service Integration meetings this quarter. Four meetings were missed, 3 due to being at mandatory training and 1 due to Peer Specialists not being aware of meeting.

(4) A Peer Specialist had documented contact with all clients admitted to RPC this quarter.

(5) A Peer Specialist processed all grievances filed within 1 business day of grievance receipt for this quarter.

(6) Client satisfaction surveys were offered to 46 clients this quarter. Of those 46 surveys offered, 13 clients declined completing the survey.

PROBLEM:

(1) Peer Specialists are not attending all client Comprehensive Treatment Team Meetings.

- (2) All level I grievances are not being responded to within the time allowed.
- (3) Peer Specialists are not attending all client Service Integration Meetings.
- (6) Client satisfaction surveys are not being completed for all clients at RPC.

STATUS:

(1) Compliance with attendance at client treatment team meetings was down 1% this quarter at 86%. Although this is above threshold, the goal is to attend all client treatment team meetings.

The numbers of meetings missed due to attendance at admissions, attendance at other meetings, peers being unavailable, and clients not wanting peer support present were down (10, 6, 4, 1 respectively). The number of meetings missed due to mandatory training and peers being out sick were up 6 and 16 respectively. The biggest increase in missed meetings was due to a Peer Specialist being out sick for an extended period of time.

Compliance was highest in the month of February at 92% and the lowest in January at 83%.

Attendance was 86% for the month of March. The decreased compliance in January and March was due to a Peer Specialist being out for an extended period of time (January) and an increase in training (March).

(2) Overall compliance with grievance response deadline was up 2% this quarter. Lowest compliance was in January at 96% and highest in February at 100%. Compliance for March was 97%. The number of grievances filed was highest in January at 51 filed. In February grievances filed decreased more than half at 21 and were up in March to 37 filed.

(3) Four Service Integration meetings were missed this quarter. Three of the four were due to attendance at training in the month of March. The other meeting was missed in January due to a Peer Specialist going home sick and not notifying another Peer Specialist of the meeting. In January compliance was 94%, spiked to 100% in February, and dropped sharply in March to 85%.

(4) Peer Specialists had documented contact with all clients admitted to RPC during the quarter. This was up from 97% from last quarter.

(5) Peer Specialists processed all client grievances within 1 business day of receipt.

(6) This was the first full quarter of peer support offering client satisfaction surveys to clients. An annual assessment schedule was obtained from Upper Saco and surveys are being offered to those clients during the month of their annual assessment. Clients on Lower Saco were randomly chosen to complete surveys and civil clients were offered surveys upon discharge from RPC. For last quarter 12 clients were offered surveys and 83% completed them. For this quarter 46 clients were offered surveys and 33 were completed. Only 5 clients were offered surveys in the month of January. After establishing a system to track due dates and discharge schedules, more clients were offered surveys. In February, 21 clients were offered surveys with 16 being completed and 14 of 20 being completed in March. Clients have identified one main reason for not completing surveys, which is the fear of the results affecting their treatment and discharge. Clients are reassured that the survey is anonymous, but still refuse to complete the survey.

ACTIONS:

- A peer support team leader was established and assigned the task of scheduling to ensure that all client treatment team meetings and Service Integration meetings are attended.
- The Peer Support Coordinator will continue to meet with the Risk Manager/designee 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 in order to problem solve ways to address the reason for missed meetings.
- Peer Specialists will be counseled at least twice per month on issues related to missed meetings and work attendance.
- Peer Specialists will make additional efforts to adjust their schedules to be available for meetings and problem-solve with the Peer Support Coordinator on how to manage their schedule and overcome barriers to attending team meetings.

- Peer Support Coordinator will meet with the Social Services Director and Continuity of Care Managers as needed to coordinate meeting schedule in order to ensure Peer Support attendance.
- A system will be developed for peer specialists to be notified of pending discharges so satisfaction surveys can be offered on all other units.

CLIENT SATISFACTION SURVEY: 3rd Quarter Jan-Feb-Mar 2007

ASPECT: Client satisfaction with care

OVERALL COMPLIANCE: 80%

Indicators	Findings		Threshold	+/-
1. Has anyone informed you about your rights?	10 of 13	77%	85 %	-13%
2. Has anyone talked to you about the kinds of services that are available to you?	10 of 13	77%	85 %	-13%
3. Are you informed ahead of time of changes in your privileges, appointments or daily routines?	11 of 13	85%	85 %	+15%
4. Do you know someone who can help you get what you want or stand up for your rights?	11 of 13	85%	85 %	-5%
5. Has your community worker visited or contacted you since you have been in the hospital?	11 of 12	92%	85 %	+12%
6. Do you know how to get in touch with your community worker if you need to?	11 of 13	85%	85 %	+35%
7. Do you have an individualized support plan (ISP)?	6 of 11	55%	85 %	-23%
8. I feel more confident in my ability to deal with crisis situations?	13 of 13	100 %	85 %	+11%
9. I am less bothered by my symptoms now?	10 of 13	77%	85 %	+7%
10. I am better able to function?	12 of 13	92%	85 %	+2%
11. I do better in social situations?	11 of 12	92%	85 %	+14%
12. I experience less difficulty in my life?	9 of 12	75%	85 %	+8%
13. I am treated with dignity and respect?	11 of 14	79%	85 %	+23%
14. I feel comfortable asking questions about my treatment and medications?	11 of 13	85%	85 %	+29%
15. I am encouraged to use self-help/peer support and support groups after discharge?	10 of 12	83%	85 %	+3%

16. My medication benefits and risks were discussed with me?	10 of 14	71%	85 %	+1%
17. I am given information about how to understand and manage my illness?	10 of 13	77%	85 %	+10%
18. My other medical conditions are being treated?	9 of 13	69%	85 %	-21%
19. I feel free to voice complaints and suggestions?	12 Of 13	92%	85 %	-8%
20. I feel my right to refuse medication or treatment is respected?	9 of 13	69%	85 %	+9%
21. I participate in planning my discharge?	12 of 13	92%	85 %	+25%
22. I feel I had enough privacy in the hospital?	9 of 14	64%	85 %	+14%
23. I feel safe while I am in the hospital?	11 of 12	92%	85 %	+25%
24. If I had a choice of hospitals, I would choose this one?	7 of 13	54%	85 %	+14%

Overall compliance was up 7% from last quarter.

Finding: Of the 24 indicators, 11 were at or above threshold for this quarter. This is up by 4 from last quarter.

Problem: Clients are not satisfied with all aspects of care provided by RPC

Status: Increases and decreases in findings are indicated in the table above.

Ten of the indicators that were below threshold last quarter remained below threshold, although 9 of those indicators increased 1-23%; one dropped 23%. Of the 7 indicators at or above threshold last quarter, 5 went down 2-21%, while the others went up 2-11%. Three of the indicators that were above threshold last quarter are now below threshold 13-21%.

Of the indicators below threshold, clients identified reasons for their negative answers for items 7, 13, 22, and 24. Comments related client response to; "Do you have an ISP?" indicated that clients did not know if they had an ISP. A response to the question, "I am treated with dignity and respect?" client comment was, "yes and no." To the question, "I feel I had enough privacy in the hospital?" client comment stated, "to much gossip [by staff]." "If I had a choice of hospitals, I would choose this one?" was responded to with feelings that RPC kept clients too long.

Actions:

- Peer Support will encourage and support clients to voice their concerns with their treatment teams regarding these aspects of care.
- Peer Support will provide feedback to RPC about client concerns/suggestions.

CONTINUITY OF CARE/Social Services Department
ASPECT: Preliminary Continuity of Care Meeting and
Comprehensive Psychosocial Assessments
Overall Compliance: 84%

Indicators	Findings	Compliance	Threshold
1. Preliminary Continuity of Care meeting completed by end of 3 rd day	28/30	93%	100%
2. Service Integration form completed by the end of the 3 rd day	28/30	93%	100%
2a. For any client readmitted within 30 days CCM should assess with the client problematic behaviors, level and type of access to community supports and any other critical issues that contributed to re-hospitalization. Assessment should be documented in a progress note.	2/2	100%	100%
3a. Client Participation in Preliminary Continuity of Care meeting.	29/30	96%	80%
3b. CCM Participation in Preliminary Continuity of Care meeting.	30/30	100%	100%
3c. Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation in Preliminary Continuity of Care meeting.	29/30	96%	80%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	15/30	50%	80%
3e. Correctional Personnel Participation in Preliminary Continuity of Care Meeting.	2/15	13%	60%
4. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission	26/30	86%	95%
5. Annual Psychosocial Assessment completed and current in chart	28/30	93%	95%

Findings:

The sample size for this aspect was 15 charts for the quarter from each of the two admission units, Lower Saco and Lower Kennebec for the indicators 1-3d. For indicator 3e the sample was for Lower Saco only. For indicator 5 the sample was 15 charts for the quarter from both Upper Saco and Upper Kennebec.

Problems: Indicators 1 and 2 fell below compliance as indicated with two clients served on Lower Saco. One client refused initially to participate in his Service Integration Meeting but did minimally complete the process by the fourth day on the unit. The second client began the process but struggled to engage and stay focused during the course of the meeting. The process was completed with the client over the course of several meetings and was complete by the 7th day on the unit. Indicator 3d fell below the threshold percentile and this quarter was at 50%. In several instances clients declined to sign releases to have community providers participate in their Service Integration Meeting. In other situations clients were not returning to their current providers and did not have new providers identified at admission. In a few instances scheduling conflicts and the short notice of the Service Integration Meeting timeframe impacted the ability of some providers to attend but in many

cases the team had some input from those individuals.

Indicator 3e fell below the threshold percentile and this quarter was at 13%. Most clients refuse to have corrections personnel participate in their treatment process. On two occasions clients had corrections representatives engage with them in the Service Integration Meeting. One was a probation officer and the other was a representative from Maine Pre-Trial Services.

Indicator 4 fell below the threshold percentile for two reasons. For two assessments clients acuity levels caused the assessment process to be extended past the 7 day mark for the document to be completed. In the other circumstances poor staff time management prevented staff from completing the assignment within the set timeframe guideline.

Indicator 5 fell below the threshold percentile due to staff error and each situation has been corrected.

Status: Director will continue to monitor all aspect areas and utilize individual supervision to enhance areas impacted by staff time management and organization. As a team we will utilize our department meetings to problem solve clinical aspects that impact these areas and how to better support clients who struggle to engage.

Corrective Actions:

Indicators 1 and 2: These areas will continue to be focused on and monitored. For clients who may struggle with the process due to their level of acuity or challenges the process could begin immediately upon admission which would provide an increased opportunity for the process to be complete by the 3rd day. Last quarter the compliance in this area was 96 % which represents for this quarter a 3 % decrease to 93%.

Indicator 3d: Though this indicator fell below the threshold percentile for this report it was up from 33% to 50% which indicates an increase of 17%. The department will continue to focus on fostering the value of community providers in the overall treatment process and continue to encourage clients to allow them to be part of their course of treatment at RPC.

Indicator 3e: Though this indicator fell below the threshold percentile it is up from zero participation last report to 13% percent this report indicating an increase of 13%. The department will continue to monitor this area and strategies ways to increase participation and support clients to see the potential value in their communication with the corrections system.

Indicator 4: The individual staff has been advised that the guideline is mandatory and have offered strategies to better manage workload requirements. This area will continue to be monitored through individual supervision.

Indicator 5: One of the charts that was out of compliance was on Upper Saco. The client had been a transfer from Lower Saco and was overlooked. It has since been completed. The other was overdue on Upper Kennebec by one week and has also been completed.

CONTINUITY OF CARE/ Social Services

ASPECT: **Forensic Unit: Institutional Reports**

Overall Compliance: 100%

Indicators	Findings	Compliance	Threshold Percentile
1. As part of the Individualized Treatment Meeting all Forensic clients will be prompted to indicate the initiation of a court petition.	79/79	100%	95%
2. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	3/3	100%	95%
3. The assigned CCM will review the new court order	5/5	100%	95%

with the client and document the meeting in a progress note or treatment team note.			
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Findings: This is the first full quarterly report for this aspect area and encompasses all represented client treatment meetings.

Problems: None indicated this quarter all compliance thresholds are met.

Status: Last quarter this aspect area had an overall compliance of 88%. As indicated the overall compliance this quarter is 100%. That is an increase of 12% from last quarter. The increase can be attributed to an improved tracking system and a commitment by team members to prioritize this important process and designating a single point person for gathering signatures and delivery the reports to the court clerk's office.

Corrective Actions: None indicated for this aspect.

Continuity of Care/Social Services

Aspect: Client Discharge Plan Report/Referrals

Overall Compliance: 88%

Indicators	Findings	Compliance	Threshold Percentile
1. The Client Discharge Plan Report will be updated/reviewed by each CCM minimally one time per week.	11/13	84%	80%
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by of Social Services.	13/13	100%	95%
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	10/13	76%	95%
3. Each week the CCM team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	12/13	92%	95%

Findings: The timeframe for this aspect area was 13 weeks. During that time the report was sent out on 9 occasions via email. The report was distributed to stakeholders in hardcopy on two occasions at the Wednesday meeting.

Problems: Indicator 2a, on one occasion an updated report was not distributed because the document was experiencing a technical issue and updates were not appearing in the document as inputted. The MIS team supported a rapid fix of the report and it was back on-line within two days. During that week we referenced the previous weeks report and gave verbal updated to the region. The second time the report was not distributed was the last week of March. The focus of the report is in transition and we are working on the new format.

Indicator 3, this indicator fell below on one occasion because we did not have a housing options list from the region in time to discuss it at our weekly meeting. Once we received the e-mail we prioritize through e-mails back and forth between team members.

Status: The new format for the report will be instituted in April. Team members are updating each of

their client's status in the new format.

Corrective Actions: Continue monitoring as indicated and ensure that an updated and streamlined report is distributed weekly. Utilize individual supervision

Continuity of Care/ Social Services

ASPECT: PROGRESS NOTES

Overall Compliance: 91%

Indicators	Findings	Compliance	Threshold Percentile
1. Contact notes/progress notes will indicate at minimum weekly 1:1 meeting with all clients on assigned CCM caseload.	53/60	88%	90%
2. Contact note/progress note will indicate monthly meeting with all clients on assigned CCM caseload regarding Comprehensive Treatment Planning needs/Progress.	57/60	95%	95%
3. On Upper Saco contact notes/progress notes will indicate at minimum bi- weekly 1:1 meeting with all clients on assigned CCM caseload	14/15	93%	90%

Findings: This aspect area includes chart samples from all units except as noted in Indicator 3 which represents information from Upper Saco only.

Problems: Indicator 1 fell below the threshold percentile. This area is up 3% from last report but did not meet the set compliance threshold.

Status: The overall compliance was up 1% for this aspect area. The department will continue to monitor this area and continue to focus on compliance. In addition with the new Treatment Plan the team will focus on more client specific and individualized discharge plans with notes that will have quality content and meaningful documentation of efforts to build positive rapport with clients to promote increased engagement.

Corrective Actions: Indicator 1 Director of Social Services will continue to discuss work assignments during individual supervision and CCM team meeting regarding the on-going completion of progress notes/treatment team note and any potential barriers to meeting the prescribed timelines for this indicator.

REHABILITATION

ASPECT: UPPER SACO CLIENT'S ATTENDANCE to prescribed treatment

COMPLIANCE: 57%

Indicators	Findings	Compliance	Threshold
Number of Scheduled Program Hours Offered	154.50 of 153.75	99.5%	100%

Number of Program Hours Attended	87.25 of 153.75	57%	75%
Number of Program Hours Refused	63.50 of 153.75	41%	25%
Number of Program Hours Excused	3.75 of 153.75	2%	5%
Level of Engagement	45 out of 155	3.0 average	4.0 average

Findings: Data for this indicator was taken from the week of March 18th to March 24th. Each of the charts that were reviewed showed that clients were offered a different number of program hours ranging from as little as 16.0 hours to the high mark of 31.75 hours. The number of programs offered this quarter increased by over 50%. Of the 24 clients on the unit, 6 charts were reviewed. The total number of programs offered to all 6 clients was 105.75 hours. All but .75 of these hours were scheduled and provided. The .75-hour that was not offered was due to an Individual Therapist being out for the scheduled appointment on the Mall. Of the total 153.75 hours of programming offered to clients, the clients participated in 87.25 hours for a 57% total. The number of hours that client's refused or were excused from programming represented 43% of the 153.75 hours offered. Clients were rated on a scale from 1-4, with 1 being distracted/disengaged and 4 being actively engaged in discussion or activity. For this report period, clients averaged a 3.0, representing intermittent engagement.

Problem: Although the referral system was started, they were not used by all the disciplines, mainly Rehab. Service staff is the only one using them. The level of engagement scale has been added to the notes; however there were a couple of notes that were reviewed that did not have this section completed. After review of the care plans, there are several clients that have incomplete schedules, meaning they are not maximizing their involvement in programs offered by signing up for the classes. The stat sheets continue to need some refinement, but have improved in collecting data from last review.

Status: Although more hours of programming were offered this past quarter, the attendance rate dropped by 3%. The program hours refused rate increased by 11%, while the excused rate went down by from 8% to 2%. The level of engagement is also a point below the threshold, however this information is incomplete as not all areas were adequately completed.

Actions:

- The Harbor Mall Ward Clerk will review each note prior to filing to ensure that the level of engagement section is completed. IF it is not, that note will be returned to the group leader to complete data and then filed.
- The Director of Rehabilitation Services will meet with the Upper Saco team to discuss and further educate team members regarding the referral system and importance of.
- The newly assigned Recreation Therapist for Upper Saco will continue to assess all clients using the Readiness assessment.

The Recreation Therapist assigned to Upper Saco will review each client's schedule, with the goal of having each client scheduled for a minimum of 20 hours each.

PSYCHOLOGY

ASPECT: CO-OCCURRING DISORDERS INTEGRATION

3rd Quarter 2007 December 06, January, February 2007 Co-Occurring Disorders Integration			
Indicators	Findings	Compliance	Threshold
1. There is evidence of an integrated co-occurring assessment.	20/26	77%	100%
2. There is evidence of an assessment of "stage of change".	0/26	0%	100%
3. There is evidence of an integrated co-occurring comprehensive service plan for identified clients.	5/10	50%	85% To be Reported Quarterly
4. Positive change in staff practices as measured by the COMPASS (Co-Morbidity Program Audit and Self-Survey for Behavioral Health Services) on each clinical unit.	COMPASS completed on four treatment units	No report this quarter	Four units participating 10% Increase To be Reported Annually
5. Consumer Satisfaction Survey indicates clients were "encouraged to talk about and work on any mental health and alcohol and drug issues at the same time"	9/9	100%	85%
6. Consumer satisfaction survey indicates that since beginning treatment with us, their condition is better.	8/9	88%	95%
7. Consumer satisfaction survey reports client satisfaction with current treatment experience is better than with any other previous treatment experiences.	2/9	22%	85%
8. Percent of clients with co-occurring disorders as reported by NASMHPD	Jan. 76/148 (February data not available)	48.08 Dec 51.35 Jan.	50%

Findings:

For indicators #1-3 an additional 26 charts were audited with 10 clients positive for co-occurring disorders.

1. Evidence of an integrated assessment increased from 35% to 77%.
Threshold was changed to 100%.
2. Stage of change assessment evidenced a marked decrease from 64% to 0%.
The threshold was changed from 15% to 100%.
3. Integrated service plan for identified clients improved from 25% to 50% this quarter.

- The threshold was raised to 100%.
4. No data to report this quarter.
 - 5.-7. A total of 17 surveys were administered. Of those 9 were co-occurring identified clients. Baseline data collected and thresholds established.
 - 100% of the co-occurring clients reported co-occurring treatment.
 - The threshold was set at 85%.
 - 88% reported that their condition is "better". The threshold was set at 95%.
 - 22% reported that this current treatment (Riverview) was "better" than previous treatment.
 - The threshold was set at 85%.
 8. NASMHPD reports indicate a marked unexpected increase in number of co-occurring clients identified in Nov, Dec. and Jan. (Feb. not available).

Problems:

- 1.-3. All indicators fell below threshold
4. NA
5. Threshold exceeded- no problem
6. Indicator below threshold. Threshold set at 95%.
7. Indicator below threshold. Threshold set at 85%
8. Indicator slightly above threshold.

Status:

1. There is significant improvement in integrated assessments from 35% to 77%. Admissions assessment documentation forms do not adequately reflect screening and assessment information for needed co-occurring treatment.
2. The sharp decline in stage of change assessment was unexpected. One possibility is that the psychosocial assessment form was changed and there may be a possible delay in getting it into the chart.
3. There was significant improvement in integrated CSP's for identified clients from 25% to 50%. This indicator is still significantly below the threshold expected of 85%.
4. NA
5. 17 Surveys completed this quarter. Compliance exceeded expectations. Continue to monitor to establish trend.
6. Indicator below threshold. Continue to monitor to establish trend.
7. Significantly below threshold. Note: clients with 'mental health only' report a significantly higher satisfaction at 77% "better" as compared to 22 % for co-occurring clients.
8. Indicator at threshold. Monitor for trend.

Actions:

- 1.-3.: An additional 25 charts will be audited each quarter. Meet with new admissions personnel to provide education regarding the need for admissions integrated assessment. Work with the Director of Social Work to assess psychosocial assessments addition to chart and timing of co-occurring audits. Continue to work on staff education re: co-occurring plans in CSP.
4. Capital Community Clinic and the Forensic ACT team to complete COMPASS assessments within the next quarter. Each unit/service area will identify specific targeted change goals within the next quarter.
- 5.-7. Conduct additional consumer surveys for clients prior to discharge. Monitor trends. Report findings to Riverview "co-occurring coaches" and ask for input. Include education with staff regarding addressing needs of co-occurring clients.
8. Investigate data collection methods for possible change in practice of data collection. Meet with admissions personnel and medical records to clarify diagnosis recordings practice.

SAFETY**ASPECT: LIFE SAFETY****OVERALL COMPLIANCE: 96%**

Indicators	Findings	Compliance	Threshold
1. Total number of staff assigned to Upper Saco and Upper Kennebec who have received training with the evacuation chair.	59/62	95%	100%
2. Total number of fire drills and actual alarms conducted at RPC during the quarter compared to the total number of alarm activations required per Life Safety Code, that being (1) drill per shift, per quarter.	3/3	100%	100%
3. Total number of staff that knows what R.A.C.E. stands for.	6/6	100%	100%
4. Total number of staff that knows if there was there a situation requiring one-on-one, i.e. client would not leave room, they should stay with them.	6/6	100%	100%
5. Total number of staff that knows how to activate the nearest fire alarm pull station.	6/6	100%	100%
6. Total number of staff that knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	6/6	100%	100%
7. Total number of staff that knows the emergency number.	6/6	100%	100%
8. Total number of staff that knows what the verbal code is used to announce a fire.	5/6	83%	100%
9. Total number of staff that knows it is necessary to close all doors after checking rooms or areas.	6/6	100%	100%
10. The total number of staff that knows what the acronym, P.A.S.S. stands for.	6/6	100%	100%
11. The total number of staff that knows the locations of the two nearest exits to evacuate away from a fire area	6/6	100%	100%
12. The total number of staff that knows two ways that may be used to move a person who is non-ambulatory to safety.	6/6	100%	100%

Findings:

1. Upper Saco has (31) out of (31) who have received the training. This equates to 100% of staff trained for the evacuation chair. Upper Kennebec has (28) assigned staff out of (31) who have received the training. This equates to 90%. This is a combined total of 95%.

2. The (3) alarms reported for the hospital meets the required number of drills per JCAHO and Life Safety Code. Of the (3) alarms, one was a drill activated by the Safety Officer.

4-10. Indicators 4 through 10 are new indicators with the purpose of evaluating the knowledge and skills of staff as it relates to critical skills and knowledge necessary to carry out functions in the event of a fire and/or smoke emergency. The hospital conducts 1 drill per shift per quarter, (3 drills total) plus 1 drill at the Portland clinic, and 1 drill at the Homestead Program, for a hospital total of 5 drills per quarter. At the conclusion of each drill, a single staff person is selected to answer indicators 4-10. Because of overlapping months for this report, there were 6 drills conducted, and thus 6 staff surveyed.

Problems:

1. Out of the 3 on UK that have not had the training, 1 is on light duty, 2 staff transferred from a lower unit. If staff need to be utilized on upper units, may not have had the fire chair training.
8. 5 out of 6 staff knows the verbal code, Code 77, used to announce a fire. One person was not sure, and this uncertainty prompted the Safety Officer to look at industry standards.

Status:

- 3-12. These are new indicators.
8. Has now been implemented hospital wide and is monitored through the fire drills and the HAP surveys. The results of this monitoring will be reflected in the next quarterly report.

Actions:

1. One is on light duty. Safety has had communications with the PSD on that unit and will train the 2 assigned. All staff from Lower Units will be trained in fire chair transport by the end of May 07.
 2. With regard to Code 77, the verbal code to announce a fire, being changed to "CODE RED," the Safety Officer was brought to both the Safety Committee and the Executive Leadership Committee, approved, and has now been implemented hospital wide and is monitored through the fire drills and the HAP surveys. The results of this monitoring will be reflected in the next quarterly report.
- 4-12. Beginning in March 2007, during the hospitals' required monthly HAP surveys, staff from each unit during that survey, will also be assessed for knowledge of items 4-12 and reflected in the next quarterly report.

SAFETY

Aspect: Fire Drills Remote Sites

Compliance: 83 %

Indicators	Findings	Compliance	Threshold
1. Total number of fire drills and actual alarms conducted at Homestead compared to the total number of alarm activations required per Life Safety Code, that being (1) drill per shift, per quarter.	2 day shifts 2 night shifts	66%	100%
2. Total number of fire drills and actual alarms conducted at Portland Clinic compared to the total number of alarm activations required per Life Safety Code (1) drill.	1 drill	100%	100%

Findings:

Homestead had 4 alarms.

- 2 alarms were unannounced drills
- 2 alarms were due to dust in an attic detector

Portland Clinic had the required amount of fire drills. NOTE: This clinic only operates during the day.

Problems: There was no evening fire drill at Homestead. (1) drill resulted in one client taking more than 3 minutes, but less than 13 minutes to evacuate.

Status: The attic smoke detector has been replaced.

Actions: The safety officer will perform a fire drill at Homestead on evening shift within the next 7 days. The Safety Officer has spoken to staff with regard to being more assertive getting the clients out and has spoken to the clients, reiterating the importance of following the direction of staff during evacuation.

Securitas/RPC Security manager

Aspect: Safety/security

Overall Compliance: 80% compliance

Indicators	Findings	Compliance	Threshold Percentile
1. Security search/screening of all clients (Forensic & Civil) being admitted to Riverview for treatment. (total # of admissions vs. total # of admissions screened).	78/78	100%	100%
2. Security searches done with a metal detector in the Saco & Kennebec courtyards. (Total # of searches to be done monthly vs. total # of searches done.)	56/92	61%	90%
3. Security/safety checks done of the "lower" client units during the hours of 8:00 am thru 8:00 pm. (To be done 6 times in this 12 hour period.)	407/504	81%	95%

Findings: The metal detecting yard sweeps of the "fenced in" client courtyards are well below the "target" threshold due to the Winter Season. The safety/security checks of the client units did not meet the threshold this quarter due in part to the busy Holiday times during the month of December. Security Officers were very busy with a "high volume" of visitors and packages to be screened. There were fewer chances for officers to get to the units for these checks, especially on the weekends.

Problems: Winter season/Weather has been the major problem for client courtyard "sweeps" with the wand. Yards are visually assessed by the officers before yard breaks but the metal detectors are not appropriate to use with rain and snow.

On weekends, there is 2 security staff on duty; during the week there is four security staff on duty, making the decision to not perform unit checks six times in a twelve hour period has resulted in the unit checks being low.

Status: New indicators.

Actions: With the upcoming spring season, the client courtyard sweeps will resume.

Riverview's clients are now using blocks of "free time" inside the hospital. Officers will perform unit checks six times in a twelve hour period and have agreed upon 15 minute checks in the dining area and gym, and the Lower Saco hallways. This will be reported to Risk Management on a weekly basis until meets threshold for one month, and will continue to be monitored in quarterly report.

STAFF DEVELOPMENT

ASPECT: New Employee and Mandatory Training

Indicators	Findings	Compliance	Threshold Percentile
1. New employees will complete new employee orientation within 60 days of hire.	9 of 12 completed orientation	75 %	100 %
2. New employees will complete CPR training within 30 days of hire.	7 of 7 completed CPR training	100 %	100 %
3. New employees will complete NAPPI training within 60 days of hire.	8 of 10 completed Nappi training	80 %	100 %
4. Riverview staff will attend CPR training bi-annually.	276 of 276 are current in CPR certifications	100 %	100 %
5. Riverview staff will attend NAPPI Mod 1 training annually. (September/October). Goal to be at 50% by end of each month. 100 % by end of October.	338 of 340 have completed annual Nappi training	99 %	100 %
6. Riverview staff will attend NAPPI Mod 2 training annually. (November/December). Goal to be at 50% by end of each month. 100 % by end of December.	236 of 237 have completed annual training	99 %	100 %
7. Riverview staff will attend NAPPI Mod 3 training annually. (February/March). Goal to be at 50% by end of each month. 100 % by end of March.	226 of 237 have completed annual training	95 %	100 %
8. River staff will attend Annual training. Goal is to be at 50% after Fall training.	218 of 340 have completed annual training	64 %	50 %

Findings: The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. **9 out of 12** (75%) new employees completed these trainings. **276 of 276** (100%) employees are current with CPR certification. **338 of 340** (99%) employees are current in Nappi Module 1 training. **236 of 237** (99%) employees are current in Nappi Module 2. **226 of 237** (95%) employees are current in Nappi Module 3. **218 of 340** (64 %) employees are current in Annual training. 3 employees were sick during Orientation and could not complete orientation during the month. All employees

are schedule during next orientation to complete those sections that they missed due to illness. All indicators remained at 100 % compliance for quarter 3-FY 2006.

Problem: Indicators 1, 3, 5, 6 and 8 are identified as problems as they are below established threshold. 3 employees were sick during Orientation and could not complete orientation during the month. All employees are schedule during next orientation to complete those sections that they missed due to illness.

Status: This is the third quarter of report for these indicators. CPR remains stable at 100% compliance. Annual training continues to be above the 50% threshold after the Fall Training Fair. Spring Training Fair is scheduled for May 2nd. New employee orientation is below threshold, as 3 employees from Peer Support did not complete all of orientation due to other responsibilities from their supervisor. They will complete it next month within the 60-day requirement. Nappi Initial is below threshold due to 2 employees not attending due to the weather. They have completed their classes in the April orientation just outside the 60-day requirement. They have received an overview of Nappi. Nappi Module 2 is below the 100% threshold by 1%. 1 employee has not completed Module 2 of Nappi. She has just returned from a Leave of Absence and trainers have not been able to catch up with her during her shift. Nappi Mod 3 is below the 100% threshold by 5%. 11 staff did not attend the module as required. We will offer a last chance module in May to get them compliant in this module.

Actions: Supervisors of those employees that are not current with their Nappi Module trainings have been notified and recommendations of oral counseling were made. A last chance-training day will be held in May for those individuals and those out on leave who have not attended some of the modules or Training Fair in an attempt to get everyone trained and compliant in training for the fiscal year. Staff Development has discussed the importance of completion of mandatory training with employees and supervisors and all employees that are currently not up to date in the Nappi Modules will attend the May 17th make-up day. Continue to monitor.

STAFF DEVELOPMENT

ASPECT: COMMUNITY PROVIDER TRAINING

Topic	Type	Date(s)	Level of Participation	Information Packets/Publications
BEST PRACTICES				
Body Dysmorphic Disorder: Recognizing and Treating Imagined Ugliness	Psychiatric Grand Rounds	1/9/07 RPC	10 Participants	Hard copy available
Implementing a mandate for Evidenced-Based Practices at the State and Street Level	Psychiatric Grand Rounds	1/23/07 RPC	3 Participants	Hard copy available
Cognitive-Behavioral Treatment of PTSD in persons with Severe Mental Illness	Psychiatric Grand Rounds	1/30/07 RPC	7 Participants	Hard copy available
The Empire Strikes back: C. difficile colitis	Medical Grand Rounds	1/5/07 RPC	4 Participants	Hard copy available
Sex Steroids and the Skeleton in Men	Medical Grand Rounds	1/19/07 RPC	3 Participants	Hard copy available
Immune Therapy following Transplantation: From	Medical Grand Rounds	1/19/07 RPC	3 Participants	Hard copy available

Bench to Bedside and Back				
Pathogens and Therapy of Osteoporosis	Medical Grand Rounds	1/26/07 RPC	4 Participants	Hard copy available
CPR	Initial	1/16/07	19 Participants	Hard copy available
CPR	Initial	1/17/07	3 Participants	Hard copy available
New Treatment option for Schizophrenia	In-service	1/11/07	7 Participants	Hard Copy Available
Urgency in Schizophrenia	In-service	1/31/07 RPC	19 Participants	Hard copy available
The PACE model of Care	Medical Grand Rounds	2/2/07 RPC	3 Participants	Hard copy available
Understanding High Value Care and Reducing Unwarranted Variation in Health Care Delivery: A collaborative project of the Mayo Clinic, Intermountain Health Care and the Center for the Evaluative Clinical Services	Medical Grand Rounds	2/9/07 RPC	5 Participants	Hard copy available
Paradigms Lost, Paradigms Regained: The story of Rituximab Treatment of Systemic Lupus Erythematosis	Medical Grand Rounds	2/16/07 RPC	5 Participants	Hard copy available
Les Liaisons danger use: First in human studies of novel biomolecules/chemical entities	Medical Grand Rounds	2/23/07 RPC	4 Participants	Hard copy available
Coping with Disease-Related Pain: Issues and Opportunities	Psychiatric Grand Rounds	2/6/07 RPC	6 Participants	Hard copy available
Participatory (Shared) Planning and Decision Making in Collaborative Health Care	Psychiatric Grand Rounds	2/13/07 RPC	7 Participants	Hard copy available
Child Traumatic Stress: Scope, Impact and Dissemination of Evidence-Based Interventions	Psychiatric Grand Rounds	2/27/07 RPC	9 Participants	Hard copy available
Collaborative Care for Depression in Primary Care: The IMPACT Model	Psychiatric Grand Rounds	3/6/07 RPC	7 Participants	Hard copy available
Strategies for	Psychiatric	3/20/07	10	Hard copy available

Improving Quality of Mental Health Care	Grand Rounds	RPC	Participants	
Spending Quality and the Paradox of Plenty	Psychiatric Grand Rounds	3/27/07 RPC	9 Participants	Hard copy available
Medically Unexplained Symptoms and the Environment?	Medical Grand Rounds	3/2/07 RPC	2 Participants	Hard copy available
The Edema Syndromes	Medical Grand Rounds	3/9/07 RPC	3 Participants	Hard copy available
Understanding and Treating Medically Unexplained Symptoms	Medical Grand Rounds	3/16/07 RPC	7 Participants	Hard copy available
A Rash Overview of Cutaneous Manifestation of Agents of Bioterrorism	Medical Grand Rounds	3/23/07 RPC	5 Participants	Hard copy available
Inherited Cardiovascular Disease: Diagnosis and Management	Medical Grand Rounds	3/30/07 RPC	6 Participants	Hard copy available
CPR	Initial Class	2/13/07 RPC	4 Participants	Hard copy available
CPR	Re-Certification	2/21/07 RPC	5 Participants	Hard copy available
CPR	Instructor Course	2/24/07 RPC	8 Participants	Hard copy available

Attendees evaluated all classes and all attendees gave positive results.

COMMUNITY FORENSIC ACT TEAM

Aspect: Descriptive Report on various components
January, February, & March 2007

Case Management	ACT	ICM
January, 2007	31	16
February, 2007	31	15
March, 2007	32	15

Number of Clients Discharged from ACT

January, 2007	0
February, 2007	0
March, 2007	0

Number of Clients Referred to PTP

January, 2007	2
February, 2007	2 1 court ordered & one pending
March, 2007	2 1 court ordered, one client elected to stay hospitalized

Number of clients non forensic, non PTP

January, 2007	1
February, 2007	1
March, 2007	1

Number of Crisis Calls between 8A and 8P

January, 2007	3
February, 2007	3
March, 2007	3

Number of Crisis calls between 8P and 8A

January, 2007	2
February, 2007	0
March, 2007	1

RESOLUTION OF CRISIS CALLS**Number of clients admitted to Hospital**

January 2007	0
February 2007	1
March 2007	1

Number of clients admitted to Respite

January 2007	0
February 2007	0
March 2007	0

Number of contacts requiring law Enforcement

January 2007	0
February 2007	1
March 2007	1

SUBSTANCE ABUSE**Number of clients with substance abuse as a matter of clinical focus**

January 2007	8
February 2007	8
March 2007	8

LIVING SITUATION**Number of Clients residing in supervised setting**

January 2007	20
February 2007	20
March 2007	22

Number of clients in own apartments

January 2007	7
February 2007	7
March 2007	8

Number of Clients incarcerated

January 2007	0
February 2007	0
March 2007	0

Number of Clients homeless

January 2007	0
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February 2007	0
March 2007	0

Number of Clients in shelters

January 2007	0
February 2007	0
March 2007	0

Number of Clients who remain hospitalized

January 2007	4
February 2007	4
March 2007	3

VOCATIONAL / EDUCATIONAL

Number of clients working at community work sites

January 2007	10
February 2007	11
March 2007	11

Total number hours worked by clients served by ACT

January 2007	237.5 hours
February 2007	714 hours
March 2007	668 hours

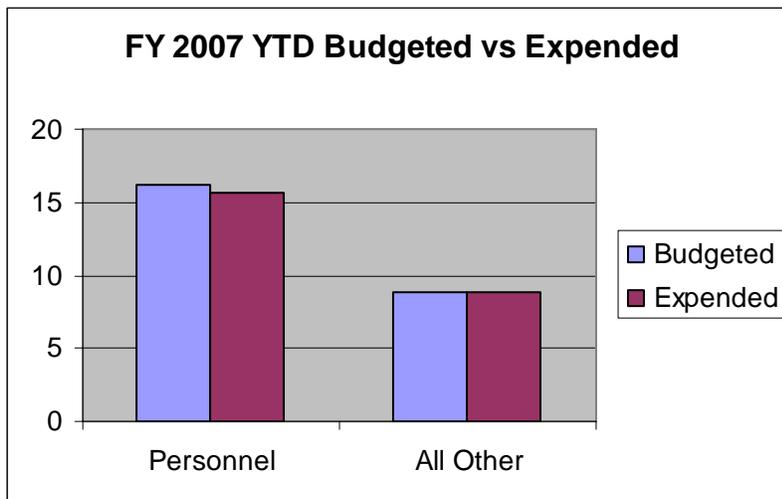
Average number of hours worked per client a month

January 2007	23.7 hours
February 2007	59 hours
March 2007	60 hours

Section II: Riverview Unique Information

BUDGET

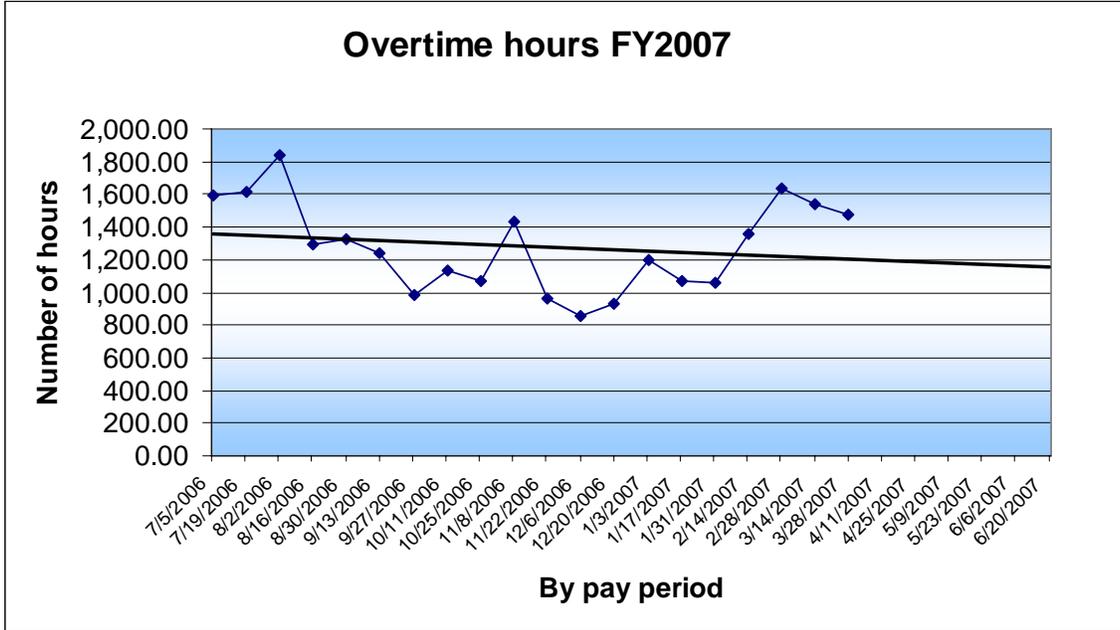
ASPECT: BUDGET INFORMATION



The hospital currently continues to stay within budget. Action plan includes continuing to carefully monitor and manage overtime and mandates. Continue aggressive management of all contractual

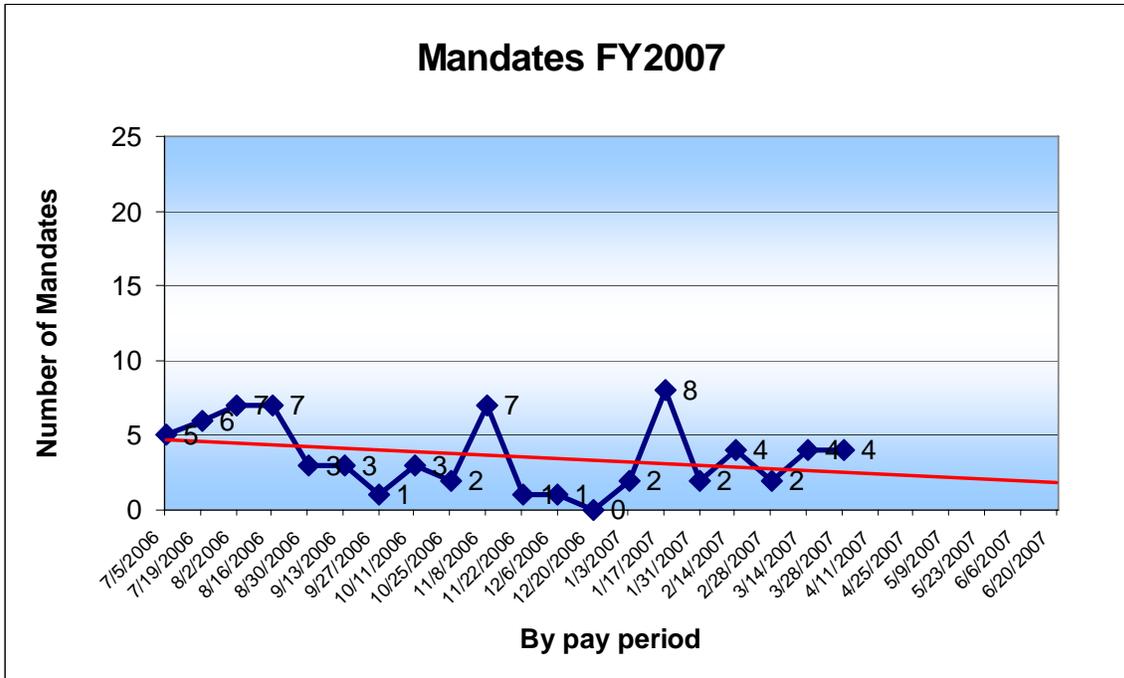
services via fiscal and programmatic accountability.

HUMAN RESOURCES
Overtime



Overtime has increased this year as compared to last year. During this same time period (Jan 2006 - Mar 2006) we were at a total of 8,448.25 hrs of overtime. This year we are at 9,328.5 hrs of overtime. This represents a 10% increase.

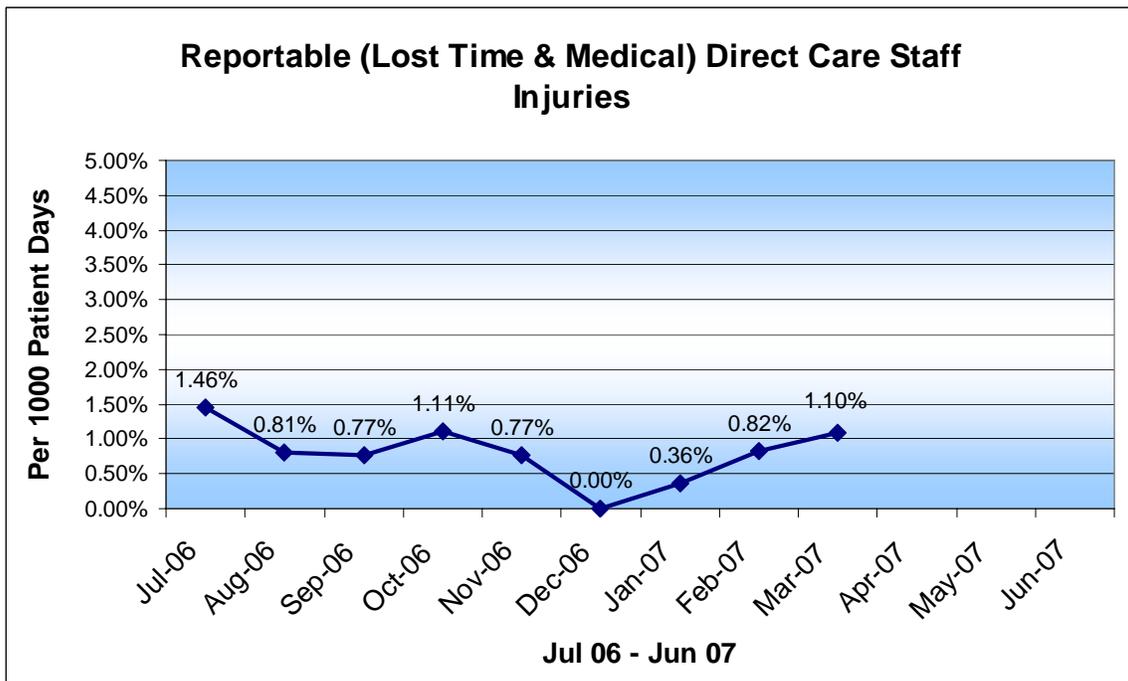
HUMAN RESOURCES
ASPECT: MANDATES



Mandated shifts have increased this third quarter of 2007 as compared to last year at this same time frame. During Jan 2006 - Mar 2006 we had 24 mandates, this year we've had 26 mandates for this same timeframe. This is a 8% increase from last year

HUMAN RESOURCES/RISK MANAGEMENT

ASPECT: Direct Care Staff Injury resulting in lost time & medical care



This quarter review reveals that there was an increase in direct care staff injuries from .63% per 1000 patient days to .76% per 1000 patient days. This number represents six (6) direct care staff who sought medical treatment or lost time from work, as compared to five (5) last quarter.

HUMAN RESOURCES

ASPECT: Performance evaluations.

OVERALL COMPLIANCE: 71.60%

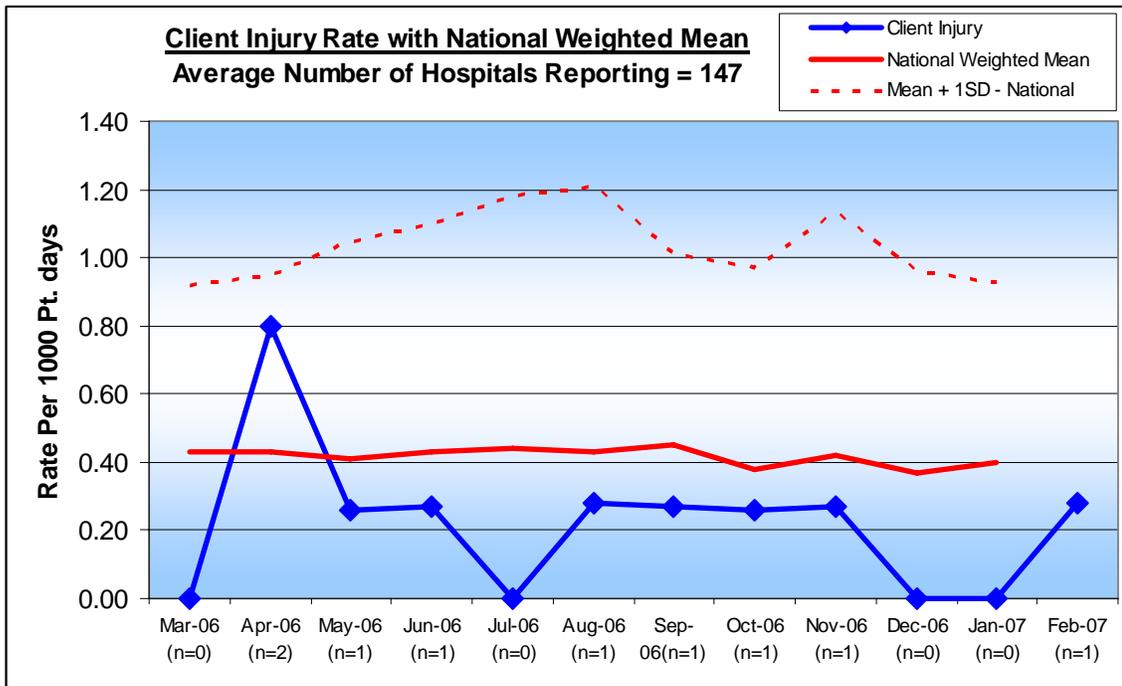
INDICATOR Employee Performance Evaluations expected to be completed within 30 days of the due date.	FINDINGS		TARGET PERCENTILE
Jan 2007 (Nov evals)	17 of 29	58.62%	85%
Feb 2007 (Dec evals)	26 of 32	81.25%	85%
Mar 2007 (Jan evals)	15 of 20	75.00%	85%

As compared to last quarter (55.35%) this quarter's increase to 71.6%. As compared to the same quarter last year, 2006, we were at 52% compliance. During this quarter 81 performance evaluations were sent out; 58 were received in a timely manner. During this rating period we hired a RN IV on one of the lower units and this has helped the PSD in getting the performance evaluations up to date.

Section III: Performance Measurement Trends Compared to National Benchmarks.

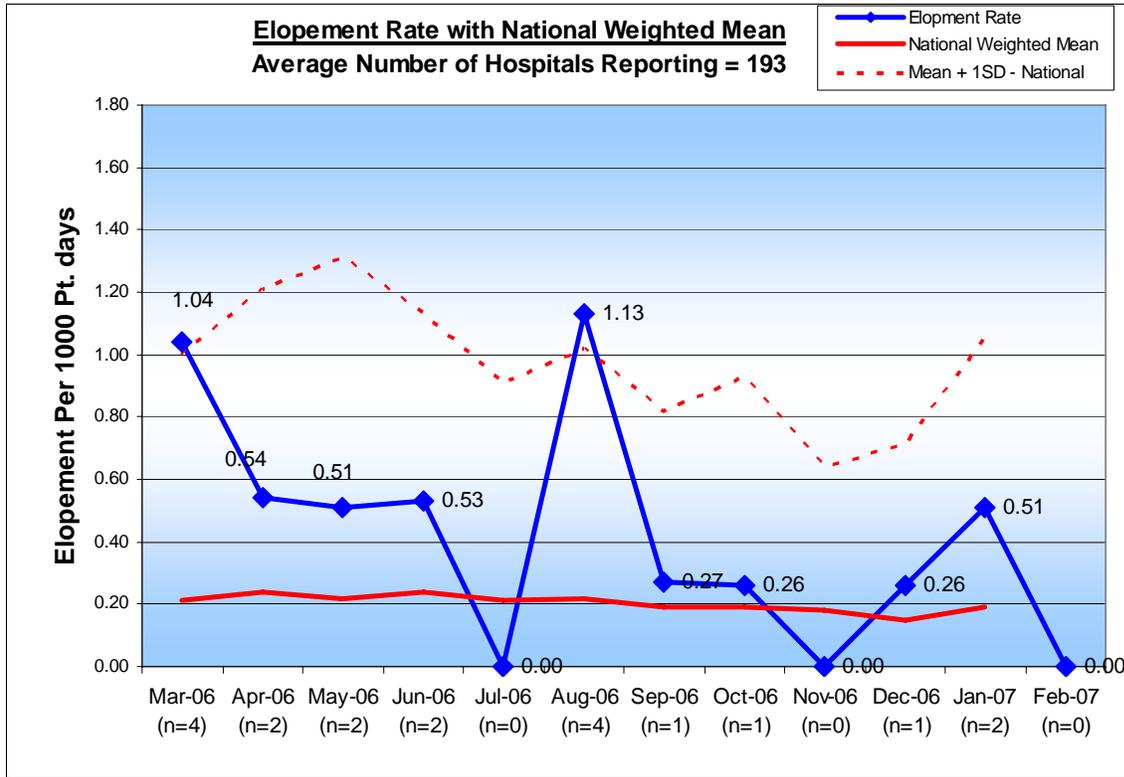
This section contains a number of graphs that compare Riverview Psychiatric Center to a national sample (the range is approximately 75-215 hospital across all aspects) of participating like facilities. Each line graph presents the national weighted mean (solid red line) and the limit of the first standard deviation (dashed red line) as reference points. Practically speaking, about 68% of participating hospitals' rates would be within the limit denoted by the dashed red line. The solid blue line represents Riverview's rate by comparison. As the majority of these graphs will show, Riverview's rates do vary above and below the weighted national mean, but are typically within the "normal" range (within the 1st Standard Deviation) of other hospitals in the sample.

CLIENT INJURY RATE GRAPH



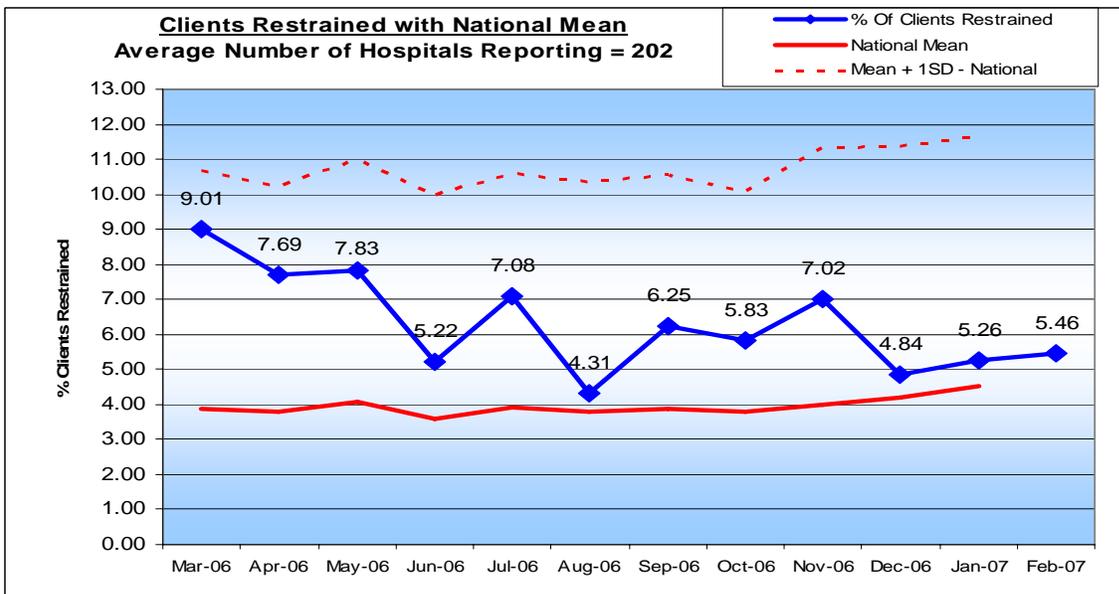
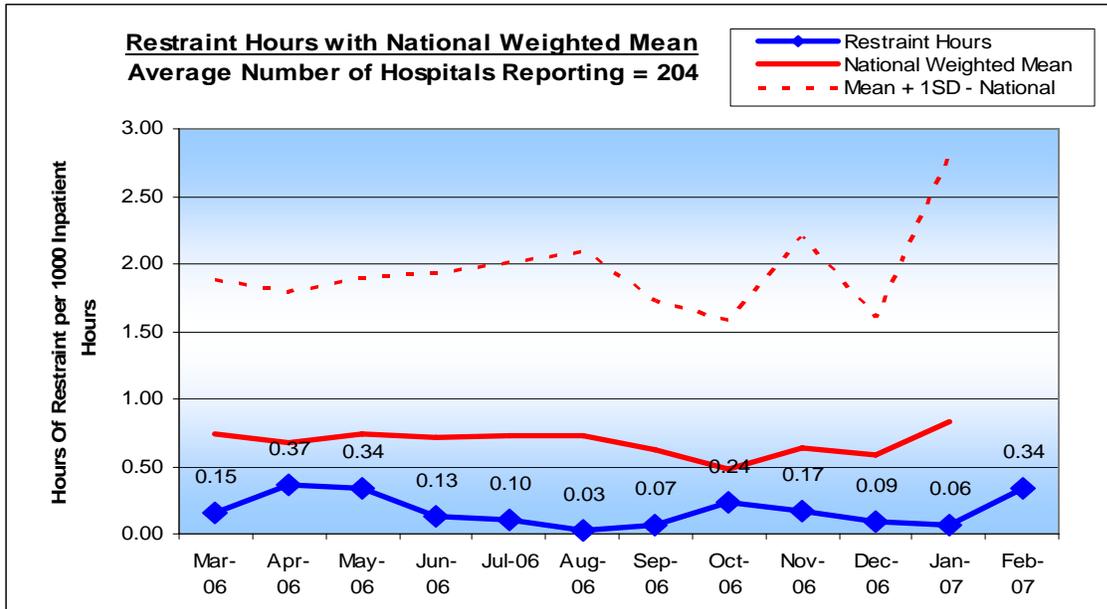
Client Injury Rate considers slips, trips and falls; self-injurious behavior; and client-to-client injury that requires more than first-aid. The numbers of such incidents are low, as shown by the little n under each month. Riverview's line, although appearing to have dramatic fluctuation, is in part the result of the scale used on the Y-axis. Riverview is well within the 1st standard deviation of the national sample. Please note the sheer number of events at Riverview is very low, between zero and 3 each month. Over the last 3 months, there was one injury requiring more than first aid level of care. Taking the mean of Riverview's rate over the quarter (given client injuries are very infrequent) would put Riverview's rate below the national mean at 0.18.

ELOPEMENT RATE GRAPH



Elopement Rate is calculated per 1000 patient days. Elopement risk is evaluated by the treatment team and is treatment planned if necessary to keep the client and the community safe. All Riverview's numbers are within the 1st standard deviation of the national sample over the quarter. Please note the sheer number of events at Riverview is very low, between 0to 4 each month over the last year. Over the last 3 months reported on this graph there were 3 elopements.

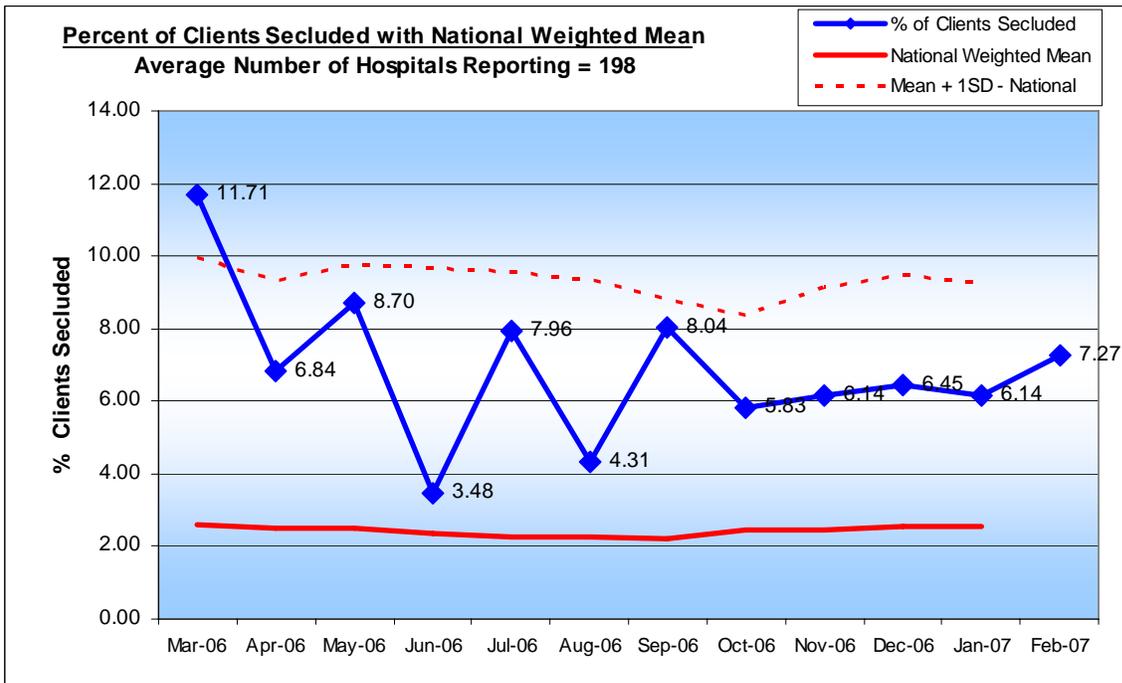
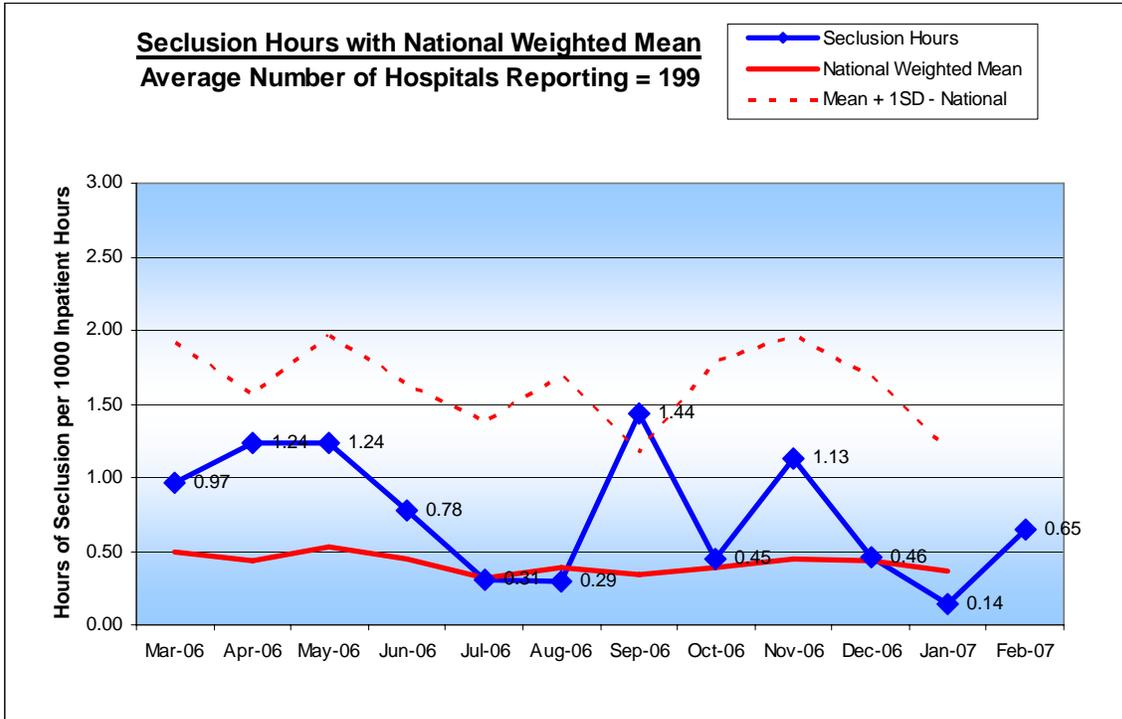
RESTRAINT GRAPHS



Riverview's rate of clients restrained, although above the statistical mean, is comparable to at least 68% of hospitals in the national sample. The restraint hours (duration) rate is well below the statistical mean, but also comparable to the bulk of hospitals in the national sample. The data would suggest that Riverview's restraint events are short by comparison, and efforts to reduce the frequency of restraint use would have the most impact. Corrective actions applied are: reducing the time for restraint order renewal from 4 hours to 1 hour; revision of debriefing process; new protocol and form to guide treatment plan revisions within 72 hours following the event is in place; education initiatives; increased clinical, supervisory and administrative oversight; expanding opportunities for client choice is a priority to be monitored and tracked in monthly administrative reports; the hospital has put forward a proposed tobacco-free campus policy, that is being phased in and will be fully implemented by 4/2/07, as national data show that tobacco-related issues are often precipitants to restraint/seclusion events in a national

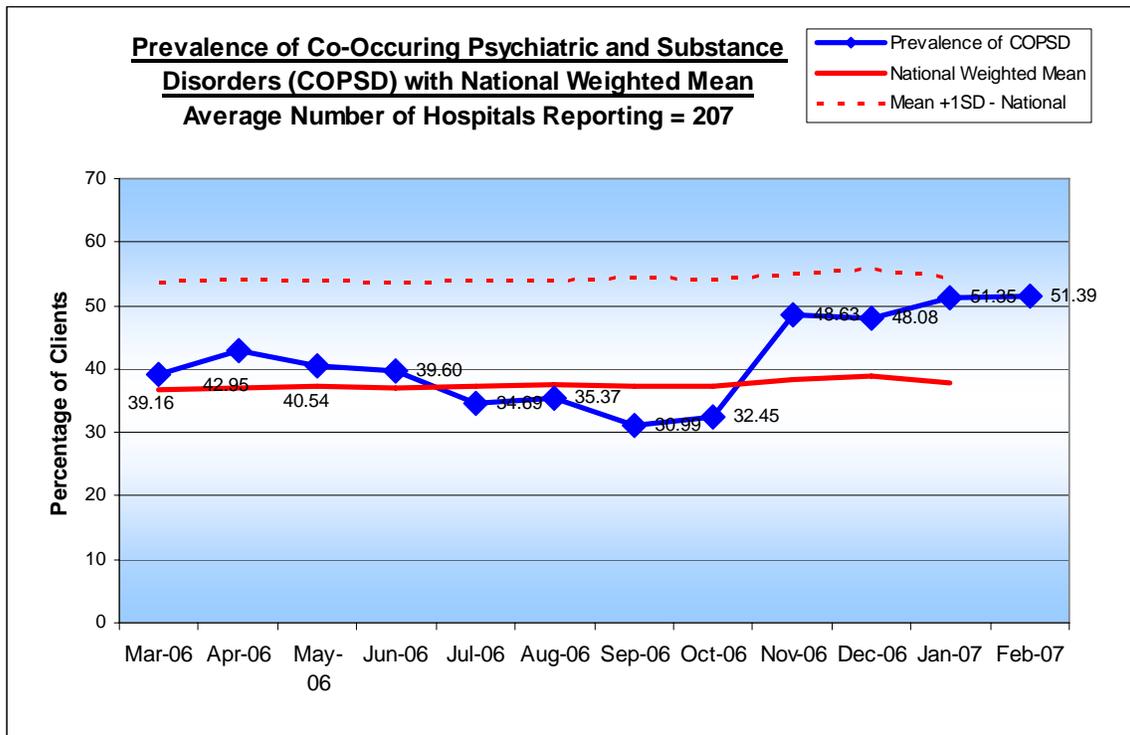
sample (smoking/tobacco as significant precursor to restraint/seclusion events was **5%** in non-smoking facilities vs. **34%** in smoking facilities--7 times more).

SECLUSION GRAPHS



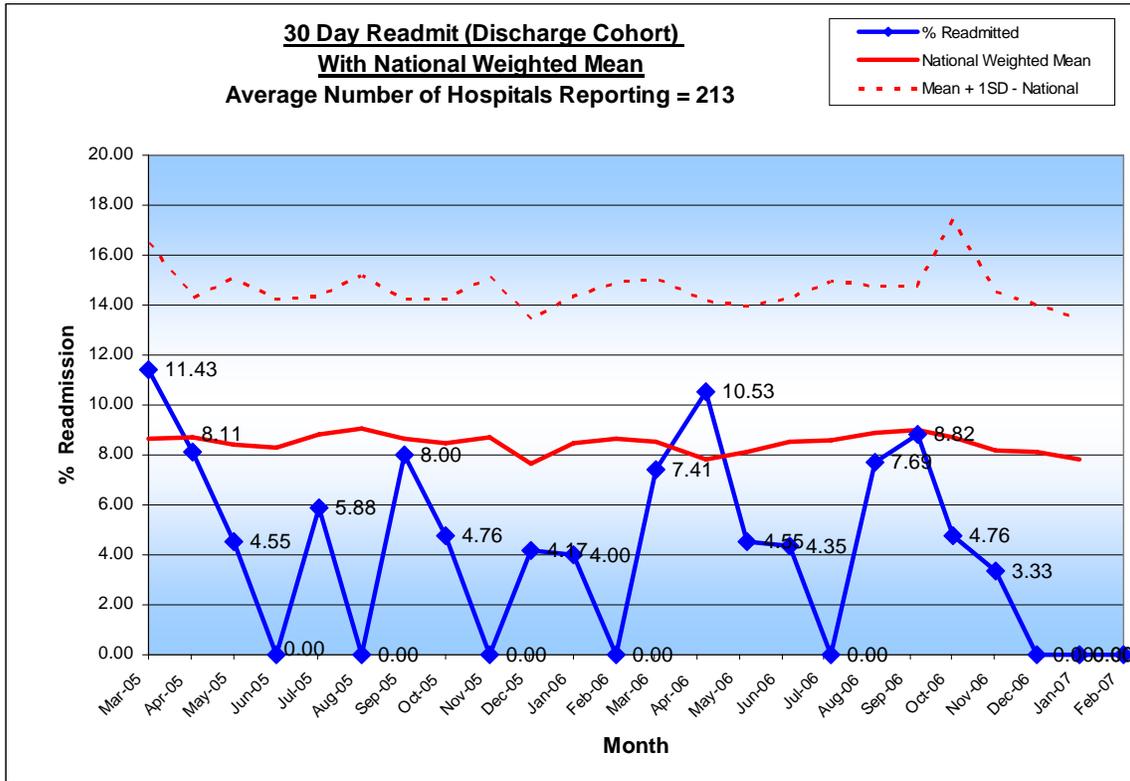
Riverview used seclusion more frequently than 68% of hospitals in the national sample in the month of March, but the rate is generally comparable to the national sample in other months. Seclusion hours (duration of events) at Riverview, although tending to be above the national weighted mean, are within the 1st Standard Deviation of other hospitals in the national sample. Riverview's efforts to reduce use of these interventions should focus on both the frequency and duration of seclusion events. Corrective actions applied are: reducing the time for seclusion order renewal from 2 hours to one hour; revision of debriefing process; new protocol and form to guide treatment plan revisions within 72 hours following the event is in place; expanding opportunities for client choice is a priority to be monitored and tracked in monthly administrative reports; education initiatives; increased clinical, supervisory and administrative oversight; the hospital has put forward a proposed tobacco-free campus policy, that is being phased in and will be fully implemented by 4/2/07, as national data show that tobacco-related issues are often precipitants to restraint/seclusion events in a national sample (smoking/tobacco as significant precursor to restraint/seclusion events was 5% in non-smoking facilities vs. 34% in smoking facilities--7 times more)

CO-OCCURRING PSYCHIATRIC AND SUBSTANCE ABUSE DISORDERS GRAPH



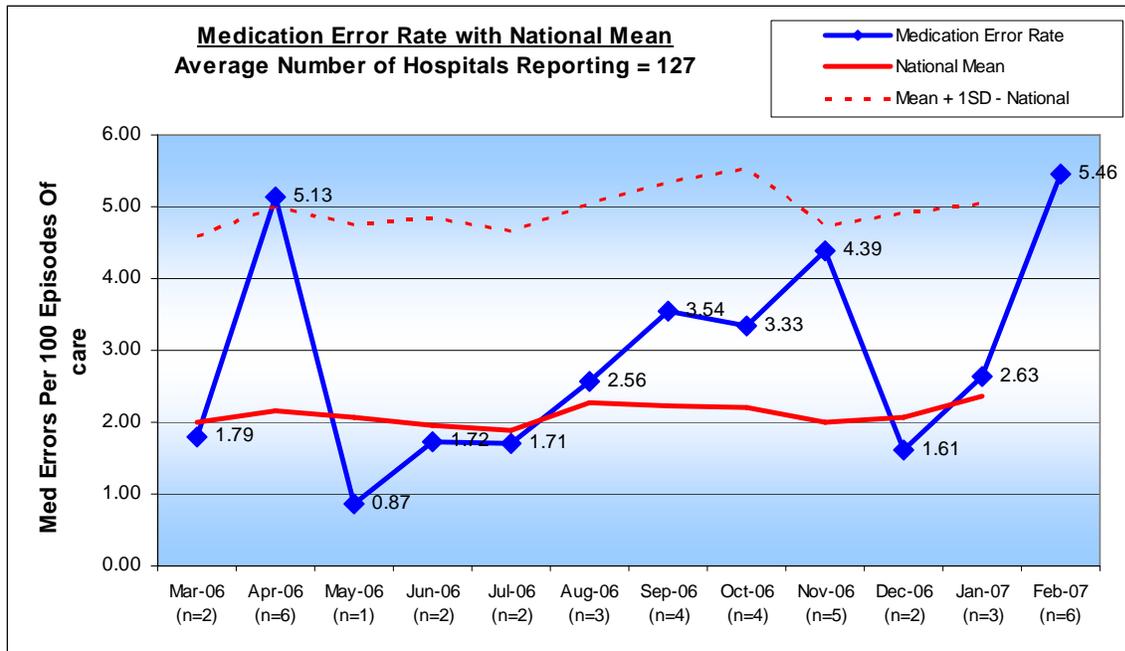
RPC has recently begun a collaborative effort with Spring Harbor Hospital Co-Occurring Disorders providers to contract with RPC to develop a Co-Occurring program. Though RPC is currently a bit above the trend line, this is an indicator current initiatives are working as anticipated; with the advent of this program to help identify and treat clients with co-occurring disorders it should rise above the trend line. This information is gathered from admission diagnosis.

THIRTY DAY READMIT GRAPH



30 Day Readmission Rate is at or below the mean of the 209 other facilities reporting on this indicator. Thirty day readmission rate is calculated considering the percent of discharges for the facility that returned within 30 days of a discharge of the same client from the same facility. At RPC readmissions on the forensic unit are at will of the court are not considered in the calculation. The last three months reported have had no readmissions in 30 days.

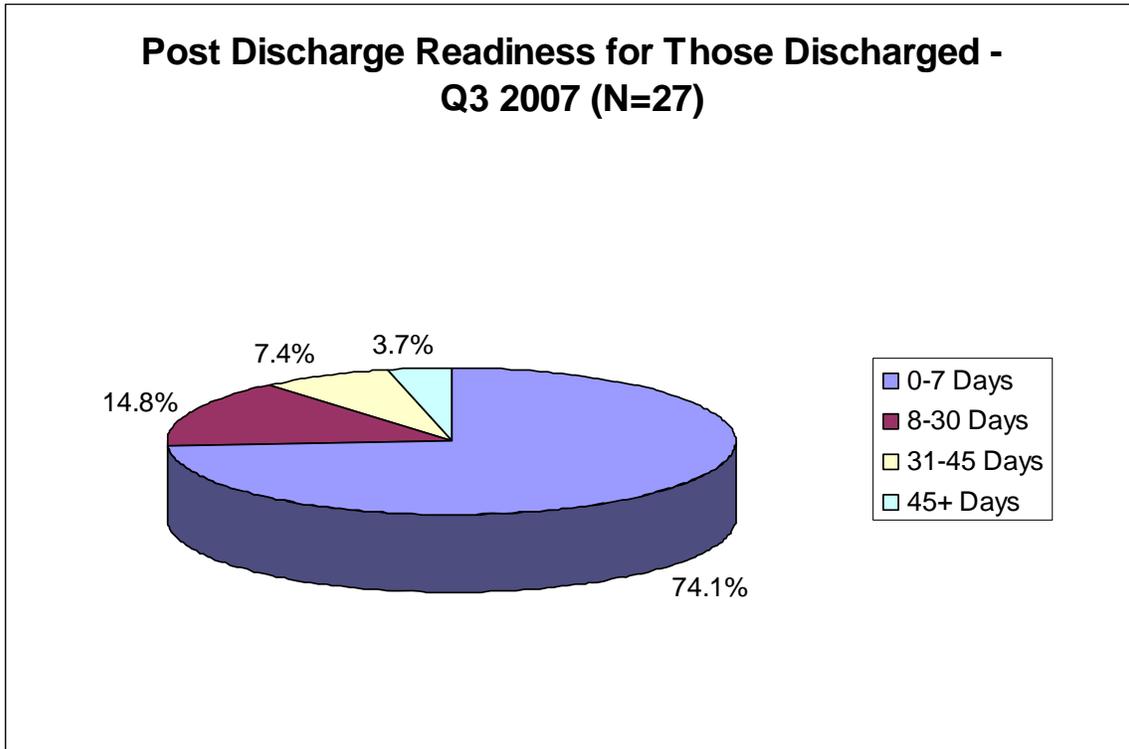
MEDICATION ERROR RATE WITH NATIONAL MEAN GRAPH



The medication error rate considers the number of medication errors for every 100 episodes of care. For example a medication error rater of 1.6 means that 2 medication errors occurred each 125 episodes of care.

The medication errors report was up in February as the hospital did a pilot of daily MAR (medication administration records) which causes a more frequent assessment of the medication process on a daily basis.

POST DISCHARGE READINESS PRIOR TO DISCHARGE



This chart shows the percent of clients who were discharged within 7 days of their discharge readiness to be at 74.1% 8- 30 days post readiness 14.8%; 31-45days at 7.4% and Greater than 45 days post discharge ready 3.7% of clients discharged this quarter. Cumulative percentages and targets are as follows:

- Within 7 days = 74.1% (target 75%)
- Within 30 days = 88.9% (target 90%)
- Within 45 days = 96.3% (target 100%)

This quarter has shown marked progress towards meeting these targets.

The previous 3 quarters are displayed in the table portrayed below:

Quarter	Within 7 days	Within 30days	Within 45 days	45 +days
Target	75%	90%	100%	0%
Q2 2007	64.1%	82% (17.9%)	85.6% (2.6%)	15.4%
Q12007	51.0% (51%)	22.4% (73.4%)	81.6% (8.2%)	18.4%
Q4 2006	44.7% (44.7)	21.1% (65.8%)	81.6 (15.8%)	18.4%

Section IV: Process Improvement Team Reports

Comprehensive Service Plan Process PIT:

A PIT was assigned to review and revise our comprehensive service plan form and associated processes. This was completed and the associated forms were approved at Executive Leadership, now submitted to Medical Records for formal adoption at the November meeting. In the interim, this was piloted on Lower Kennebec. Mandatory Training for RN's, PSD's, CSW, Psychologist, MD's and treatment team coordinators occurred the week of 4/8 and 4/15 and the new treatment planning process will be implemented Hospital wide beginning 4/23/07.

FMEA process initiated and completed regarding devising a monitoring system to assure clozapine is utilized as safely as possible at RPC. Clozapine requires weekly lab work for at least the first six months, and missed doses need to be noticed by the MD and the pharmacy to assure the client receives the maximum benefit and does not have untoward effects. The outcome of the FMEA was that a clozapine drive has been established for use by the MD's, Nurses and pharmacists. An excel spread sheet has been established for each client who is on Clozapine, with the dose they are on, if they miss any doses (medication nurse faxes to pharmacy and notify clients provider if medication is refused) lab results are posted weekly, and if lab work is missed (Lab tech notifies the Charge nurse who faxes to Pharmacy and notifies the client's provider if lab work missed); The Clozapine drive is monitored by the Risk Manager to assure the information was being received by the pharmacist and entered into the data base by reviewing both the data base and the clients MAR and the lab book. There has been no discrepancy. It will be monitored for the next two months and then intermittently if there continues to be no discrepancies.