

Riverview

PSYCHIATRIC CENTER



PERFORMANCE IMPROVEMENT REPORT

SECOND QUARTER
SFY 08
OCTOBER, NOVEMBER AND DECEMBER 2007

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01/23/08

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Introduction:

The second quarter of SFY 08 was impacted by surveyors from professional's in psychiatric care from the Center for Medicare and Medicaid Services (CMS) who reviewed the hospitals compliance with the Special Conditions of Participation for Psychiatric Hospitals; the Joint Commission to provide us with triennial Hospital Accreditation Survey and Behavioral Health Standards Survey of the Forensic ACT program; Lastly, the Department's Sentinel Event program staff visited to review our policies and processes for sentinel event prevention. All of the surveyors were positively impressed with care provided at Riverview Psychiatric Center.

Section I: Departmental Quality Assessment & Performance Improvement

Infection Control

Aspect: Hospital acquired infection

Overall Compliance: Hospital average for 2nd quarter SFY08 = 2.33

Indicators	Number	Rate	Threshold Rate
Hospital Acquired (healthcare associated) Infection rate, infections per 1000 patient-days	28	2.33	5.8 or less

Findings: Infection rate is obtained by total house surveillance. Total house surveillance remains the best method for behavioral healthcare facilities to identify trends or problems. Surveillance is accomplished by chart reviews, review of antibiotic prescribing (used for infections or prophylaxis), and clinical staff reporting.

Problem: None noted. This quarter's numbers are 28 infections for a rate of 2.33. This is well within the threshold percentile.

Status: Infection rate for this period is within the accepted 2 standard deviation for threshold of action.

Actions:

Hand hygiene continues to be stressed to staff and clients. Informational e-mails have been routinely sent out to staff regarding the flu, availability of vaccines and clinics. Posters displayed to remind staff and clients to cover coughs and sneezes to stop the spread of infections. The flu vaccine has been available to all staff and clients.

Information Management

Aspect: Confidentiality

Overall compliance: 100%

INDICATORS	COMPLIANCE	THRESHOLD PERCENTILE
1. All client information released from the Health Information department will meet Joint Commission, State, Federal & HIPAA standards.	100 %-no issues in October. 100 %-no issues in November. 100%-no issues in December.	100%
2. All new employees/contract staff will attend confidentiality/HIPAA training.	100 % -3 new employees/contract staff in October.	100%

	<p>100% -6 new employees/contract staff in November.</p> <p>100%-6 new employees/contract staff in December.</p>	
<p>3. The Director of Health Information will track the number of confidentiality/privacy issues through incident reports.</p>	<p>There were 0 confidentiality/Privacy-related incident reports in October.</p> <p>There were 0 confidentiality/privacy related-incident reports in November.</p> <p>There were 0 confidentiality/privacy-related incident reports in December.</p>	<p>Incident reports will be monitored for privacy issues. The incident rate will remain at 0%.</p>

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. **1703 out of 1703** (100%) requests for information (1545 police checks and 158 requests for client information) were released from the Health Information department during this quarter. 15 out of 15 (100%) new employees/contract staff attended Confidentiality/HIPAA training. All indicators remained at 100 % compliance for quarter 2-FY 2008.

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 quarter 2. Continue to monitor.

Actions: The above indicators will continue to be monitored.

Information Management

Aspect: Documentation & Timeliness

Overall compliance: 89 %

Indicators	Findings	Compliance	THRESHOLD PERCENTILE
<p>1. Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.</p>	64/72.	88%	80%
<p>2. Discharge summaries will be completed within 15 days of discharge.</p>	70/72	97%	100%
<p>3. Forms used in the medical record will be</p>	0/0	100%	100%

reviewed by the Medical Record Committee.			
4. Medical transcription will be timely & accurate.	341/399	85%	90%

Findings: The indicators are based on the review of all discharged records. There was 88% compliance rate with record completion within 30 days. There was 97% compliance rate with discharge summaries. Weekly "charts needing attention" lists are distributed to all medical staff, including the Medical Director, along with the Superintendent, Deputy Superintendent of Administrative Services, and the Risk Manager. There was 85% compliance rate with timely medical transcription services.

Problem: Discharge Summary completion has increased (97%) since Q1, although it still remains below the threshold. Record completion dropped (88%) since Q1, although it remains above the threshold. Timely medical transcription dropped (85%) below the threshold.

Status: 88% compliance rate with record completion within 30 days and 97% compliance rate with discharge summary completion. 85% timely medical transcription reports.

Actions: All medical staff (including the Medical Director) receive weekly notification regarding "charts needing attention". Medical Staff are notified via telephone call and or e-mail regarding any discharge summaries that need to be completed prior to deficiency. The above indicators will continue to be monitored. I spoke directly to the President of Northeast Transcription who assured me the reports would be expedited. There were several unanticipated medical leaves that accounted for the delay. Update: the reports were received within 2 working days of the conversation.

MEDICAL STAFF

Aspect: Review of Suicide Risk Assessment on clients for 2nd Quarter FY08

Overall compliance: 73%

October, November, December, 2007							
Indicator	Findings/Score			Compliance			Target %
	Oct	Nov	Dec	Oct	Nov	Dec	
1. Presence or absence of current suicidal ideation/intent is documented.	NA	17 of 21 passed	15 of 20 passed	NA	81%	75%	90%
2. Presence or absence of current suicidal plan is documented.	NA	16 of 21 passed	13 of 20 passed	NA	80.9%	65%	90%
3. Presence or absence of current suicidal command hallucinations is documented.	NA	17 of 21 passed	14 of 20 passed	NA	81%	70%	90%
4. Presence or absence of current feelings of hopelessness/ helplessness is documented	NA	17 of 21 passed	12 of 20 passed	NA	81%	60%	90%
5. Presence or absence of prior suicide attempts is documented.	NA	13 of 21 passed	10 of 20 passed	NA	61.9%	50%	90%

Findings: This is a new medical staff performance monitor. The adequacy of suicide risk documentation was assessed for the five identified elements of suicide in a total of 41 admission notes and discharge summaries.

Problems: All indicators (elements) were below the target of 90%. The worst performance was on the presence or absence of prior suicide attempts: the best performance was on presence or absence

of current suicidal ideation or intent. There were no trends relevant to individual practitioners, but it did appear that the admission notes were better documented than discharge.

Status: New this quarter.

Actions: There was consensus amongst the medical staff a more specific form in the chart mandating the recording of multiple suicide risk elements would be preferable. The medical staff approved the use of the Tool for the Assessment of Suicide Risk (TASR) to be added to the medical record. Medical director reinforced the importance of suicide risk assessments at several medical staff meetings. Pilot use of TSAR began in December. The use of the TASR was approved commencing on January 1, 2008 hospital wide. Training provided to Medical staff regarding use of TASR. These indicators will be monitored by reviewing admission/discharge notes and/or the completed TASRs until the thresholds are consistently met.

Pharmacy

Aspect: Height Weight Available to Pharmacist

Compliance: 99%

OCT	Missing Heights and Weights	Total Clients	Percent Compliance	Threshold Compliance
Missing heights and weights before pharmacist intervention	8	88	90.9	95 %
Missing heights and weights after initial pharmacist intervention	4	88	95.5	95%
Missing heights and weights after second pharmacist intervention	0	88	100	100%
November 07	Missing Heights and Weights	Total Clients	Percent Compliance	Threshold Compliance
Missing heights and weights before pharmacist intervention	4	88	95	95 %
Missing heights and weights after initial pharmacist intervention	1	88	98.9	95%
Missing heights and weights after second pharmacist intervention	0	88	100	100%
December 07	Missing Heights &	Total Clients	Percent Compliance	Threshold

	Weights			Compliance
Missing heights and weights before pharmacist intervention	6	91	93.4	95 %
Missing heights and weights after initial pharmacist intervention	0	91	100	95%
Missing heights and weights after second pharmacist intervention	Not necessary!!			100%

Methods: In order to provide the best pharmaceutical care for our clients, it is essential that the height and weight for each client be sent to the pharmacy. With this information, we are able to provide the most accurate dose for our clients. All four units of the hospital continued to be evaluated on a monthly basis for client's height and weight values. Upon noting the discrepancies, an initial attempt by the pharmacist was made to obtain these values by sending each unit a form that included the client name as well as a place to indicate the missing height and/or weight or to document if the client refused having these done. If the unit did not comply with this request, a second attempt was made to get the information. This involved the pharmacists' going to the floor and looking through the client's chart, and documenting the information.

Findings: The sample size ranged from 88-91 clients per month. It is important to note that due to the diagnoses of this client population, there may be an increase in the number of refusals of heights and weights as compared to the general population. These refusals may not have been appropriately documented, thus contributing to decreased compliance.

Status: The pharmacist intervention for obtaining heights and weight on each client was instituted in November 2006. Before any intervention, the overall compliance for all units during the month of November 2006 was only 70%. Looking at the results from this current reporting quarter, the overall compliance is now 90% before any monthly pharmacist intervention. While we are still not at 100%, this increase is encouraging and represents the effectiveness of this particular intervention. For this reporting quarter, after both pharmacist interventions there was no missing information. Overall, with the institution of the two different means of intervention, an increase in compliance of sending height and weight information to the pharmacy has been seen over the last year.

Actions: On-going nursing education regarding required forms that need to be sent to the pharmacy will continue to facilitate increasing compliance. Reinforcing the importance of documentation, particularly refusals may have an effect on compliance. In order to maintain our goal of 100%, we will continue to monitor compliance on a monthly basis and report the progress every quarter this fiscal year.

Nursing

Aspect: Seclusion and Restraint Related to Staffing Effectiveness

Compliance: 100%

Indicators	Findings	Compliance	Threshold Percentile

Seclusion/Restraint related to staffing effectiveness:			
1. Staff mix appropriate	75 of 75	100%	100%
2. Staffing numbers within appropriate acuity level for unit	75 of 75	100%	100%
3. Debriefing completed	75 of 75	100%	100%
4. Dr. Orders	75 of 75	100%	100%

Findings: 100% Compliance

Problem: None identified.

Status: The indicator continues to be at 100% but is important to continue monitoring.

Actions: None at this time. An additional staffing effectiveness indicator to be added Jan 1, 2008 monitoring the staffing levels when there is an injury.

Nursing

Aspect: Redlining

Compliance: Redlining 97%

Indicators-Redlining	Findings	Compliance	Threshold Percentile
Lower Kennebec	272 of 276	99%	100%
Upper Kennebec	270 of 276	98%	100%
Lower Saco	252 of 276	91%	100%
Upper Saco	271 of 276	98%	100%

Findings: Redlining' is a safety check of each client's medical record, performed by nurses at the beginning of each shift to assure all medical orders have been noted, faxed and carried out in the previous 8 hours. The actual redlining occurs on the 11-7 shift when the MAR is also assessed for accurate transcription of any medication changes that have occurred in the previous 24 hours as well.

Problem: Redlining is not always completed; Redlining hospital wide is at 97%

Status: Lower Kennebec has remained at 99% Upper Saco remained at 98%; Upper Kennebec 100% last quarter is 98% this quarter; Lower Saco was 95% last quarter is 91% this quarter.

Actions: The two ADONs will monitor the Redlining checks daily to assure compliance.

The redlining protocol will be reviewed on each unit at the Professional Staff meeting. The night NOD will continue to check with the charge nurse on each unit and report on the progress of the redlining procedure on each unit on the daily nursing report.

Nursing

Aspect: Code cart checks

Compliance: Code cart checks 100%

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

Findings: 100% Compliance

Problem: None identified.

Status: All code cart checks have been completed 100% of the time on all units. This is the first quarter that all have been at 100%.

Actions: Continue to monitor the code carts on the shift report as an extra reminder for nursing to complete this task. The on coming Nursing Supervisor and NOD's have been checking Room I-580 to make it a part of their shift report, this too needs to continue. Code carts are used in emergency situations and must be complete and ready to use. Code cart checking will continue to be reviewed with the nurse who is responsible for narcotic count and key change during each shift change. Nurses will be thanked for their diligence in completing this important task.

Nursing

Aspect: Pain Management

Overall compliance: PRE: 99% POST: 90% OVERALL: 95%

Aspect		Findings	Compliance	Threshold Percentile
Preadministration	Assessed using pain scale	792 of 797	99%	100%
Post-administration	Assessed using pain scale	717 of 797	90%	97%

Findings: The indicator for assessing pain using pain scale pre medication administration is at 99% as it was last quarter. The indicator for assessing pain post administration is at 90% which is down 1% from last quarter.

Problems: Nurses have not been consistently documenting their assessment post administration of pain meds . Pre and post assessments are done by the Registered Nurse and the changes with nursing have made a 1% improvement but more consistency is needed.

Status: The preadministration has remained the same. The post administration has decreased by 1% to 90% to the same compliance that it was two quarters ago. With the initiation of Primary Nursing the Upper units, the post administration assessment is done more consistently. As other units go to Primary Nursing during the next quarter there should be improvement in this indicator.

Actions:

The two ADONs will work with unit nursing staff to assure that this is done more consistently..
Continue to move toward primary nursing.

NURSING 2nd Quarter SFY 2008**Aspect: Chart Review****Overall compliance: 73%**

Indicators	Findings	Compliance	Threshold Percentile
1. Universal Assessment completed by RN within 24 hours	50 of 59	85%	100%
2. Care Plan Initiated	53 of 59	91%	85%
3. Client Preference Identified	52 of 59	88%	100%
4. Signature Finalizing Assessment	57 of 59	97%	100%
5. Re-assessment if pain present	22 of 31	71%	100%
6. <u>GAP notes at a minimum</u>			
a. Identifies STG goal/objective	5 of 14	36%	90%
b. Once per shift either MHW/RN (observational note as appropriate)	9 of 14	64%	95%
c. Minimally Q 24 hours RN after first 72 hours	9 of 14	64%	100%
7. Initial care plan documented within 24 hours	11 of 11	100%	85%
8. Presenting Problem in behavioral terms	5 of 14	36%	85%
9. Strengths Identified	12 of 14	86%	85%
10. Client LTG is observable and measurable	7 of 14	50%	100%
11. Comprehensive Plan completed by the 7 th day	13 of 14	93%	85%
12.. STG/Objectives are written, dated, numbered, observable and measurable	5 of 13	38%	85%
13. Interventions are identified	13 of 13	100%	85%
14. a. Integrated Needs/Assessment prioritized by scale at bottom of sheet	12 of 14	86%	85%
b. Integrated Needs/Assessment contains all needs/issues/problems found within the assessments/evaluations since admission	6 of 14	43%	
15. Active medical issues addressed via medical/nursing care plans	7 of 14	50%	85%
16. Documented in the chart on the day of Comprehensive Service Plan meeting	14 of 14	100%	85%
17. States whether further assessments will be needed or not	11 of 14	79%	85%

per MD, PA or psychiatrist			
18. Documents the client or guardian participation in the treatment planning process	12 of 14	86%	85%

Findings: Charts were audited from all four hospital units for nursing documentation in this quarter. Overall, this group of indicators has decreased for two quarters in a row. This time total compliance is 73% which is down from 76% last quarter and 81% the quarter before. Eight indicators are above the threshold.

Problems: The following indicators are below established thresholds: # 1 universal assessment is completed within 24 hours is at 85%. #2 Client preference identified 88% of time; #4 Signature finalizing assessment 97%; #5 Reassessment for if pain is present documented 71% of time; #6 Regarding GAP notes STG 36%;Once per Shift 64%;Q 24Hrs RN note after the first 72 Hours; #8 Present problem in behavioral term 36% of the time; #10 LTG observable and measurable 50% of time. #12 Stg objectives are written, dated, numbered, observable and measurable 38% of time. #14b. Integrated needs assessment contains all needs/issues problems found in assessments or reassessments since admission is at 43%. # 15 Active medical issue addressed in medical or nursing care plans 50% of time. #17 States whether further assessments will be needed or not per MD, PA or psychiatrist is at 79%.

Status: Overall this group of indicators has decreased for two quarters in a row. This time total compliance is 73% which is down from 76% last quarter and 81% the quarter before. # 1 has improved since last quarter from 77% to 85%. #3 remains 88%.#4 improved from 89% to 97%;#5 decreased slightly from 75% to71%; #6a decreased from 50%-36% 6b.increased from 60-64% 6c. decreased from 83% to 64%. # 8 Decreased from 63% to 36%; #10. improved from 43% to 50%: #12. Decreased slightly from 42% to 38%; #14b,decreased from 66% to 43% this quarter; #15 decreased from 67% to 50%; #17 improved from 74-79%;

The education for comprehensive service plan and notes has been provided to all nurses in group sessions. Education has also been provided to many nurses on individual basis. Education manuals with guidelines for staff have been placed on each unit. The education will be repeated hospital wide to attempt to close the knowledge gaps and improve the documentation.

Actions:

- The nurses who audit charts are educating nurses to “fill in the blanks” on the Universal assessment. If the client is unable to complete because of their acuity, nurses will be expected to document this and to check on each shift until it is completed. This information should be captured on the daily nursing report. This action will continue for the next quarter and be part of the education.
- Reassess pain is addressed under the pain indicator. And will be removed from this indicator.
- The nursing staff will be directed to include upon admission any Medical issues that have been identified. Templates will be given to all units. This action will continue for the next quarter.
- The two ADONs, Nurse Educator have all been assigned nursing units. This will address the low percentages in the NAP note area included in several indicators. There has been a great deal of education but behavior must now change. The education will be redone hospital wide focusing on areas that are low compliance from this quarter.
- More treatment plan templates will be added to the education manual on each unit.
- Some indicators will be changed to reflect the important aspects of documentation and to eliminate duplication with PSD tracking.

PSD 2nd Quarter

Aspect: Comprehensive Treatment Plan

Indicators	Compliance
1. Evidence of initial treatment plan (minimum of one Safety STG & one Treatment STG each having minimum of two interventions) is in place within 24 hours of admission.	100%
2. The Presenting Problem of the CSP identifies specific client symptoms, stated in behavioral terms , causing admission (identifies any functional behavioral collapse)	100%
3 The CSP incorporates for treatment, all “active” client needs/problems obtained through the assessment process. (“active” as designated by the priority status “1” on the Integrated Needs / Problem List)	100%
4. Client strengths and preferences which can be utilized to achieve / enhance treatment outcomes are identified. (should be evident within the interventions)	83%
5. The CSP has a “Safety Goal” , based on identified individual risks, stated in observable and behavioral terms.	100%
6. The CSP has at a minimum one “Treatment Goal” based on individual assessed needs to reduce or eliminate symptom or illness stated in observable and measurable terms.	100%
7. The CSP has at a minimum one “Rehabilitation Goal” based on assessed needs to improve self selected value roles, stated in observable and measurable terms.	92%
8. The CSP has at a minimum one “Transition Goal” based on assessed needs and reflecting client preferences stated in observable and measurable terms.	88%
9. Each CSP goal has a minimum of two stepped STGs , which should reasonably lead to goal attainment, stated in clear client based behavioral terms, which are observable and measurable.	100%
10. Interventions are designated for each STG, that reasonably lead to attainment of the STG.	100%
11. Each Intervention states what the intervention is, how often it occurs, what the purpose is and who provides it.	100%
12. An individual is identified (responsible) by name to monitor/ document the effectiveness of each intervention (progress toward or away from STG).	100%
13. The CSP is properly authenticated by signature AND date, of treatment team members, no later then 7 days from the date of admission. Identify participants below:	97.9%
(a) MD**	100%
(b) RN**	100%
(c) SW**	100%
(d) Client / Guardian**	91.7%
(e) Psychology	
14. CSP has any assessed functional skill deficits including present Level of Support and Level of Support to be attained	83%

Findings:

24 charts were reviewed for this report. Ages ranged from 21 years to 60 years. Approximately ¾ of the clients had been here for previous admissions. Approximately ¾ of the clients have or had a history

of violent behaviors towards themselves or others. Approximately 4 had a fall potential. Approximately 42 % had two or more medical issues requiring intervention / planning.

Actions:

Keep teaching on an individual basis. All 7-3 RNs have at least several computerized plans that may be altered for individual symptoms / illnesses. Nursing is getting better at this but still needs assistance with doing this well.

CCM'S are writing the plans much more consistently and in computer format versus the hand written ones that were being used before. This makes for a more professional appearance for the plan. Follow up with assigned CCM for clients missing plans.

Importance of functional skill deficits and documentation surrounding prescribed treatment for them addressed at weekly staff meeting and individually, with direction from PSD for all staff to write weekly notes on primary clients. This has been happening for a couple of weeks now and has improved the quality of the documentation in the records. The flow sheets do address hygiene and Level of Support is a check box, unfortunately, this does not require the MHW to describe the actual support given to the client. It was much clearer when done in progress note format.

Unit poster outlining expectations around hygiene and it's importance in evaluating an individual's ability to care for self and to emphasize the importance associated with these skills was posted on Lower Kennebec but torn down and ripped up by a client about one week later. Have had door put in place over set of bulletin boards to prevent this from happening again. Will have to make another poster. This will be repeated on the other three units.

**PSD 2nd Quarter
Comprehensive Treatment Plan
Aspect - Integrated Summary**

Indicators	Compliance
1. Integrated Summary Note is documented in the medical record the day of CSP meeting.	100%
2. Summary briefly identifies findings of assessments / needs (MD/RN/Rehab/SW/Psychology).	83%
3. Summary identifies NEEDS not to be addressed at this time and why (deferred as denoted by "2" priority status on the Integrated Needs / Problem List.)	91.6%
4. Summary describes client preferences utilized in service planning.	91.6%
5. Summary identifies predicted community placement .	100%
6. Summary identifies additional assessment/ evaluations or services to be sought.	83.4%
7. Summary describes level of client participation in planning service.	91%

Findings:

Twelve charts on the admission civil unit were reviewed.

Problems:

#2. Summary briefly identifies **findings of assessments / needs** – 83.4% this month, same as last month. In 2 out of the 12 charts, these findings were not documented in the summary note. In two out of the two instances, the notes were written by a contract who did not use the template that we have to ensure completion of this. 80.6% for the quarter, threshold 90%.

#7. Summary describes **level of client participation in planning service.** – 91.6% in December, up from 83.4% last month. (threshold 95%) Both cases were written by a contract RN who did not follow the template guidelines for documentation. 91.6% for the quarter, 95% threshold.

Actions:

It is clear that when the template is used as a guide, the note contains all the requested information and when the guide isn't used, pieces are left out. The regularly assigned RNs on admission units will use the template.

PSD 2nd Quarter

Aspect – **Service Plan Reviews**

Indicators	Compliance
1. At a minimum review is completed within 14 days of last review for first 6 months or within the last 30 days for hospitalizations of over 6 months.	79%
2. Within 72 hours of the use of (a) seclusion, (b) restraint, (c) episode of violence, or (d) transfer a service plan review is completed.	100%
3. The review participants are documented	97.2%
(a) MD**	100%
(b) RN**	100%
(c) SW**	100%
(d) Client/ Guardian**	86%
(e) Rehab (f) Psychology	
** MANDATORY	
4. A behavioral description of client behavior related to each goal area is documented, supporting whether the goal was met or not "AEB" = as evidenced by (can be on the review form itself or the progress note as long as it is in narrative form)	100%
5. Client's self-assessment of effectiveness of current plan is documented.	90%
6. Evidence of positive client progress related to each goal is documented.	95%
7. The CSP is modified as a result of the review, as evidenced by target dates addressed as met or extended and dates changed. May also be evidenced by the addition or modification of STGs.	95%
8. Client level of participation in the service plan review is documented	100%

Findings:

24 Reviews completed.

The template form when used to document specifics of the review meeting in addition to having regularly scheduled staff have made a significant improvement in the documentation associated with review meetings. Some clients refuse to attend the service plan reviews or sign the form after the review.

Actions:

I will ask the Treatment team Coordinators (TTC) to take a look at the review form before placing it in the chart to ensure that all signatures of people present are on the form. The form will indicate when clients refuse to sign and why. Additional attempts will be made to look over the review form with clients who refuse to sign subsequent the review process.

PSD 2nd Quarter report

Aspect - **Active Treatment**

Indicators	Compliance
1. CSP has, and documentation in progress notes and or flow sheets demonstrate <i>identified functional needs</i> (Space maintenance / hygiene / clothes care / time management / self expression) [nursing assessment and care plan] <i>including present Level of Support and what Level of support is the goal.</i>	38%
2. Progress notes / flow sheets document <i>a level of functional skill support provided, consistent with the identified</i> area of need, delivered within last 24 hours.	38%
3. Documentation demonstrates that the client <i>attended all assigned psycho-social-educational interventions within last 24 hours.</i>	8%
4. A <i>minimum of three psychosocial educational interventions are assigned daily.</i>	100%
5. The client is <i>able to state what his assigned psycho-social-educational interventions are and why they have been assigned?</i>	46%
6. The client can <i>correctly identify assigned RN and MHW.</i>	64%
7. The medical record <i>documents the clients active participation in Morning Meeting within the last 24 hours</i>	58% 42-UK
8. The client can <i>identify personally effective distress tolerance mechanisms available within the milieu.</i>	83.4%
9. <i>Level and quality of client's use of leisure within the milieu</i> are documented in the medical record within the last 7 days.	96%
10. <i>Level and quality of social interactions</i> within the milieu are documented in the medical record over the last 7 days.	100%

Findings:

24 reviews completed. Limited documentation found on levels of functional support being assessed as needed and provided. Extended care unit accounted for majority of variance. Assignment and

awareness of clients as to the specific assigned psycho-educational services was not well evident in this sample. Identification of assigned nurse and MHW is also below expectations across units.

Actions:

1. Functional supports, the manner of how they are assessed, planned for, and documented is being reviewed by the Director of Nursing who will implement a staff training plan by 2-15-08, to provide education to floor RNs and MHW on this issue.
2. The Milieu Managers group has been asked to develop schemes to improve the consistency of providing and documenting fundamental functional supports and will report back to the Superintendents office by 3-1-08.
3. The Director of Nursing will re-evaluate the effectiveness of the daily care flow sheet in documenting client participation in morning meeting.
4. Continued assessment of the Primary Nursing Model.

PEER SUPPORT

Aspect: Integration of Peer Specialists into client care

Overall compliance: 86%

Indicators	Compliance	Findings	Threshold Percentile
1. Attendance at Comprehensive Treatment Team meetings.	439 of 522	84%	80%
2. Grievances responded to by RPC on time.	129 of 188	69%	100%
3. Attendance at Service Integration meetings.	58 of 59	98%	100%
4. Contact during admission.	74 of 75	99%	100%
5. Grievances responded to by peer support on time.	188 of 188	100%	100%
6. Client satisfaction survey completed.	28 of 39	72%	80%

Findings:

Overall compliance is down 3% from last quarter.

(1) Peer Specialists attended 438 of 512 treatment team meetings. Peer support was unavailable to attend meetings due to attending admissions (2), mandatory training (8), being out sick/on vacation (32), and no peer support available (41).

(2) RPC responded late to 40 grievances and 14 have not been responded to at the time of this report for a total of 54 late responses. Of the 54 late grievances, 9 were on Lower Kennebec (7 1-39 days late, 2 no response), 2 were on Upper Kennebec (1 day late), 32 on Lower Saco (22 1-23 days late, 10 no response), and 11 on Upper Saco (9 late 1-4 days, 2 no response).

(3) Peer Specialists missed 1 of 59 Service Integration meetings. Meeting was missed due to all peer support being at mandatory training.

(4) All but one client had documented contact with peer support during admission. One client did not have contact due to coming in after hours on Friday and was admitted for 72 hrs. on Lower Saco.

(5) All grievances were responded to by peer specialists within one business day.

(6) Of the 39 Client Satisfaction Surveys that were offered to clients, 28 completed the survey.

Problem:

(1) A Peer Specialist is not always available to attend all client Comprehensive Treatment Team Meetings.

(2) All level I grievances are not being responded to by RPC within the time allowed.

- (3) Peer Specialists are not attending all client Service Integration Meetings.
- (4) All clients admitted to RPC did not have documented contact with a peer specialist.
- (6) Clients are not always willing to complete a client satisfaction survey.

Status:

- (1) Peer Specialists attended 84% of treatment team meetings this quarter, which is down 2% from last quarter. More meetings were missed in the month of December (31) due to vacation time.
- (2) Compliance with grievance response time was down 16% from last quarter. The majority of grievances filed were on Lower Saco (81) and Upper Saco (58) at 74% of total grievances. Total number of grievances increased 23% from last quarter. The number of grievances increased 66% on Upper Saco, 23% on Lower Saco, and 83% on Upper Kennebec. The number of grievances on Lower Kennebec decreased 64%.
- (3) One Service Integration meetings was missed this quarter, increasing compliance 2%. Meeting was missed due to mandatory training for all peer specialists.
- (4) One client did not have contact with peer support during his admission. Compliance is down 1% from last quarter. The client was admitted as for 72 hrs. over a weekend. There was no peer support over that weekend to have documented contact. Since then a Peer Specialist has been hired to be here on weekends.
- (6) Completion of Client Satisfaction Surveys was up 3% this quarter from last quarter. Reasons cited for not completing surveys were noted as "client didn't want to," "not the way I have been treated here," "I don't have time," "I did one last time I was here."

Actions:

- 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 reasons for missed meetings.
- Peer Services Director will work with Amistad supervisor to problem solve coverage for meetings during mandatory training for all peer specialists.
- Team leader will flex part-time peer specialists' schedules to allow for more coverage during treatment team meeting hours.
- Peer specialists will notify PSDs of missed meetings due to changes in schedule to ensure that peer support is included in the notification process.
- 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 team leader on how to manage their schedule and overcome barriers to attending team meetings.
- Peer Specialists will work closely with social workers to manage the schedule of Service Integration Meetings to ensure their attendance.
- Peer Specialists will learn ways to elicit reasons for clients refusing to complete satisfaction surveys.
- Peer Services Director will meet with Risk Manager to problem solve strategies to ensure all level I client grievances are being responded to in the time allowed.

Client Satisfaction Survey 2nd Quarter 2008 October -December

Aspect: Client satisfaction with care

Indicators	Findings		Threshold Percentile	+/-
1. Has anyone informed you about your rights?	20 of 30	67%	85 %	-20%
2. Has anyone talked to you about the kinds of services that are available to you?	22 of 30	73%	85 %	-10%
3. Are you informed ahead of time of changes in your privileges, appointments or daily routines?	15 of 28	54%	85 %	-13%
4. Do you know someone who can help you get what you want or stand up for your rights?	25 of 30	83%	85 %	-6%
5. Has your community worker visited or contacted you since you have been in the hospital?	20 of 30	67%	85 %	+6%
6. Do you know how to get in touch with your community worker if you need to?	22 of 30	73%	85 %	+25%
7. Do you have an individualized support plan (ISP)?	17 of 27	63%	85 %	+7%
8. I feel more confident in my ability to deal with crisis situations?	25 of 29	86%	85 %	+10%
9. I am less bothered by my symptoms now?	23 of 28	82%	85 %	+10%
10. I am better able to function?	24 of 29	83%	85 %	+8%
11. I do better in social situations?	18 of 28	64%	85 %	-12%
12. I experience less difficulty in my life?	20 of 29	69%	85 %	+15%
13. I am treated with dignity and respect?	21 of 25	84%	85 %	+4%
14. I feel comfortable asking questions about my treatment and medications?	24 of 30	80%	85 %	-4%
15. I am encouraged to use self-help/peer support and support groups after discharge?	20 of 30	67%	85 %	-16%
16. My medication benefits and risks were discussed with me?	20 of 31	65%	85 %	+7%
17. I am given information about how to understand and manage my illness?	16 of 27	59%	85 %	-12%
18. My other medical conditions are being treated?	21 of 30	70%	85 %	+12%
19. I feel free to voice complaints and suggestions?	25 of 30	83%	85 %	0%
20. I feel my right to refuse medication or treatment is respected?	19 of 29	66%	85 %	-17%
21. I participate in planning my discharge?	22 of 27	81%	85 %	+8%
22. I feel I had enough privacy in the hospital?	21 of 27	78%	85 %	-6%
23. I feel safe while I am in the hospital?	24 of 29	83%	85 %	-5%
24. If I had a choice of hospitals, I would choose this one?	20 of 27	74%	85 %	-13%

Findings:

Of the 24 indicators, 1 met or exceeded threshold and 23 were below threshold. The number of items that met or exceeded threshold was down by 3 from last quarter. Items that did not meet threshold were up by 3.

Problem:

Clients are not satisfied with all aspects of care provided at RPC.

Status:

Increases and decreases from last quarter are indicated in the table above.

All indicators that were above threshold last quarter are now below threshold. Thirteen indicators dropped, 4 of which were above threshold and dropped below. Nine indicators increased and only one of them increased to at or above threshold.

Actions:

- Peer support will encourage and support clients to voice their concerns and needs with their treatment teams regarding these aspects of care.
- Peer support will encourage clients to use community meetings as a forum for addressing concerns.
- Peer support will provide feedback to RPC about client concerns/suggestions.
- Results of client survey are shared with all department heads with the expectation that each department will work towards improving communication with clients around at least one of the identified needs.

Continuity of Care/Social Services Department-

Aspect: Preliminary Continuity of Care Meeting and Comprehensive Psychosocial Assessments

Overall Compliance: 80%

Indicators	Findings	Compliance	Threshold Percentile
1. Preliminary Continuity of Care meeting completed by end of 3 rd day	27/30	90%	100%
2. Service Integration form completed by the end of the 3rd day	27/30	90%	100%
2a. Director of Social Services reviews all readmissions occurring within 60 days of the last discharge and for each client who spent fewer than 30 days in the community, evaluated the circumstances of the readmission to determine an indicated need for resources or a change in treatment and discharge planning or the need for alternative resources. In cases where such a need or change was indicated that corrective action was taken.	2/2	100%	100%
3a. Client Participation in Preliminary Continuity of Care meeting.	30/30	93%	80%
3b. CCM Participation in Preliminary Continuity of Care meeting.	29/30	96%	100%
3c. Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation in Preliminary Continuity of Care meeting.	27/30	96%	80%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	17/30	56%	80%
3e. Correctional Personnel Participation in Preliminary Continuity of Care Meeting.	0/15	0%	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	30/30	100%	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 and 4. 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 one client from Lower Saco SCU and two clients from Lower Kennebec. Two clients initially refused to participate in the Service Integration Meeting and were approached daily for several days following admission. Two of the forms were completed with client input and historical information though not within the threshold of 3 days. The other form was partially completed and the client struggled during the meeting which was abbreviated. The form was partially completed but not within the 3 day timeframe. Indicator 1 remained at 90% from last quarter but Indicator 2 saw a slight drop of 3% from the first quarter.

Indicator 3b fell below the threshold percentile this quarter down 4% from the first quarter. On one occasion a CCM missed a preliminary meeting due to a scheduling and time management issue. The staff person was counseled in supervision and a plan of correction to assist the staff member was put in place.

Indicator 3d fell below the threshold percentile this quarter and registered at 56% while this area remains low it is up 10% from the first quarter. In some instances clients declined to sign releases for assigned community providers to attend and participate in the initial Service Integration Meeting. On several occasions providers could not attend but had given input to the assigned CCM or had made arrangements to attend the 7 day meeting. This is an area that we continue to problem solve and have received assistance from the regional consent decree coordinators to facilitate as a go between for the hospital and providers to best support clients that are struggling to engage or reconnect with their pre-admission community providers. In this aspect we also see many clients who are requesting to change providers and sometimes communities upon discharge which can contribute to agencies not attending meetings. The introduction of the new APS managed care monitoring system may have a positive impact on this area that could be reflected in the next report.

Indicator 3e fell below the threshold percentile and for this quarter and registered at 0%. This is down 13% from the 1st quarter. As stated in previous reports clients routinely refuse to have corrections personnel as part of their treatment team. For many clients we often have input from probation officers, Maine Pre-Trial Services and jail case workers during the clients stay at subsequent treatment and discharge meetings.

Indicator 4 fell below the threshold percentile at 86% this quarter. This is up 3% from last quarter. 4 initial assessments were not completed within the 7 day timeframe. The individual staff has utilized supervision and been reminded about the importance of meeting required timelines to ensure quality service care and delivery for clients served. All 4 outstanding reports have been completed.

Status: Monitor all aspect areas and utilize individual supervision and team meetings to brainstorm continued ways to engage clients and continued dialogs with service providers. Continue to monitor individual work performance of all staff related to managing and meeting critical timeframes for the completion of documentation.

Corrective Actions:

Indicators 1 and 2: These areas will continue to be focused on and monitored. Clients with high acuity at admission will continue to pose a challenge to this aspect area and will require increased

attention and engagement.

Indicator 3b: Staff was counseled in supervision and a plan of correction was created to support the staff member in this area.

Indicator 3d: 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. We will continue to attend the Ken-Som Provider meeting at Maine General to facilitate stronger relationships between RPC and community providers. We also will continue to work with consent decree coordinators to act as a go between for the hospital and providers.

Indicator 3e: 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. A CCM from LS continues to participate at the Community Corrections Provider meeting held at the sheriff's department the last Wednesday of each month. We do see continued engagement with the corrections providers in other aspects of the treatment and discharge processes. Currently in process, the DHHS is reassigning state ICM's to support individuals from the corrections system, who have mental health issues. This should support an increase in participation for these meeting from the correctional system.

Indicator 4: This area will continue to be monitored through individual supervision.

CONTINUITY OF CARE/ Social Services

ASPECT: Forensic Unit: Institutional Reports

Overall Compliance: 70%

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.	76/78	97%	95%
2. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	5/6	83%	100%
3. The assigned CCM will review the new court order with the client and document the meeting in a progress note or treatment team note.	3/3	100%	95%
4. Reports to the commissioner for all NCR clients are submitted annually.	0/22	0%	100%

Findings: The sample size for this area is based on the number of treatment meetings held during the designated quarter. Clients with NCR status, who have not petitioned in the last six months, are asked if they are considering petitioning the court. Clients who are considering are supported to initiate the process with their lawyer or independently with support from assigned CCM. Once a petition is recorded at the court the team constructs an institutional report within 10 days. The aspect area of annual reports will be reported on in the second quarter. All annual reports to the Commissioner for NCR clients are due in December. Psychiatrists on the Forensic units were prompted in October to be mindful of timelines for completion of these required reports by December.

Problems: Indicator 1 fell below the threshold percent at 97% which is down 3% from the first quarter. On two occasions it is indicated that a client's ability to petition was not discussed during the month of their meeting.

Indicator 2 fell below the threshold percent at 83% which is down 17% from the first quarter. A client from LS petitioned the court with assistance from his team via his lawyer. The institutional report was not completed within the 10 day timeframe.

Indicator 4 fell below the threshold percent at 0%. None of the annual reports for NCR clients in the facility had been turned in to State Forensic Services by the end of the quarter.

Status: On-going

Corrective Actions:

Indicator 1: Continued monitoring of the petition process with assistance from the treatment team coordinator.

Indicator 2: Continued monitoring of the process and the communication with the client and lawyer when petitions are filed. In addition utilized individual supervision to explain the petition process in regards to the designated timeframes and the importance as it relates to the teams completion of reports.

Indicator 4: Unit teams have been reminded of the due dates established for the Annual Reports and will report on status and progress next quarter.

Continuity of Care/Social Services SFY2Q 2008

Aspect: Client Discharge Plan Report/Referrals

Overall Compliance: 87%

Indicators	Findings	Compliance	Threshold Percentile
1. The Client Discharge Plan Report will be updated/reviewed by each CCM minimally one time per week.	10/12	83%	80%
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	12/12	100%	95%
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	10/12	83%	95%
3. Each week the CCM team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	10/12	83%	95%

Findings: The timeframe for this aspect area was 12 weeks. During that time the report was sent out on 8 occasions via email. The report was distributed to stakeholders in hardcopy on two occasions at the Wednesday regional Meeting. The two occasions that the report was not sent out or distributed was due to holidays that fell on the meeting date.

Problems:

Indicator 2a and 3 Document was not distributed twice in the quarter due to holidays.

Status: Continued vigilance in monitoring the document and fine tuning the information to meet evolving needs of the department and RPC in the area of reporting unmet needs and discharge planning.

Corrective Actions: Continue monitoring as indicated and ensure that an updated and streamlined report is distributed weekly. Utilize individual supervision to support staff to ensure that the information contained in the report is concise, accurate, and encompasses all information needed in regards to

discharge planning for each individual client.

Continuity of Care/Social Services
Aspect: Treatment Plans and Progress Notes
Overall Compliance: 83%

Indicators	Findings	Compliance	Threshold Percentile
1. Progress notes in GAP/Incidental format will indicate at minimum weekly 1:1 meeting with all clients on assigned CCM caseload.	40/45	88%	90%
2. On Upper Saco progress notes in GAP/Incidental format will indicate at minimum bi- weekly 1:1 meeting with all clients on assigned CCM caseload	11/15	73%	95%
3. Treatment plans will have measurable goals and interventions listing client strengths and areas of need related to transition to the community or transition back to a correctional facility.	53/60	88%	90%

Findings: This aspect area includes chart samples from all units except as noted in Indicator 2 which represents information from Upper Saco only.

Problems: All indicators in this aspect area fell below thresholds and in most instances can be contributed to the change over in format for documentation and treatment planning. Indicators 1 and 3 were both improved this quarter 15% and 22% respectively.

Status: On-going improvement is indicated for this aspect area and report should see increased compliance next quarter.

Corrective Actions:

Indicator 1 and 3: Continued monitoring of the process with unit teams and focus on engagement/strengths based treatment planning.

Indicator 2: Staff was supported in individual supervision to utilize improved time management skills and establish a plan of improvement.

PSYCHOLOGY

ASPECT: CO-OCCURRING DISORDERS INTEGRATION

2 nd Quarter 2008 October, November, December 2007 Co-Occurring Disorders Integration			
Indicators	Findings	Compliance	Threshold
1. There is evidence of an integrated co-occurring assessment.	73/73	100%	100%
2. There is evidence of an assessment of "stage of change".	73/73	100%	100%
3. There is evidence of an integrated co-occurring comprehensive service plan for identified clients.	27/49	55%	85%
			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 and ACT team and Capital Clinic	All treatment units ACT Team and Capital Clinic	100% (10-15% increase in most all domains) No report this quarter	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"	5/8	63%	85%
6. Consumer satisfaction survey indicates that since beginning treatment with us, their condition is better.	11/16	69%	95%
7. Consumer satisfaction survey reports client satisfaction with current treatment experience is better than with any other previous treatment experiences.	9/16	56%	85%
8. Percent of clients with co-occurring disorders as reported by NASMHPD	(July/Aug./Sept.) 60% Nat. Mean 36%	60%	50%

Findings:

For indicators #1-3 73 charts were audited indicating 49 clients positive for co-occurring disorders.

1. Goal met. Evidence of an integrated assessment met goal of 100% for the third consecutive quarter.
2. Goal met. Stage of change assessment threshold of 100% was met for the second consecutive quarter.
3. Indicator below threshold.
4. Annual administration of COMPASS on all units shows overall greater than 10% increase. Some variability found from unit to unit and in different subject areas.

For indicators #5-7 A total of 16 surveys were administered. Of those 8 identified themselves as co-occurring clients.

5-7 Thresholds not met. Slight drop from past quarter may not be statistically significant due to the small N this quarter.

8. Threshold exceeded. NASMHPD comparative statistic report indicates that for the months of July, Aug, & Sept, Riverview reported 60% of clients with co-occurring diagnoses. This is above the national mean of 36%.

Problems:

1. No problem goal achieved
2. No problem goal achieved
3. The CSP does not accurately reflect co-occurring assessment. Disciplines responsibility for CSP integration of co-occurring treatment not clearly defined.

4. Threshold met however COMPASS indicates specific areas of weakness to be targeted by individual units.
5. *Integrated treatment not perceived by clients. Small N.*
- 6-7 Consumers report of self-improvement and satisfaction with treatment continues to be below desired outcome.
8. Threshold met.

Status:

1. Discontinue monitoring. New goal identified
2. Discontinue monitoring. New goal identified
3. Integrated service plans for identified clients up slightly from 49% to 55%. Continue departmental education re: responsibility for referrals.
4. Each unit will identify areas to target for continued improvement based on a more in depth analysis of this data. ACT team and Capital Clinic COMPASS surveys due 1st quarter next year. All others will be due 2nd quarter next year.
5. Threshold met in pervious two quarters. Slight drop from past quarter may not be statistically significant due to the small N this quarter. Increase number of surveys next quarter.
- 6-7. Co-occurring coaches have discussed this indicator and have identified several ways to improve client satisfaction with recovery.
8. Threshold exceeded. Higher diagnosis rate is most likely due to better screening by admissions personnel. Continue to monitor. Rapid cycle change project to improve completion of diagnostic specifiers to further clarify diagnosis has been completed.

Actions:

1. New indicator to begin next quarter "there is evidence of stage specific interventions on CSP"
2. New Indicator to begin next quarter "there is documentation of identified clients' participation in co-occurring treatment"
3. Responsibility of integrated co-occurring treatment plan on CSP was discussed with clinical leaders and coaches for discipline specific education and action.
4. Co-occurring integration coordinator will meet with units to identify target areas for improvement.
- 5-7 Two peer specialists were added to "co-occurring coaches" group. Coaches group to educate teams regarding the need to discuss client's perception of recovery and treatment outcomes with clients.
8. Co-occurring coaches met with psychiatry staff to educate regarding the need to complete diagnostic specifiers for dual diagnosis. Monitor for continued positive trend and goal attainment.

Safety

Aspect: Life Safety 2nd quarter SFY2008

Overall Compliance: 97%

Indicators	Findings	Compliance	Threshold Percentile
1. Total number of staff assigned to Upper Saco and Upper Kennebec who have received training with the evacuation chair.	61/61	100%	100%
2. Total number of staff assigned to Lower Saco and Lower Kennebec who have received training with the evacuation chair.	81/83	95%	100%
3. Total number if staff assigned to the Float Pool who have received training with the evacuation	14/17	82%	100%

chair.			
4. 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.	2/3	66%	100%
5. Total number of staff that knows what R.A.C.E. stands for.	8/8	100%	100%
6. Total number of staff that knows that if there was a one-on-one or situation requiring one-on-one, i.e. client would not leave room, that they should stay with them.	8/8	100%	100%
7. Total number of staff that knows how to activate the nearest fire alarm pull station.	121/121	100%	100%
8. Total number of staff that knows how to acknowledge the fire alarm or trouble alarm on the enunciator panel.	120/121	99%	100%
9. Total number of staff that knows the emergency number.	121/121	100%	100%
10. Total number of staff that knows what the verbal code is used to announce a fire.	120/121	99%	100%
11. Total number of staff that knows it is necessary to close all doors after checking rooms or areas.	8/8	100%	100%
12. The total number of staff that knows what the acronym, P.A.S.S. stands for.	121/121	100%	100%
13. The total number of staff that knows the locations of the two nearest exits to evacuate away from a fire area	121/121	100%	100%
14. The total number of staff that knows two ways that may be used to move a person who is non-ambulatory to safety.	8/8	100%	100%

Findings:

1. During the 1st quarter, it was reported that Upper Saco and Upper Kennebec entire staff had received training in the use of the evacuation chair training. This equated to 100%. Since that time, we have had a significant number of newly-hired staff and staff who have transferred from other jobs into direct care assignments. Currently (61) out of (61) have received the training. This equates to 100%.
2. Lower Saco has (42) out of (44) who have received the training. This equates to 95% of staff trained with the evacuation chair. Lower Kennebec has (39) out of (39) who have received the training. This equates to 100%.
3. Not reported in the past, is a separate new category titled "Float Pool". In compiling numbers, this is what was reported to me, so I have reported it as such. The total number of staff assigned to the Float Pool who have received training with the evacuation chair is (14) out of (17). This equates to 82%. We are currently working with Nursing Education since the number trained is

- actually higher due to the fact that training rosters have not been provided to Staff Development.
4. The (2) alarms reported for the hospital still meets the required number of drills per JCAHO and Life Safety Code. The difference being that earlier in the year, our reporting extended outside the calendar quarters. (1) drill has been delayed based on the fact that the acuity level across units has been such that conducting a drill at various times would have placed staff, other clients, and the environment at risk. The Safety Officer made the determination to withhold conducting the 3rd drill. Of the (2) alarms, (1) alarm was caused by particulate in an HVAC duct and the other alarm was an unannounced drills conducted by the Safety Officer.
- 5-14. Indicators 5 through 14 are indicators used for the purpose of evaluating the knowledge and skills of staff as it relates to critical skills and knowledge necessary to carry out functions in the event of a fire and/or smoke emergency. Some indicators were obtained during unannounced drills while others are obtained through the use of reports completed by staff during actual events. The hospital conducts 1 drill per shift per quarter, (3 drills total) plus 1 drill at the Portland clinic for a hospital total of 4 drills per quarter. At the conclusion of each drill, a number of available staff are asked to answer indicators 5-14.

Problems:

- 2, 3. A decision had been made to train all permanent staff assigned to the units. Since that time, we have had a number of newly-hired staff and staff who have transferred from other jobs into direct care assignments. We are in the process of providing the training to them. Remaining staff, the majority being those assigned to the float pool, will receive the training as soon as possible, but NO LATER than February 1st.
4. One shift drill was not conducted within the calendar quarter. This drill covered 11-7am shift.
7. One staff person from the Administrative office area noted on a fire report, filed after an actual event, that they were not sure how to acquire the location information from the enunciator panel located on that unit.

Following an actual event caused by particulate in a HVAC duct, reports were generated that noted the following:

- a. Three staff members needed an updated emergency sticker worn on their key card.
- b. Three units did not immediately employ the two-way radios.
- c. Two units had telephones which did not display the facility's designated emergency number.

Following two unannounced drills conducted by the Safety Officer, his observations and that which was reported on the unit's fire reports are as follows:

- One unit reported that a telephone did not display the facility's designated emergency number.
- One unit reported that a client did not cooperate with staff and follow their directions.

Status:

1. RPC is now at 100% compliance for this training by current staff that is permanently assigned to both upper units...and all staff receives this training at orientation.
- 2, 3. As it relates to staff that are permanently assigned to the lower units, there are 2 staff who have not received the training since they had transferred from other jobs into the direct care position. Six staff who float are being reported as not being trained. The reason is that it is believed that some out of the (6) have been trained, but the Safety Officer had not received the official documentation at report time. Training for those not trained will take place as soon as possible, but NO LATER than February 1st.

4. The 3rd fire drill will be conducted NO LATER than January 20th, and will cover the 11pm-7am shift. In the future, drills, coupled with actual events, if they should occur, shall be tracked and conducted within the calendar quarter.

7. Thirteen administrative staff members were gathered and given an overview of the enunciator panel and the necessary steps to acknowledge and obtain the event location.

Following alarm events, both actual and drills, the following corrective measures were taken by the Safety Officer:

- Telephone stickers were placed on phones which were reported not to have them.
- Current emergency stickers were given direct to the reported supervisor of Staff who were identified to not have the most current stickers.
- Staff was reminded that the two-way radios are a necessary form of communication during these type of events.

In summary, one of the last unannounced drills conducted by the Safety Officer and reported by the units produced the following results:

- A greater emphasis was placed on conducting a census of clients who were off the unit, yet still in the facility, using two-way radio communications. This went very well. Two staff members who were in the Treatment Mall with (3) clients realized that by bringing a two-way radio with them, they would be able to effectively communicate the clients' status off the unit. They also had not remembered that the Treatment Mall has a two-way radio assigned to it for use in such emergencies. All units acknowledged radio traffic by the Safety Officer. During the same drill, the NOD realized that by not carrying the two-way radio assigned to that office, that immediate collaboration with the units during such events was not possible. The Safety Officer will continue to incorporate the use of the two-way radios during events and drills.
- Unit reports were both timely and well written.
- The Safety Officer also noted that staff took the drills seriously and responded in a professional and efficient manner. Staff was cognizant of what actions were necessary and asked relevant questions during the critique conducted by the Safety Officer. It is believed that staff has done a commendable job in collaborating with each other as it relates to processing such events as evidenced by recent alarms. It is noticed by the Safety Officer that staff appear to respond well to drills conducted with regard to attitude and demeanor. Both attributes contribute to a meaningful and successful event. As time goes on, it is the Safety Officer's intent to incorporate variables into the scenarios for the purpose of assessing staff's readiness and ability to problem solve during events with require skills such as these.

SAFETY

Aspect: Fire Drills Remote Sites

Compliance: 100 %

Indicators	Findings	Compliance	Threshold Percentile
1. 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:

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

Problems:

There were no areas noted that needed improvements.

Status:

During this quarter's drill, the Safety Officer felt that the evacuation sweeps were much more efficient and orderly. This drill even included clients in the waiting area. There has been a marked improvement over the course of the past (6) months in all areas.

Securitas/RPC Security manager

Aspect: Safety/security

Overall Compliance:

Indicators	Findings	Compliance	Threshold Percentile
1. Security search/screening of all clients (Forensic & Civil) being admitted to Riverview for treatment. (total # of admissions screened vs. total # of admissions).	75/75	100%	100%
2. Security Officer "foot patrols" during Open Hospital times. (Total # of "foot patrols" done vs. total # of "foot patrols" to be done.)	1950/2024	96%	100%
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.)	639/552	116%	95%

Findings: The Securitas/RPC Security Team once again surpassed the overall compliance goal of 98% with a "score" of 100%! We recorded strong numbers for the third indicator of Lower Unit checks during this quarter and as always had a 100% mark for the first indicator of Screening all client admissions. However, we still fell short on the second indicator of foot patrols during open hospital times for this quarter.

Problems: Open hospital checks are again below threshold. Due to the winter season, some extra duties have been added to our security team which sometimes creates "time conflicts" with the scheduled times for open hospital checks. Additionally, RPC has had construction projects in the client courtyards which sometimes creates a "shortage" in available security staff for foot patrols.

Status: There are no changes to report for the screening of client admissions indicator. We were well above the target percentile for the third indicator of Lower Unit Safety/Security checks. The status for Open Hospital Checks /foot patrols has been consistently the same during each month of each quarter since we started performing (& reporting on) this indicator.

Actions: Security officers will continue to try and "roll" as many duties into each "round" of foot patrols as possible. Unfortunately, there are circumstances that arise beyond our control, and these times make it difficult to perform all 22 open hospital checks expected each day. If a foot patrol is unable to be performed the hospital will be safety officer during normal working hours and the NOD at other times will be notified, and incident report will be generated.

STAFF DEVELOPMENT

ASPECT: New Employee and Mandatory Training

2nd Quarter STFDIQ2SFY08 October, November, December 07 Staff Development

Indicators	Findings	Compliance	Threshold Percentile
1. New employees will complete new employee orientation within 60 days of hire.	15 of 15	100%	100 %
2. New employees will complete CPR training within 30 days of hire.	15 of 15	100%	100 %
3. New employees will complete NAPPI training within 60 days of hire.	26 of 26	100%	100 %
4. Riverview staff will attend CPR training bi-annually.	295 of 297	99%	100 %
5. Riverview staff will attend NAPPI training annually. Goal is to be at 100% by end of fiscal training year 08 on June 30 th . Fiscal year 07 at 100%	234 of 351	67% to date	100 %
6. Riverview staff will attend Annual training. Goal is to be at 100% by end of fiscal training year 08 on June 30 th . Fiscal year 07 at 99%	298 of 386	75% to date	100 %

Findings: The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications. **15 out of 15** (100%) new employees completed these trainings. **295 of 297** (99%) employees are current with CPR certification. **234 of 351** (67%) employees are current in Nappi training. **298 of 386** (75%) employees are current in Annual training. All indicators remained at 100 % compliance for quarter 2-FY 2008.

Problem: Indicator 4 is identified as a problem as it is below established threshold. 2 employees did not attend their annual recertification in CPR due to illness.

Status: This is the second quarter of report for these indicators. The 2 employees that missed their CPR recertification have been mandated to go to the January 24th training.

Actions: Supervisors of those employees that are not current with their training have been notified and recommendations of counseling were made as well as scheduling them for the next class in those classes for January. 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 mandatory training are scheduled for the next available class in January.

STAFF DEVELOPMENT

ASPECT: COMMUNITY PROVIDER TRAINING

Topic	Type	Date(s)	Level of Participation	Information Packets/Publications
BEST PRACTICES				
Telepsychiatry: Overcoming Barriers in Access	Psychiatric Grand Rounds	10/2/07 RPC	3 participants	Hard copy available
Integrated Mind and	Psychiatric	10/9/07	7	Hard copy available

Topic	Type	Date(s)	Level of Participation	Information Packets/Publications
Brain in Borderline Personality Disorder	Grand Rounds	RPC	participants	
Pediatric Depression: An Update on Assessment and Treatment	Psychiatric Grand Rounds	10/16/07 RPC	5 participants	Hard copy available
Alcohol Dependence and Psychiatric Comorbidity	Psychiatric Grand Rounds	10/23/07 RPC	11 participants	Hard copy available
The ten-Year Course of Co-Occurring Serious Mental Illness and Substance Use Disorder	Psychiatric Grand Rounds	10/30/07 RPC	6 participants	Hard copy available
Hans Fromm Memorial Lecture: Hemochromatosis: Genetic Diagnosis and Treatment	Medical Grand Rounds	10/5/07 RPC	6 participants	Hard copy available
Incretins: A New Avenue for Treatment in Type 2 Diabetes	Medical Grand Rounds	10/12/07 RPC	3 participants	Hard copy available
Moving from Bench to the Bedside and Back	Medical Grand Rounds	10/19/07 RPC	5 participants	Hard copy available
Moving Pharmacogenomics from Research into Clinical Practice	Medical Grand Rounds	10/26/07 RPC	7 participants	Hard copy available
Mental Health Specialist Training	In-Service	10/22&23/07	57 participants	Hard copy available
Can Empathy Be Taught?	Psychiatric Grand Rounds	11/6/07 RPC	11 participants	Hard copy available
Stemming and Epidemic of Cardio metabolic Illness and Early Mortality: Research in Integrated Health Promotion and Health Care for Older Persons with Serious Mental illness	Psychiatric Grand Rounds	11/13/07 RPC	4 participants	Hard copy available
American Mania: Have we Spawned and Addictive Society	Psychiatric Grand Rounds	11/27/07 RPC	6 participants	Hard copy available
Partnering with Patients and Families to Improve the Quality of Care": A Progress	Medical Grand Rounds	11/2/07 RPC	4 participants	Hard copy available

Topic	Type	Date(s)	Level of Participation	Information Packets/Publications
Report on Measurements and Outcome				
Chitinases in Asthma: Found in Translation	Medical Grand Rounds	11/9/07 RPC	2 participants	Hard copy available
Special MGR: Great Issues in Medicine and Global Health Symposium: Dying in the Shadows: Morbidity and Mortality Among Boston's Rough Sleepers	Medical Grand Rounds	11/16/07 RPC	4 participants	Hard copy available
New Interventions for the Treatment of the Type 2 Diabetes Epidemic: How many, how fast, how good?	Medical Grand Rounds	11/30/07 RPC	6 participants	Hard copy available
Mental Health Specialist Training	In-service	11/8,13,20	91 participants	Hard copy available
Frontoparietal contributions to recognition deficits in Schizophrenia	Psychiatric Grand Rounds	12/11/07 RPC	5 participants	Hard copy available
EUREKA!...Now what do I do? Insights from a Medical Device Entrepreneur	Medical Grand Rounds	12/7/06 RPC	6 participants	Hard copy available
Special MGR Translational Research	Medical Grand Rounds	12/14/07 RPC	4 participants	Hard copy available
A Developmental Path to Mental Illness and Suicide	In-service	12/10/06 RPC	22 participants	Hard copy available
The Power of Intentional Relationships	In-service	12/17/07 RPC	10 participants	Hard copy available
Dialectical Behavioral Therapy	In-service	12/18/07 RPC	11 participants	Hard copy available

COMMUNITY FORENSIC ACT TEAM

Aspect: Descriptive Report on various components
2nd quarter Oct November and December 07

CASE MANAGEMENT:

Clients enrolled in the ACT program	
	Number of ACT clients
Oct 2007	34
Nov 2007	34
Dec 2007	34

Riverview ACT Team is now serving all but one of the clients previously case managed by their ICM. One client intends to grieve this change of case managers. ACT case management is presently at capacity.

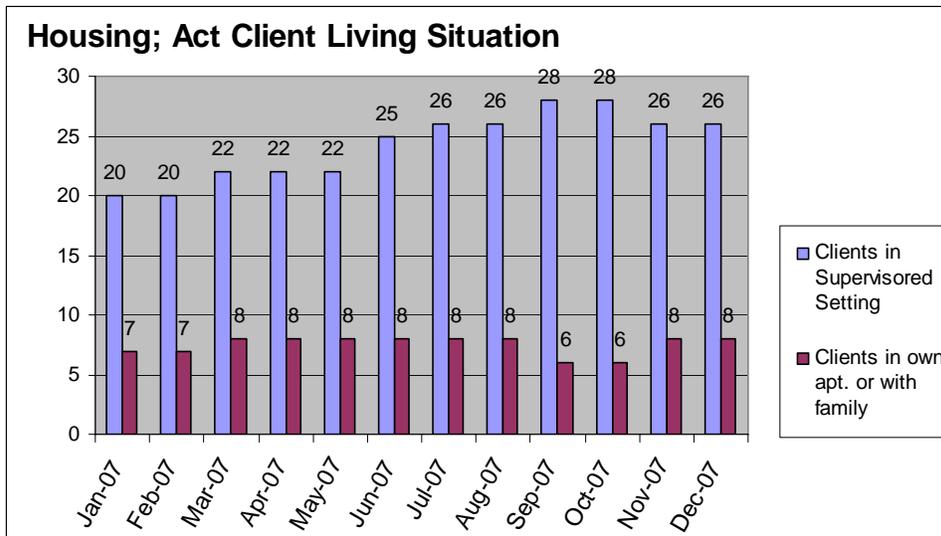
CRISIS MANAGEMENT:

2nd Quarter 2008	Client incidents	Hospitalized RPC	Hospitalized Medical
Oct 2007	0	0	0
Nov 2007	2	1	0
Dec 2007	3	2	0

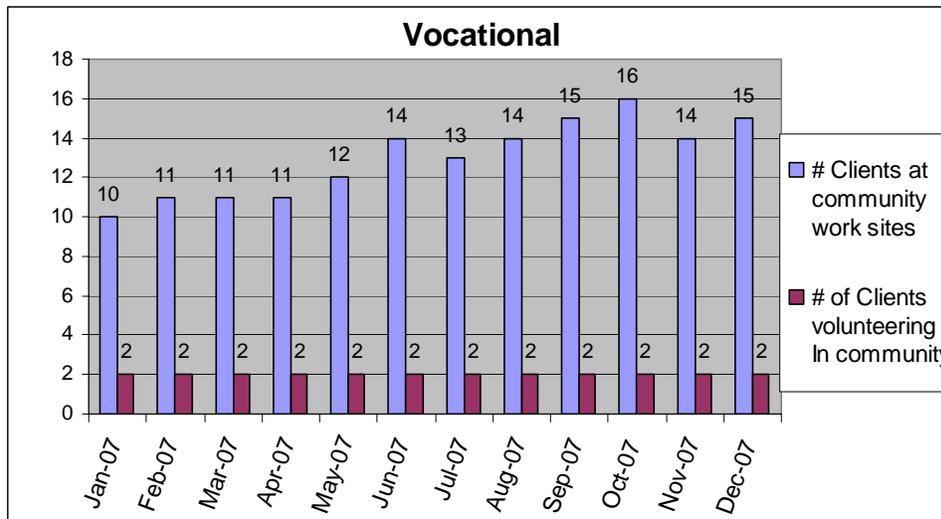
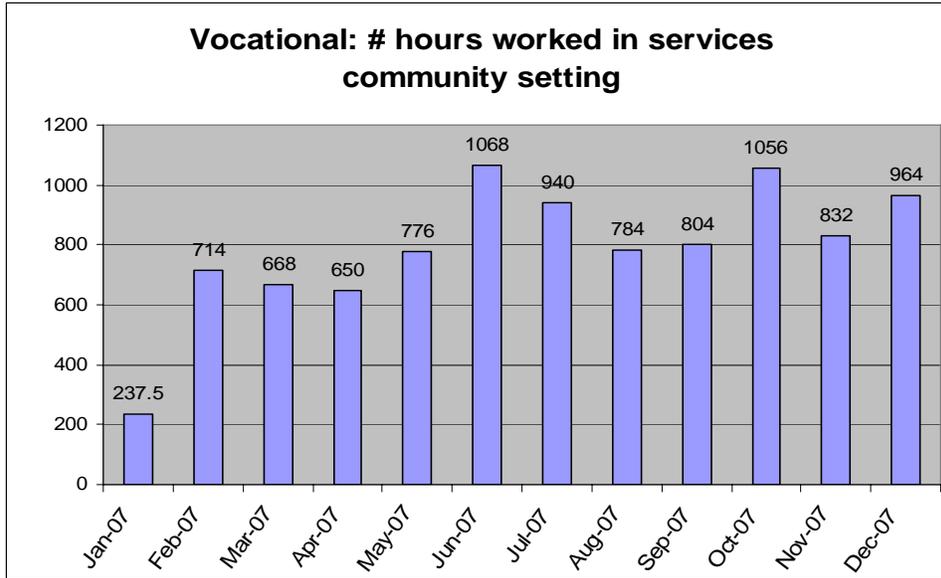
SUBSTANCE ABUSE:

2nd Quarter 2008	Client with Substance Abuse as a Clinical Focus	Percent of ACT Clients In SA treatment
Oct 2007	9	26%
Nov 2007	9	26%
Dec 2007	9	26%

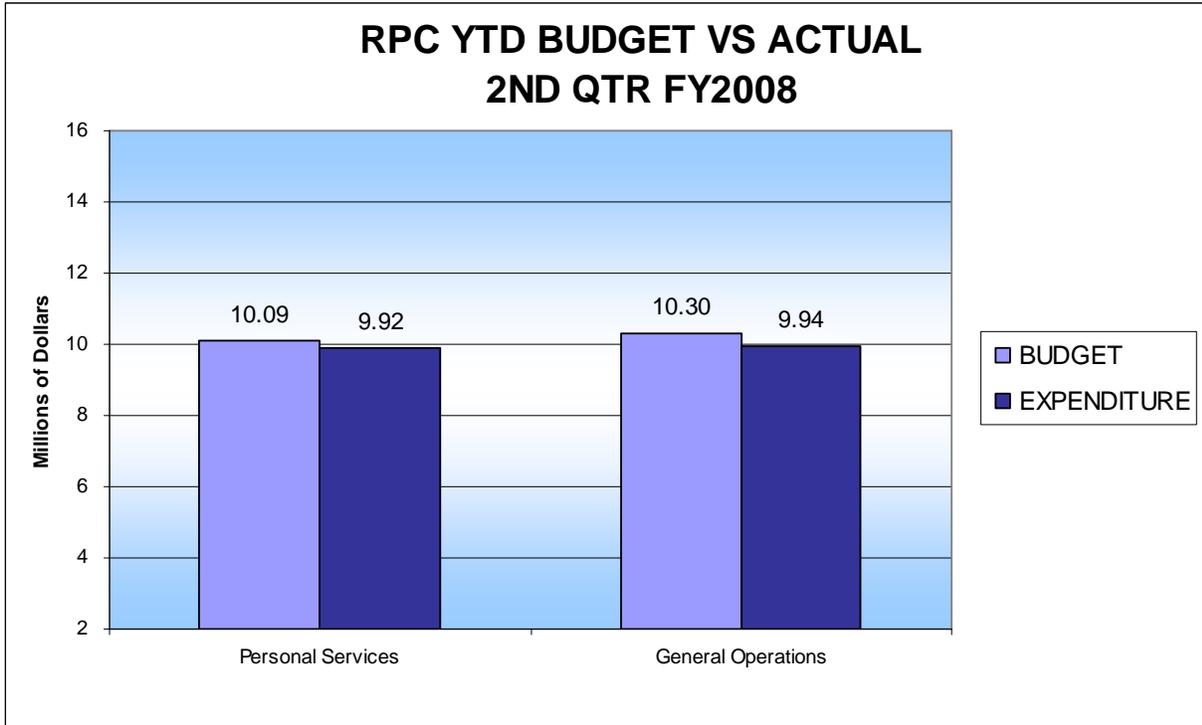
HOUSING:



VOCATIONAL / EDUCATIONAL:

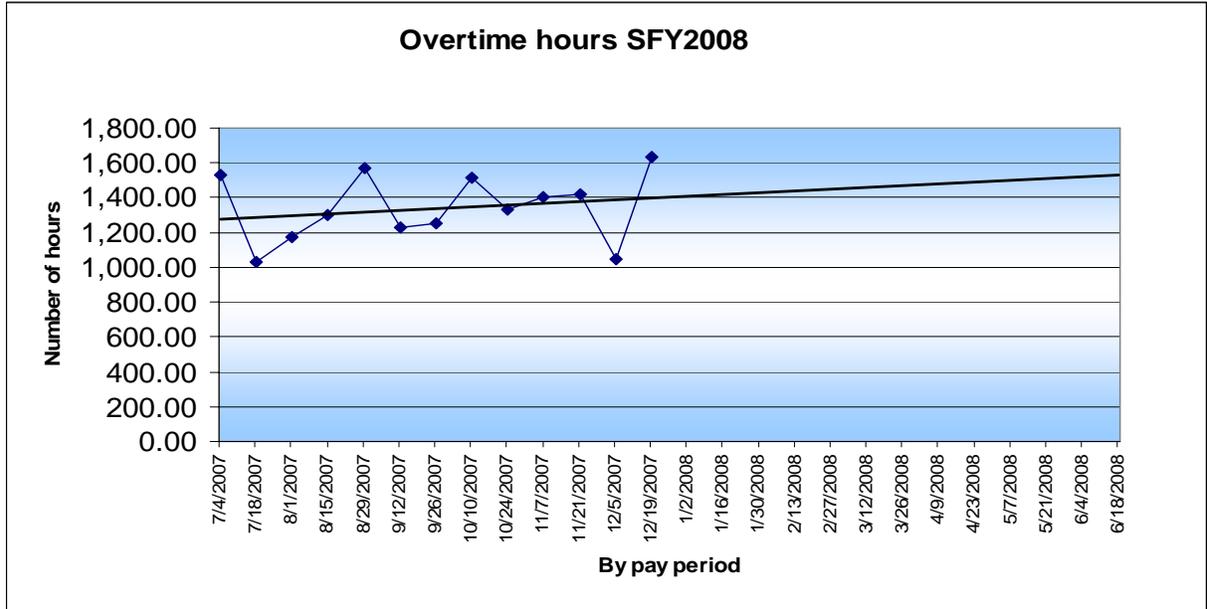


Section II: Riverview Unique Information
BUDGET
ASPECT: BUDGET INFORMATION



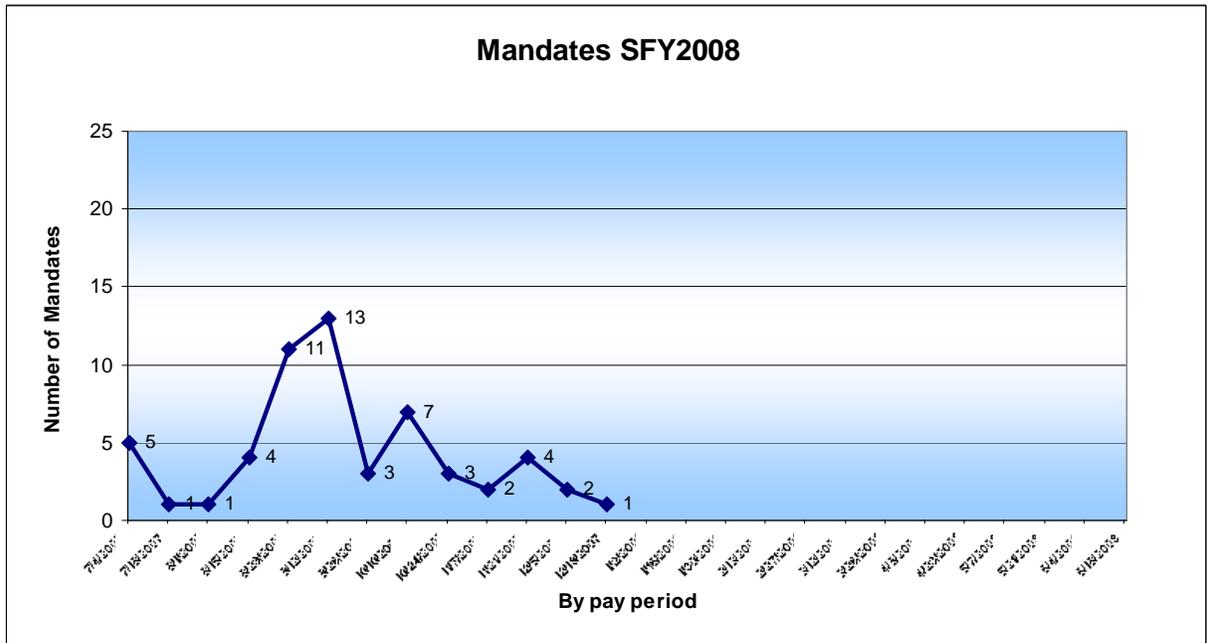
The hospital currently continues to stay within budget. Action plan includes continuing to carefully monitor and manage overtime and mandates. Continue aggressive management of all contractual services via fiscal and programmatic accountability.

HUMAN RESOURCES
OVERTIME



Overtime has decreased this quarter as compared to last quarter, 9,076.50 hrs down to 8,338.75. As compared to the same quarter last year (Oct 06 - Dec 06) we had 6,397.25 hrs of overtime. This year we have 8,338.75 hrs of overtime, this represents an increase of 1941.5 hours from last year.

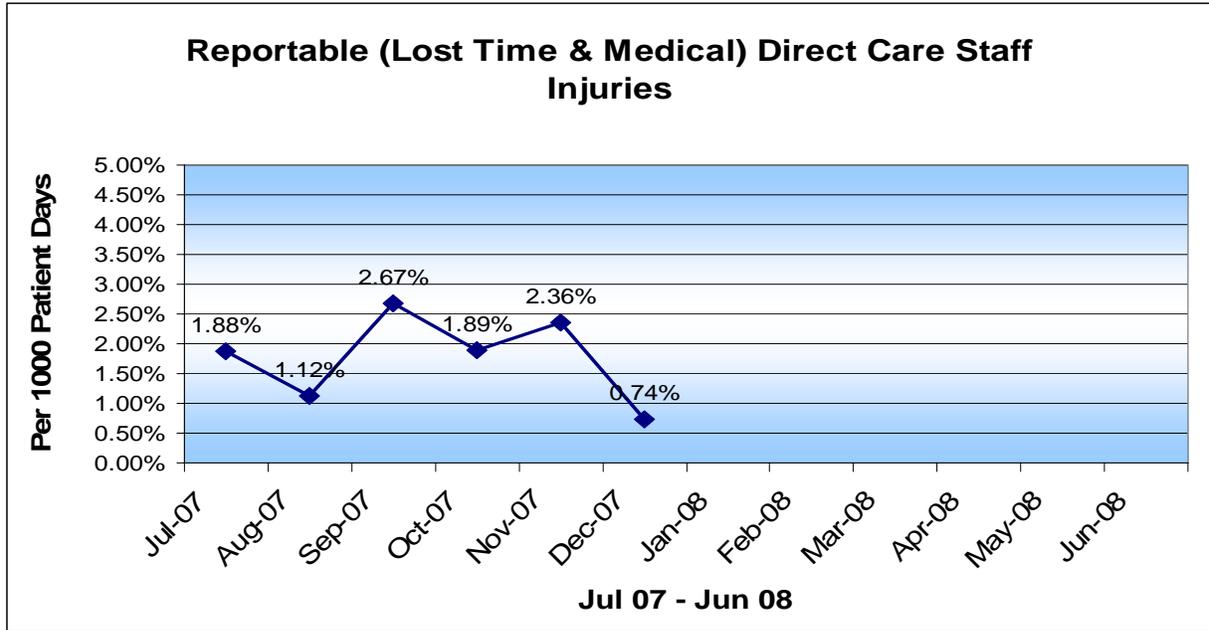
HUMAN RESOURCES
ASPECT: MANDATES



Mandated shifts have decrease this past quarter from 38 to 19. This is a 50% decrease this quarter. Last year we had a total of 14 mandated shifts during this same rating period (Oct 06 - Dec 06), this year we had 19.

HUMAN RESOURCES/RISK MANAGEMENT

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



This quarter review reveals that there was a decrease in direct care staff injuries from 1.89% per 1000 patient days to 1.66% per 1000 patient days. This number represents (13) direct care staff who sought medical treatment or lost time from work, as compared to (15) last quarter.

Management of Human Resources

ASPECT: Timely Performance Evaluations

OVERALL COMPLIANCE:

ASPECT: Management of Human Resources

OVERALL COMPLIANCE: 87.20%

<u>INDICATOR</u>	<u>FINDINGS</u>		<u>TARGET PERCENTILE</u>
Employee Performance Evaluations expected to be completed within 30 days of the due date.			
October 2007 (August Evals)	34 of 36	94.44%	85%
November 2007 (September evals)	26 of 30	86.67%	85%
December 2007 (October evals)	33 of 41	80.49%	85%

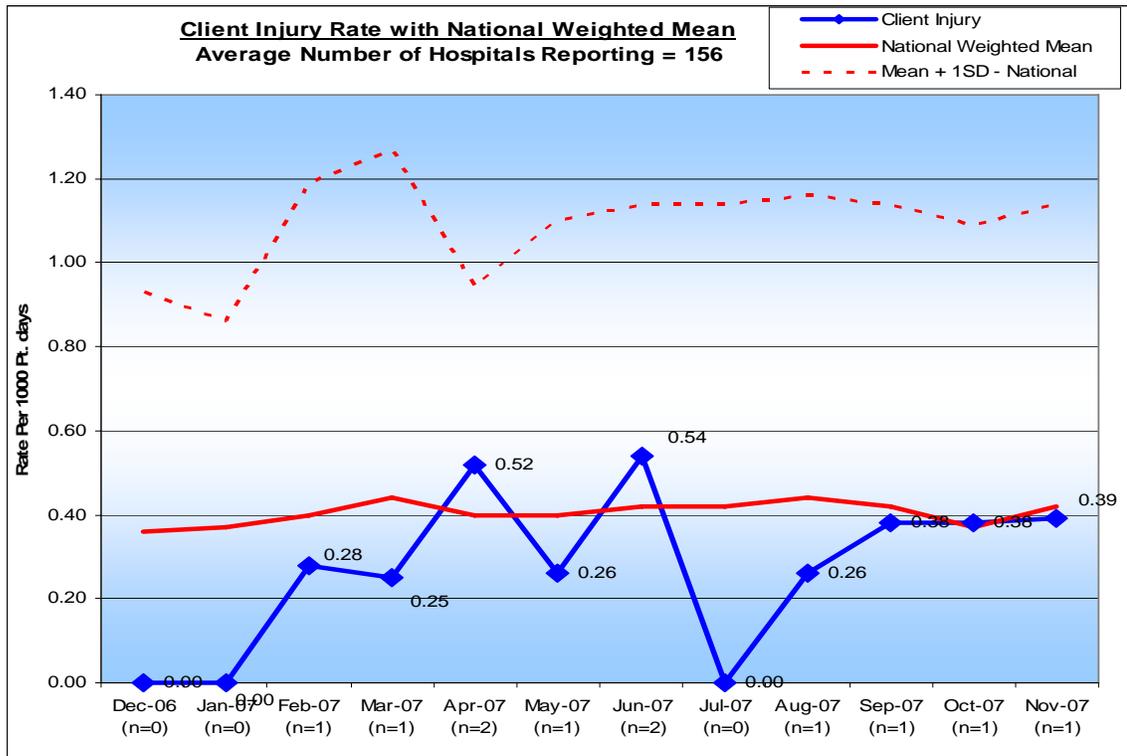
As compared to last quarter (95.89%) this quarter's *decreased* to 87.20%. As compared to the same quarter last year, 2006, we were at 55.35% compliance. This is a significant improvement. During

this quarter 107 performance evaluations were sent out; 93 were received in a timely manner. Human Resources continues to stress the importance of timely submission and requested from all Department Heads to submit their evaluations for processing of timely merit increases for staff.

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.

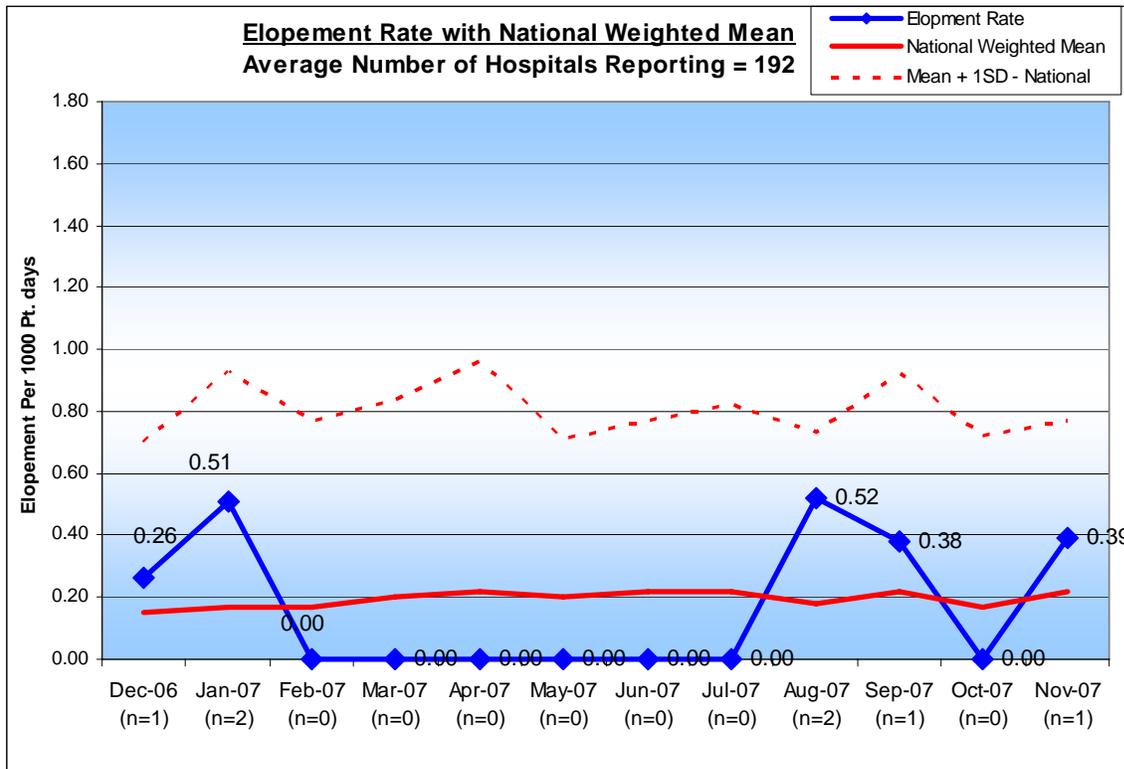
CLIENT INJURY RATE GRAPH



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.

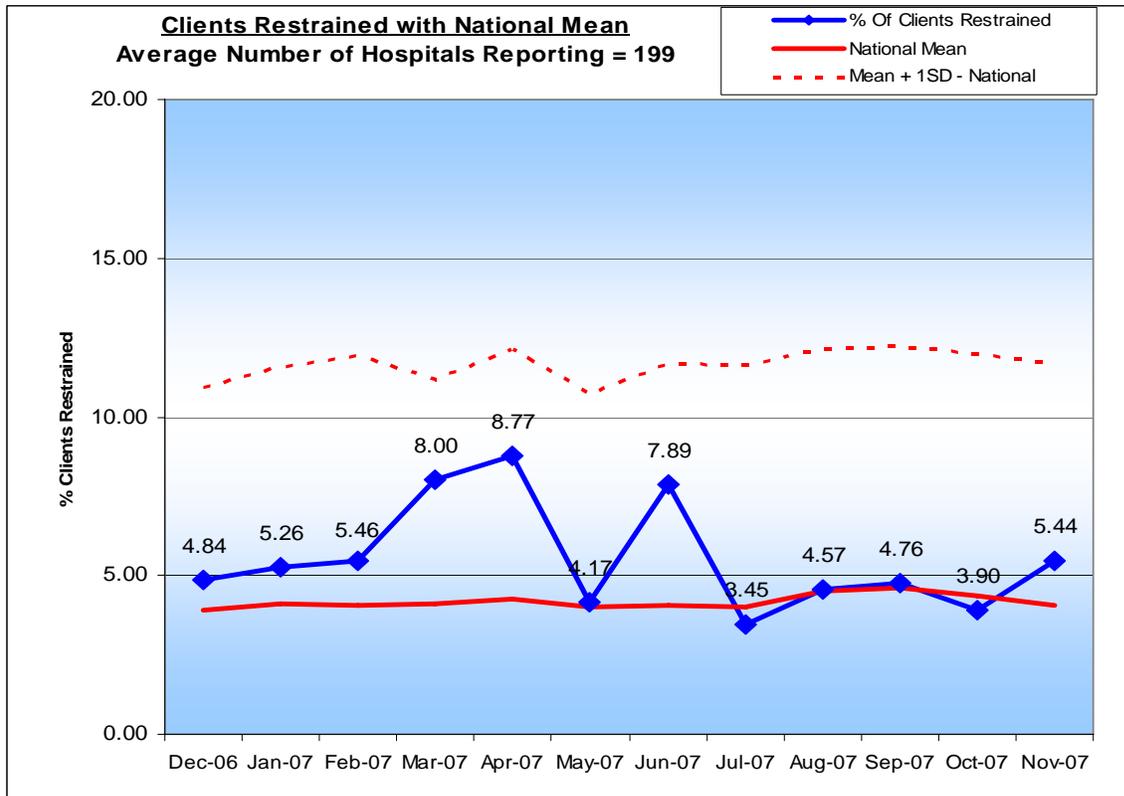
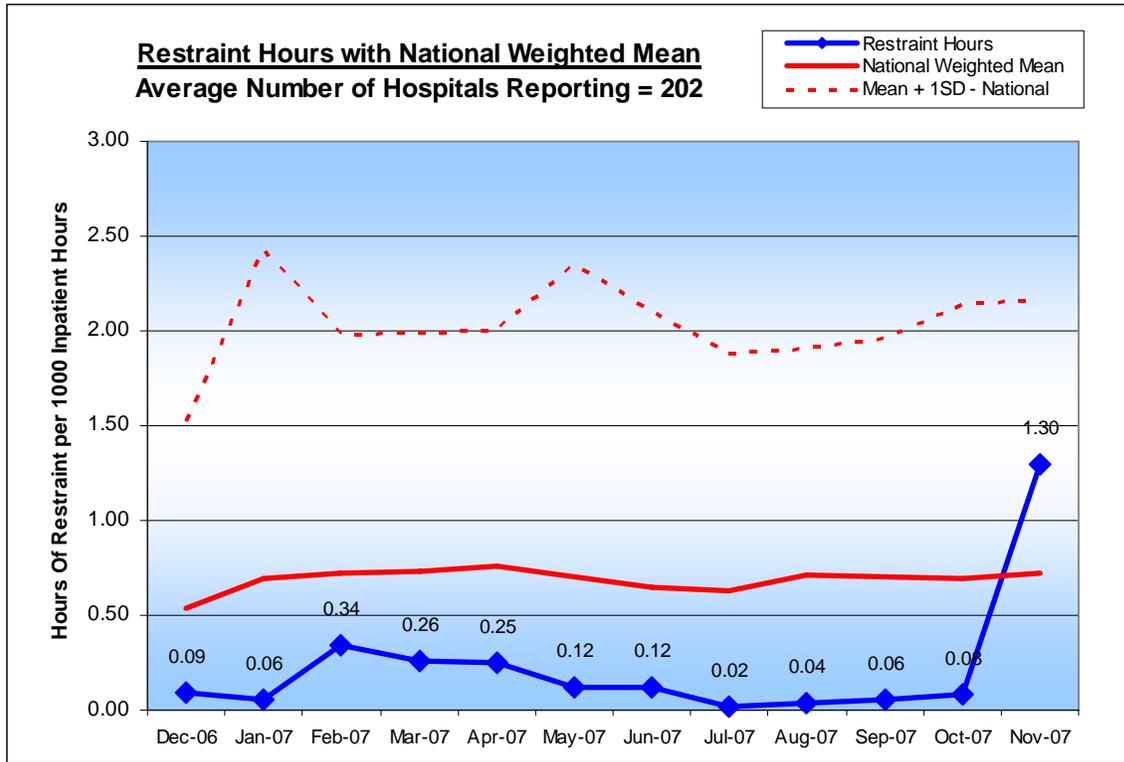
Over the last 3 months reported in this graph, there were 3 injuries requiring more than first aid level of care.

ELOPEMENT RATE GRAPH



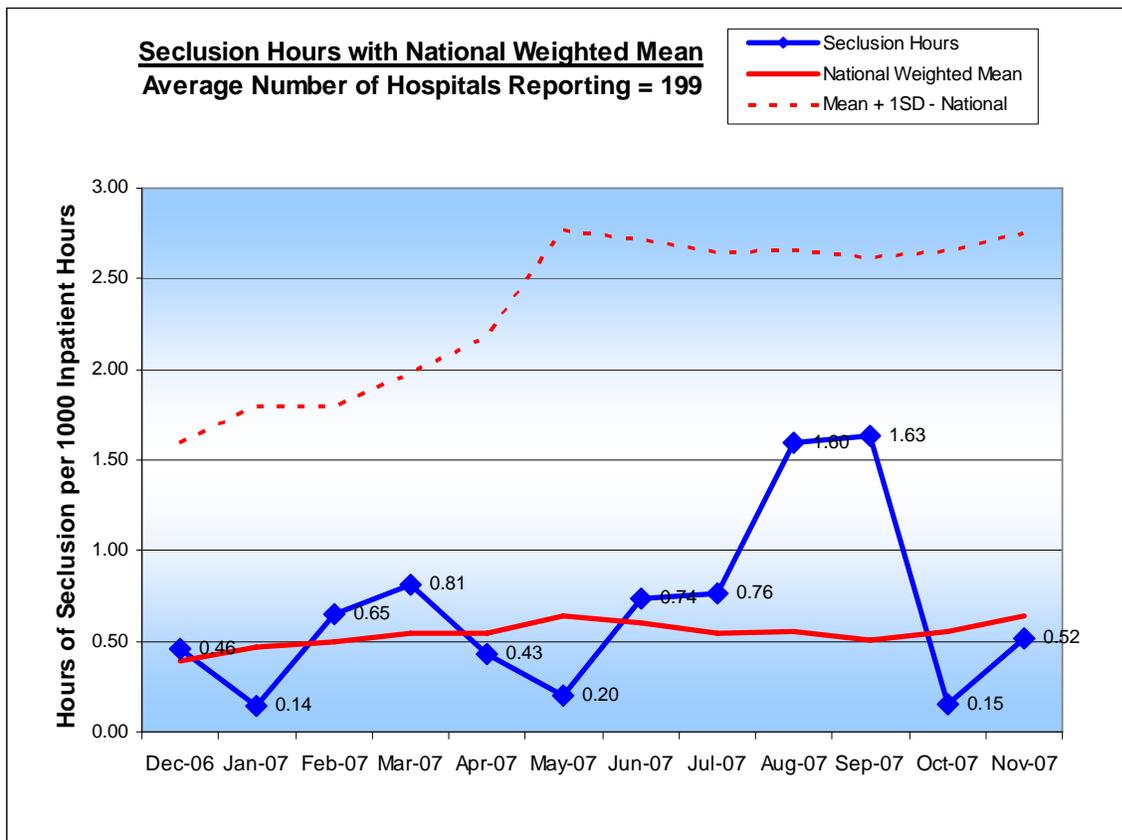
Elopement Rate is calculated per 1000 patient days. Elopement is defined as the client not being where expected at any given time, for instance if the client is supposed to return at 8 pm but is late and does not call to report the circumstance the client is considered to have eloped. Elopement risk is evaluated by the treatment team and is treatment planned if necessary to keep the client and the community safe.

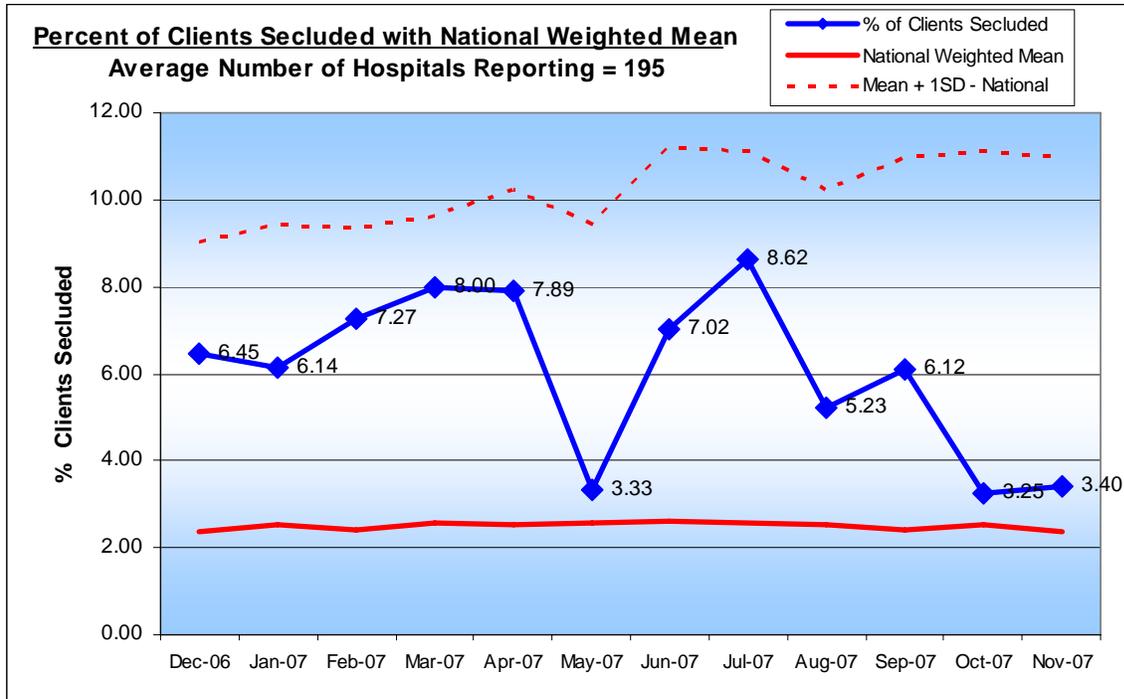
RESTRAINT GRAPHS



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 tobacco-free campus policy, that was 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).

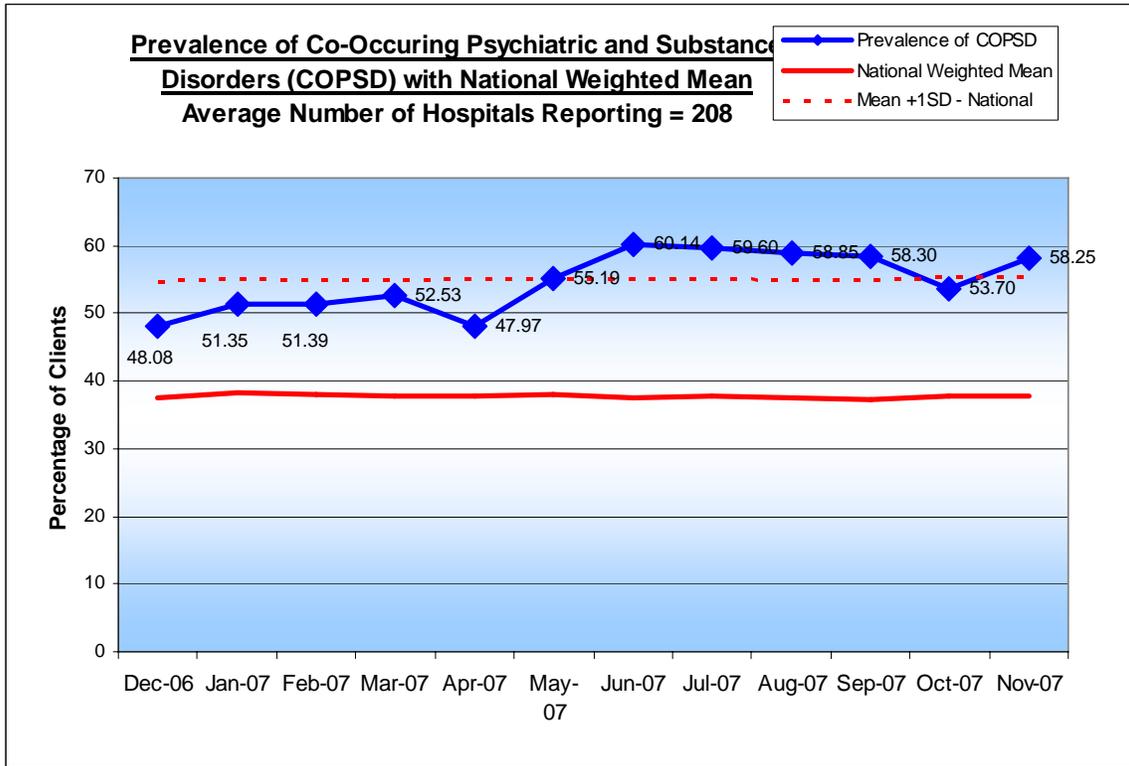
SECLUSION GRAPHS





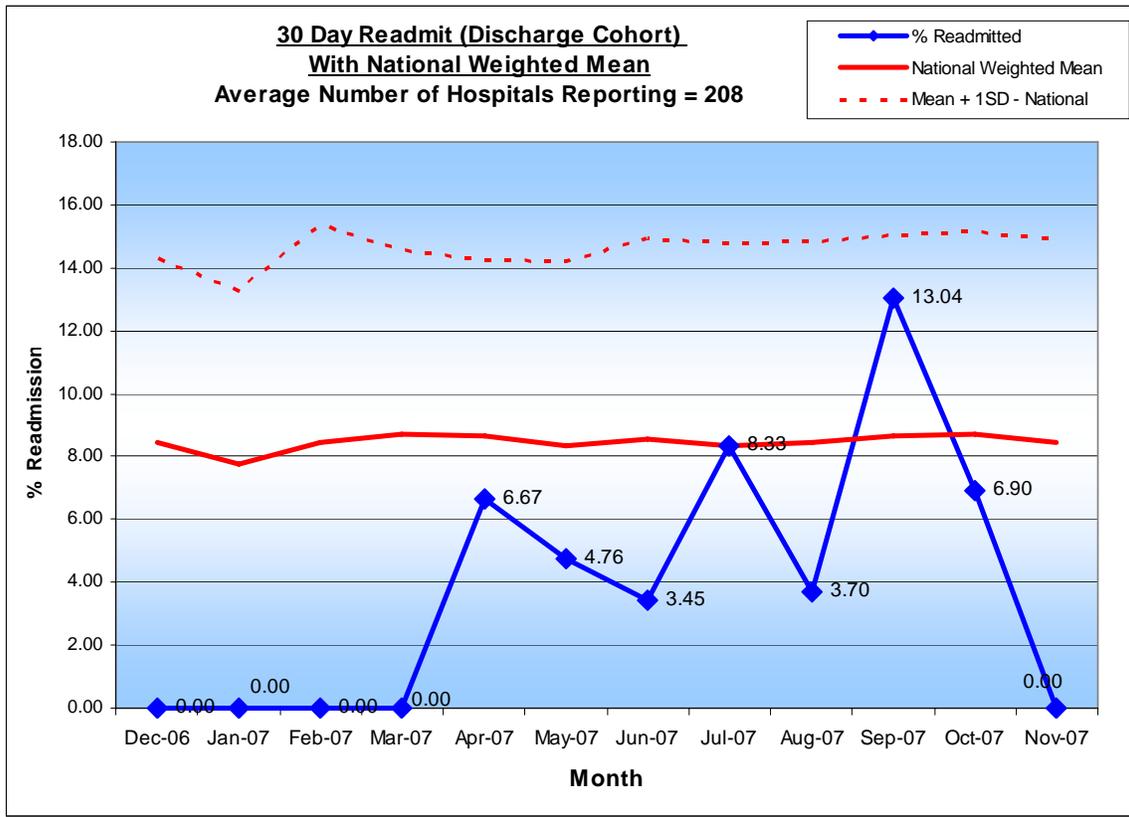
Riverview used seclusion more frequently than 68% of hospitals in the national sample in the months of March and July, but the rate is generally comparable to the national sample in other months. Seclusion hours (duration of events) at Riverview, although tending to be above the national weighted mean, 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 became tobacco-free campus 4/2/07. 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



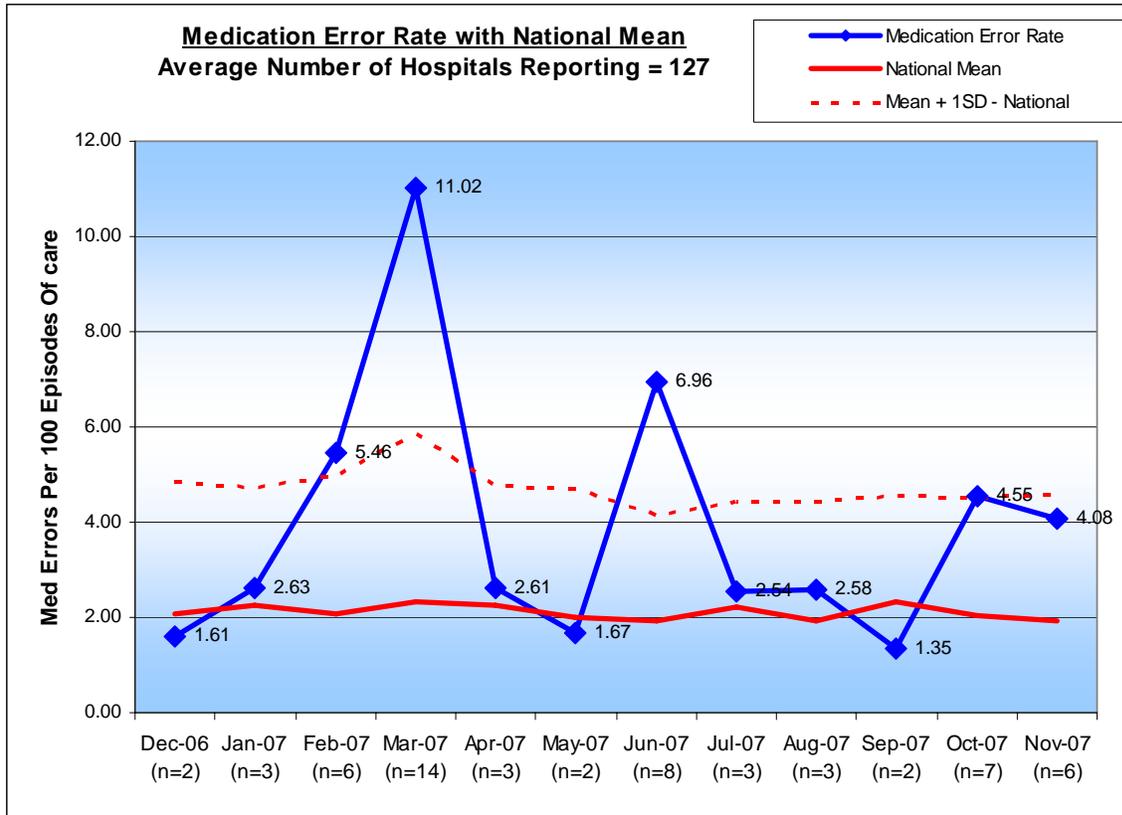
RPC has collaborative effort with Spring Harbor Hospital Co-Occurring Disorders providers to contract with RPC to develop a Co-Occurring program. Though RPC is currently a bit above the trend line, this is an indicator current initiatives are working as anticipated; with the advent of this program to 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 208 other facilities reporting on this indicator, except in September 07. 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. All RPC readmissions that occur in less than 30 days of discharge are reviewed by the Director of Social Work Services.

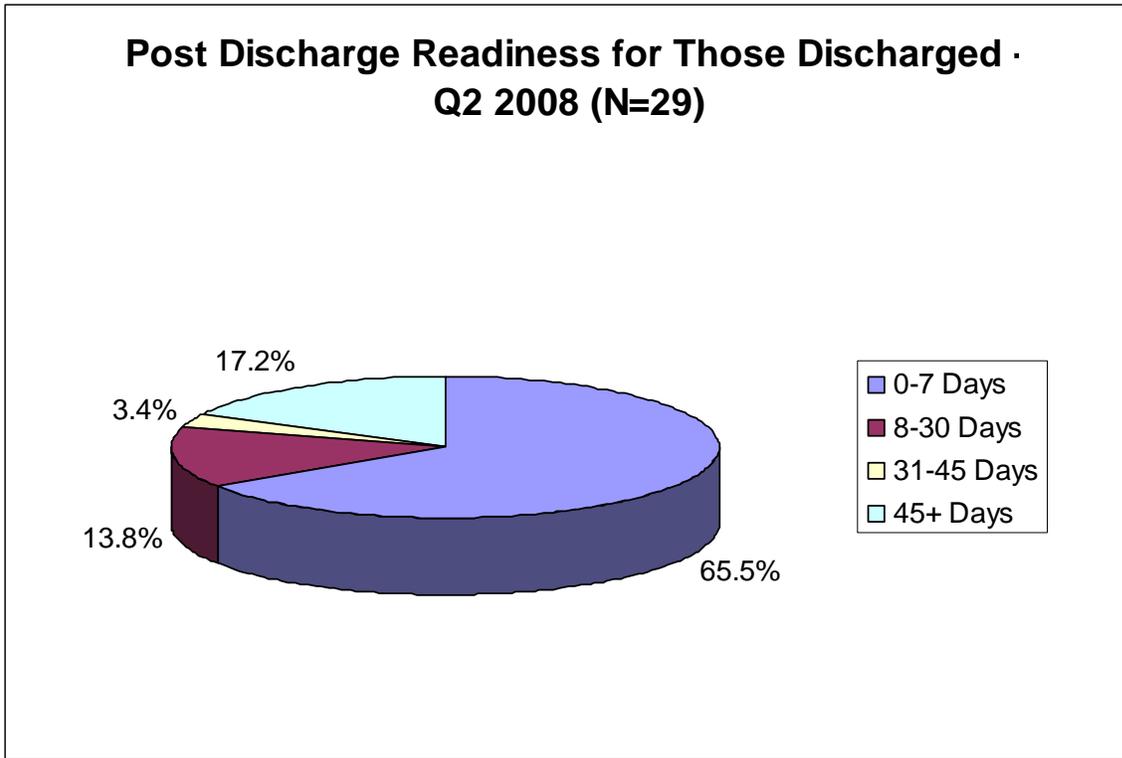
MEDICATION ERROR RATE WITH NATIONAL MEAN GRAPH



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 PRIOR READINESS



READINESS PRIOR TO DISCHARGE

This chart shows the percent of clients who were discharged within 7 days of their discharge readiness to be at 65.5%; 8- 30 days post readiness 13.8%.; 31-45days at 3.4% and Greater than 45 days post discharge ready 17.2% of clients discharged this quarter. Cumulative percentages and targets are as follows:

- Within 7 days = 65.6% (target 75%)
- Within 30 days = 79.3% (target 90%)
- Within 45 days = 82.7% (target 100%)

There was a slight increase in the discharges within 7 days from 61.1 % to 65.5% this quarter, a decrease 89.9% to 79.3 % within 30 days of being discharge ready, and a decrease within 45 days from 94.1% last quarter to 82.7% in the 2nd quarter.

The previous 4 quarters are displayed in the table portrayed below:

Quarter	Within 7 days	Within 30days	Within 45 days	45 +days
Target	75%	90%	100%	0%
Q12008	61.1%	89.9 %	94.1%	5.9%
Q42007	78.8 %	94%	94	6.1%
Q32007	74.1%	88.9% (14.8%)	96.3% (5.6%)	3.7%
Q2 2007	64.1%	82% (17.9%)	85.6% (2.6%)	15.4%