Motion for Immediate Relief

Exhibit 22

STATE OF GEORGIA

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

f/k/a DEPARTMENT OF HUMAN RESOURCES, DIVISION OF MHDDAD

SYSTEM-WIDE COMPREHENSIVE AUDIT

Status Report of Issues Targeted for Substantial Compliance by January 15, 2010
Pursuant to the CRIPA Settlement Agreement between the United States of America and the State of Georgia

Issues Audited within the CRIPA Settlement Agreement

1. Choking and aspiration risk assessment and prevention
2. Suicide risk assessment and prevention
   Prevention of patient on patient assault
3. Implementation of emergency medical codes consistent with generally accepted professional standards
4.

Audit Team Composition

1. Registered Nurse
2. Registered Nurse
3. Licensed Masters Social Work

Locations and Dates of Comprehensive Audits

1.	West Central Georgia Regional Hospital	WC GRH	October 19-21, 2009
2.	Georgia Regional Hospital at Savannah	GRH Sav	October 26-28, 2009
3.	Northwest Georgia Regional Hospital	NW GRH	November 9, 10 & 12, 2009
4.	Georgia Regional Hospital at Atlanta	GRH Atl	November 16-19, 2009
5.	Southwestern State Hospital	SWSH	November 30- December 3, 2009
6.	East Central Georgia Regional Hospital	EC GRH	December 7-10 and 14-15, 2009
7.	Central State Hospital	CSH	December 28-30, 2009 and January 4-7, 2010

Methodology for Comprehensive Audit

- Review of relevant documents
- Review of relative systems, such as incident reporting, risk management, etc.
- Review of quality management activities
- Staff interviews with any person employed by the hospital, and administrators
- Patient interviews
- Observation of patient activities
- Review of no less than five per cent of active patient records, each hospital

Comprehensive Audit Rating Scale Interpretation of Ratings as Measured against the Plan of Implementation and Report of Compliance submitted to the Department of Justice September 15, 2009.

Not Compliant	No evidence of compliance
Beginning Compliance	Policies and protocol are in place
Partial Compliance	Training of staff is completed on policies or procedures. There is evidence of consistent implementation of practice in patient records
Moderate Compliance 1	Oversight of implementation of practice is occurring through fidelity checks
Moderate Compliance 2	Quality of patient care is determined and addressed by individual clinician, patient care unit and hospital program using fidelity check data that is tracked, aggregated, trended and reported.
Substantial Compliance	All active elements previously noted are fully implemented. Care provided is patient centered and internally driven. Exceptions or violations are minor or occasional and are not systemic

ISSUE SUBSTANTIAL COMPLIANCE: Assessment and Prevention of Aspiration and Choking
D. Medical and Nursing Care, Items 11 and 12

11. Establish an effective physical and nutritional management program for patients who are at risk for aspiration or dysphagia, including but not limited to the development and implementation of assessments, risk assessments, and interventions for mealtimes and other activities involving swallowing. The physical and nutritional management program shall:

OUTCOME 1: Care of patients who are at risk for aspiration or dysphagia will occur according to generally accepted professional standards.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
1.2010	All Hospitals	Hospitals were audited against the Policy Directive for Physical Nutritional Management, adopted at the Departmental level and implemented at each hospital effective October 2009

a. Identify patients at risk for aspiration or choking and assign an appropriate risk level to that patient;

OUTCOME 1: Each individual admitted to a Department of BHDD hospital is assigned a risk level for aspiration and choking.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Partial Compliance	CSH	1.7.10. Screenings are performed as a part of the history and physical by the physician. Screenings occasionally did not identify all noted risk factors. Mechanisms are in place for referring patients determined to be at risk for follow-up.
Beginning Compliance	EC GRH	12.15.09. Screenings are performed as a part of the history and physical by the physician. Screenings did not consistently identify all noted risk factors. Screening tools for several Gracewood units need to be filed in the record. There is not a mechanism for assuring all patients at risk are referred for follow-up evaluation when indicated at the Augusta campus.
Partial Compliance	GRH/Atl	11.19.09. Four of 19 charts were missing screening forms.
Substantial Compliance	GRH/Sav	10.28.09. 100% of the records reviewed contained an initial screening with an assigned level of risk.
Substantial Compliance	NW GRH	11.12.09. Screening was completed with assigned level of risk.
Partial	SWSH	12.3.09. Screening was completed with an assigned level of risk, however rescreening for AMH patients was not done routinely with change of status.

Compliance		
Beginning Compliance	WC GRH	10.21.09. 50% of the records reviewed contained an initial screening with an assigned level of risk.

b. Identify triggers on an individualized basis for patients identified as at risk;

OUTCOME 1: Triggers for aspiration and choking are clearly documented for each individual.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Beginning Compliance	CSH	1.7.10. Generic triggers were noted on most meal plans; however plans were not a part of the patient record. There is not a method to document individual triggers as they occur, or to report them to the team.
Beginning Compliance	EC GRH	12.15.09. 24 hour plans, including meal plans, are not a part of most records. General triggers are listed on the back of all meal plans. There is not a method to document individual triggers as they occur or to report them to the team.
Partial Compliance	GRH/Atl	11.19.09. Triggers were noted on plans, however plans were not a part of the patient record. There is not a method to document individual triggers as they occur, or to report them to the team.
Moderate Compliance 1	GRH/Sav	10.28.09. 21 of 159 patients currently required and had in place a physical nutritional management plan. All plans were reviewed during this audit. The plans contained triggers and were immediately evident in the medical record.
Beginning Compliance	NW GRH	11.12.09. Triggers were noted on all meal plans, but meal plans were not a part of the clinical record. There is not a method to document individual triggers as they occur or to report them to the team.
Beginning Compliance	SWSH	12.3.09. Triggers were generally not seen in the meal plans, though they were identified in the assessments.
Partial Compliance	WC GRH	10.21.09. One physical nutritional management plan was required and was in place. Triggers were documented.

c. Assess and determine appropriate and safe positioning for each at risk patient for the 24 hour day;

OUTCOME 1: Positioning requirements are clearly documented for each individual, and are consistently implemented.

	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Moderate Compliance 2	CSH	1.7.10. Plans requirements were clearly documented. Monitoring for fidelity is done by the nurse managers. Follow-up to issues is recorded on the monitoring sheet. Findings are aggregated on a spreadsheet and reported to QI.
Partial Compliance	EC GRH	12.15.09. Plans address positioning for 24 hours; however fidelity checks are not in place.
Beginning Compliance	GRH/Atl	11.19.09. Plans were not 24 hour plans. Competency checks were performed in groups and were not individualized. Fidelity checks are not currently in place.
Moderate Compliance 2	GRH/Sav	10.28.09. Positioning requirements were clearly documented. Monitoring for fidelity is done by the dietician and dietary tech. The findings were aggregated and reported.
Beginning Compliance	NW GRH	11.12.09. Positioning plans address meal times only, not for the 24 hour day. The noted positioning requirements for the same individual may vary by the discipline doing the evaluation. Fidelity checks to monitor actual performance were done informally and findings were not reported to the Quality Assurance process.

Beginning Compliance	SWSH	12.3.09. Plans are not 24 hour plans. Competency checks are performed in groups initially. Fidelity checks are not currently in place. Pictures were posted at bedside indicating correct positioning.
Not Compliant	WC GRH	10.21.09. Positioning requirements were not documented. Random monitoring for fidelity checks was not evidenced therefore, no findings were available for aggregation, report, or available to the hospital's QI processes.

d. Develop and implement plans that include specific instructions on implementation of the appropriate techniques for all patient activities based on the patient's assessment, with clinical justifications;

OUTCOME 1: Detailed plans are in place for all persons at risk for aspiration and choking.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Moderate Compliance 1	CSH	1.7.10. The individual plans contained all required elements and were immediately accessible.
Beginning Compliance	EC GRH	12.15.09. Plans are not present for all persons determined to be at risk. Patient units have been triaged with more involved persons having plans completed first. Two units have not completed all consults currently.
Beginning Compliance	GRH/AtI	11.19.09. Plans that were available were detailed and very individualized, however were not utilized on all units during meals. Some persons with texture modified diets did not have plans.
Moderate Compliance 1	GRH/Sav	10.28.09. The individual plans contained all required elements and were immediately accessible with beginning oversight of fidelity checks.
Beginning Compliance	NW GRH	11.12.09. Meal plans were in place, however not all elements were consistently noted. Plans do not address all activities of daily living or correct head positioning. The hospital currently is in need of a speech pathologist.
Beginning Compliance	SWSH	12.3.09. Meal plans were in place for the Developmental Disabled population, but did not consistently include triggers and all elements required. Meal plans were not immediately available on the mental health units.
Beginning Compliance	WC GRH	10.21.09. The one plan that was in place did not contain all the required criteria.

REGISTERED DIETICIAN - brief description of duties and responsibilities

Adequate numbers of Registered Dieticians are available to support the nutritional needs of patients. Registered Dieticians:

1. Assure meal and snacks are nutritionally balanced
2. Plan and prepare special diets, such as low sodium, low fat, etc.
3. Provide foods to patients with difficulty chewing or swallowing through adjustments in texture and thickening

OUTCOME 2: Adequate numbers of professional dieticians are available to support special dietary needs of patients.
Using the ratios noted below and based on the May 2009 gap analysis, the state is targeting to hire registered dieticians

Skilled nursing level of care (including very medically involved ICF/MR patients) and ICF/MR level of care

1. Dietician per patient ratio is 1:100

All patient care services except what follows

1. Dietician per patient ratio is 1:150

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Substantial Compliance	CSH	1.7.10. There are three fulltime and three part time dietitians noted for a 609 bed capacity (including 172 skilled beds).

Substantial Compliance	EC GRH	12.15.09. There are four fulltime dieticians noted for a 485 bed capacity (including 30 skilled beds). Dietitians are available on the Augusta campus by consultation only.
Substantial Compliance	GRH/Atl	11.19.09. There are four fulltime dieticians noted for a 306 bed capacity (including 36 skilled beds).
Partial Compliance	GRH/Sav	10.28.09. GRH/Sav requires and has in place one registered dietician of two that are required.
Partial Compliance	NW GRH	11.12.19. The hospital currently has one full time and one part time dietician of a total three that are required.
Substantial Compliance	SWSH	12.3.09. There are two fulltime and one 80% dieticians for 180 patients (including 20 skilled nursing beds).
Substantial Compliance	WC GRH	10.21.09 WC requires and has in place one registered dietician of a total of one that is required.

e. Monitor and document objective clinical data for at risk patients; and

OUTCOME 1: Episodes of aspiration or choking are documented.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Moderate Compliance 2	CSH	1.7.10. There is a method for reporting individual episodes of aspiration or choking to the nurse for documentation. Treatment team notes reflect reviews of episodes for individual patients. Episodes are reviewed by the Program Review Committee.
Not Compliant	EC GRH	12.15.09. There was no adequate method for documenting and reporting individual episodes. These episodes were not documented, aggregated or reviewed.
Not Compliant	GRH/Atl	11.19.09. There was no adequate method for documenting and reporting individual episodes. These episodes were not documented, aggregated or reviewed. Staff reports there have been no episodes of coughing or choking. One coughing episode was observed during a meal during this review, with no report given to the nurses.
Partial Compliance	GRH/Sav	10.28.09. Five episodes of choking or aspiration have occurred since January 1, 2009. These episodes were documented but not aggregated and reviewed.
Beginning Compliance	NW GRH	11.12.19. A record to capture episodes of aspiration or choking has not been developed. Several incidents of choking, gagging and coughing were noted in direct care staffs' progress notes but missed or omitted in the nurse's weekly summary note.
Not Compliant	SWSH	12.3.09. There was no adequate method for documenting and reporting individual episodes. These episodes were not documented, aggregated or reviewed.
Partial Compliance	WC GRH	10.21.09. One episode of choking has occurred in the past six months. This episode was documented.

f. Implement a system to review and revise plans based on appropriate triggering events and outcomes.

OUTCOME 1: Each individual's plan is timely reviewed.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Partial Compliance	CSH	1.7.10. Generally plans are reviewed and revised when indicated. Monthly reviews are not noted.
Not	EC GRH	12.15.09. There is no formal mechanism in place to review of plans.

Compliant		
Beginning Compliance	GRH/Atl	11.19.09. No formal review system is in place. Some monthly reviews were documented, but were inconsistently noted.
Substantial Compliance	GRH/Sav	10.28.09. The dietician reviews plans weekly. There is mechanism for nurse review every two weeks on the longer term units. There is also a quarterly review.
Not Compliant	NW GRH	11.12.19. Plans were not reviewed and revised after patients have had a hospitalization for aspiration pneumonia. Data related to individual episodes of choking or coughing was not aggregated and used for team review of the plan.
Not Compliant	SWSH	12.3.09. Plans were not routinely reviewed and revised after patients have had a status change such as a hospitalization for aspiration pneumonia. Data related to individual episodes of choking or coughing was not aggregated and used for team review of the plan.
Beginning Compliance	WC GRH	10.21.09. The one physical nutritional plan in place was written retrospectively on 8/28/09 after a choking episode that had occurred in 05/09. No interventions were required at the time of the episode. The patient (not the plan) was assessed 06/01/09 & 09/14/09. This patient has had no subsequent episodes. Documentation on this patient's ISP indicated the goal related to risk of aspiration/choking was resolved 9/21/09.

12. Require that staff with responsibilities for patients at risk for aspiration and dysphagia have successfully completed competency-based training on duties commensurate with their responsibilities.

OUTCOME 1: Competence of all patient care staff is assessed and documented.

Moderate Compliance 1	CSH	1.7.10. Training is complete. Fidelity check processes have begun with some results aggregated and trended.
Partial Compliance	EC GRH	12.15.09. 96% of staff had completed training. There is not a system of ongoing competency assessment or fidelity checks.
Partial Compliance	GRH/Atl	11.19.09. 99% of Developmental Disability staff and 73% of Adult Mental Health staff had completed training. Staff competency checks were completed in groups and were not individualized. Fidelity checking was not currently implemented.
Partial Compliance	GRH/Sav	10.28.09. Documentation reflects that nursing staff were observed real-time. Four of 12 nurse and direct care staff competency files contained documentation of training and assessment of competency. Four physicians' competency files reviewed did not contain documentation of training or competency assessments related to care responsibilities of patients at risk of aspiration & choking. (There were documented plans to implement competency checks for the physicians beginning 11/09.)
Partial Compliance	NW GRH	11.12.09. 98% of staff has completed physical nutrition training (physicians' competence was not documented). Currently fidelity checks were completed informally and were not documented or reported.
Partial Compliance	SWSH	12.3.09. 91.3% of staff had completed physical nutrition training. Systematic fidelity checks had not been implemented.
Beginning Compliance	WC GRH	10.21.09. Five of 8 staff training files reviewed did not have documentation of training related to the prevention of aspiration & choking. No documentation was evidenced that direct care staff were observed in real-time.

ISSUE SUBSTANTIAL COMPLIANCE: Suicide Risk Assessment and Prevention
2. Treatment Planning, Item 2. o.

o. Develop and implement a policy for suicide risk assessment and management of suicidality

OUTCOME 1: Assessment of risk of suicide is conducted formally and informally.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Partial Compliance	CSH	1.7.10. Suicide assessments were completed formally upon admission, and informally during the patient stay. No fidelity checks are currently in place.
Partial Compliance	EC GRH	12.15.09. Suicide assessments were completed formally upon admission, and informally during the patient stay. No fidelity checks are currently in place.
Partial Compliance	GRH/Atl	11.19.09. Suicide assessments were completed formally upon admission, and informally during the patient stay. No fidelity checks are currently in place.
Partial Compliance	GRH/Sav	10.28.09. Evidence of documented formal and informal screening and assessments was found in patient records. No fidelity checks are currently in place.
Partial Compliance	NW GRH	11.12.09. Suicide assessments were completed formally upon admission, and informally during the patient stay. No fidelity checks are currently in place.
Partial Compliance	SWSH	12.3.09. Suicide assessments were completed formally upon admission, and informally during the patient stay. No fidelity checks are currently in place.
Beginning Compliance	WC GRH	10.21.09. Screening was evidenced by evaluating physicians at admission and screening by other professionals was generally noted. A formal assessment was documented at discharge however, formal risk assessments were not always found when indicated by positive findings or status change.

OUTCOME 2: An individual plan regarding potential for self harm is developed, documented and implemented.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Moderate Compliance 2	CSH	1.7.10. Plans generally address all elements. The Program Review Committee reviews incidents and corrective plans. Processes are in place to begin to address fidelity of clinicians, units and programs.
Partial Compliance	EC GRH	12.15.09. Individual plans were noted and implemented. The plans did not address all elements. No fidelity checks are currently in place.
Beginning Compliance	GRH/Atl	11.19.09. Plans were not consistently seen or implemented when documentation revealed a positive assessment for suicidal ideations and/or increased factors for personal risk. Generally, orders for increased observations were noted, however intervention elements: #1, 3, 4 and 5 of Outcome #2 [noted above] were not consistently found.
Beginning Compliance	GRH/Sav	10.28.09. Plans were not consistently seen or implemented when documentation revealed a positive assessment for suicidal ideations and/or increased factors for personal risk. Generally, orders for increased observations were noted, however intervention elements: #1, 3, 4 and 5 of Outcome #2 [noted above] were not consistently found.
Partial Compliance	NW GRH	11.12.09. Individual plans were noted and implemented. The plans address all elements. No fidelity checks are currently in place.
Beginning Compliance	SWSH	12.3.09. Plans were not consistently seen or implemented when documentation revealed a positive assessment for suicidal ideations and/or increased factors for personal risk. Generally, orders for increased observations were noted, however intervention elements: #1, 3, 4 and 5 of Outcome #2 [noted above] were not consistently found.
Not Compliant	WC GRH	10.21.09. Individual plans were not found in the record when patients reported suicidal ideations. Generally, orders for increased observations were noted, however intervention elements: #1, 3, 4 and 5 of Outcome #2 [noted above] were not found.

OUTCOME 3: Therapeutic programming supports an individual to safely address thoughts and feeling regarding desires for self-harm.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Partial Compliance	CSH	1.7.10. Appropriate groups were recommended, however it was noted that multiple groups were cancelled or the consumer did not attend groups and no documented reevaluation of the patient's service plan in relation to group attendance and participation was noted in the patient records reviewed. The issue of non-compliance with attendance at mental health groups is being globally addressed with a QI project.
Partial Compliance	EC GRH	12.15.09. Programming and documentation of programming address supportive interventions. Treatment mall and on-unit activities were assigned based on treatment plans and the patient's functional level.
Partial Compliance	GRH/Atl	11.19.09. Programming and documentation of programming address supportive interventions. Treatment mall activities were assigned based on treatment plans and the patient's functional level.
Beginning Compliance	GRH/Sav	10.28.09. Programming and documentation of programming was limited. A behavior specialist is working with one unit to improve group quality and documentation. A consultant is training staff on how to conduct groups. Plans were in place for the consultant to teach a treatment planning model that more closely ties treatment groups to patient's individual treatment goals.
Partial Compliance	NW GRH	11.12.09. Programming and documentation of programming address supportive interventions. Treatment mall activities were assigned based on treatment plans and the patient's functional level.
Partial Compliance	SWSH	12.3.09. Programming and documentation of programming address supportive interventions. Treatment mall and on-unit activities were assigned based on treatment plans and the patient's functional level.
Not Compliant	WC GRH	10.21.09. Treatment Mall activities were general and not clearly tied to the patient's treatment plan. Documentation was limited and does not reflect staff supports.

OUTCOME 4: If potential for suicidality persists, clinical consultation is sought.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Moderate Compliance 1	CSH	1.7.10. Events are discussed in morning reports and reviewed by the treatment teams and the Program Review Committee. Findings were sent to the Leadership Committee. Consultations with the clinical directors were evident. Aggregation of data was recently begun in this area.
Partial Compliance	EC GRH	12.15.09. Treatment team reviews after incidents of self-harm were noted. Individual incidents are reported to clinical directors immediately and reviewed by the hospital management each weekday morning.
Partial Compliance	GRH/Atl	11.19.09. Consultation was sought if suicidality persists; plans were reviewed and revised upon consultation. Effectiveness of the plan was inconsistently noted. Clinical and administrative hospital management reviews status of high risk patients daily.
Beginning Compliance	GRH/Sav	10.28.09. Documentation within patient records does not reflect consultation. There is a system in place for the Medical Director to do concurrent reviews when indicated. Plans were not often revised. Status of high risk patients is reported at morning report and to hospital management at the Incident Management meeting once a week.
Partial Compliance	NW GRH	11.12.09. Treatment team reviews after incidents of self-harm were noted. Plans were reviewed after consultation with other professionals. Individual incidents were reviewed by hospital management in the daily morning report.
Beginning Compliance	SWSH	12.3.09. Documentation did not consistently reflect consultation. Status of high-risk patients is reviewed weekly and monthly by clinical and administrative management.
Beginning Compliance	WC GRH	10.21.09. Further consultation was not indicated in the records reviewed however, high risk patients were discussed at the Safety Meetings with hospital management.

OUTCOME 5: Standard operating procedures for risk of suicide are implemented.

1.15.10 STATUS	FACILITY SUMMARY	
Beginning	CSH	1.7.10. In-hospital procedures are in place however they are not consistently followed.

Compliance		
Beginning Compliance	EC GRH	12.15.09. In-hospital procedures are limited and do not cover all areas required.
Partial Compliance	GRH/Atl	11.19.09. In-hospital procedures are in place but there is not consistent evidence of practice
Partial Compliance	GRH/Sav	10.28.09. In-hospital procedures are in place but there is not consistent evidence of practice
Partial Compliance	NW GRH	11.12.09. In-hospital procedures are in place but there is not consistent evidence of practice
Beginning Compliance	SWSH	12.3.09. Procedures were not systematically in place or implemented. Reviews were not always noted when indicated. Team involvement was not consistently noted or documented. Procedures for suicide precautions were not clearly defined.
Partial Compliance	WC GRH	10.21.09. In-hospital procedures are in place.

OUTCOME 6: Effectiveness of interventions with individuals who are at risk of suicide is documented and aggregated

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Moderate Compliance 2	CSH	1.7.10. Key indicators are tracked, trended and aggregated by individual clinician and unit.
Beginning Compliance	EC GRH	12.15.09. Data management aggregates incident reports. Morning reports list special observations in place. Indicators for effectiveness are not tracked, trended or aggregated.
Beginning Compliance	GRH/Atl	11.19.09. The hospital tracks suicidal gestures but not effectiveness of interventions.
Moderate Compliance 2	GRH/Sav	10.28.09. Key indicators for effectiveness of interventions are established and tracked, trended and aggregated beginning September, 2009.
Beginning Compliance	NW GRH	11.12.09. Key indicators for effectiveness of interventions were not established. Hospital staff reviewed records of patients with suicidal gestures made prior to admission. 83% of these records revealed that the care plans addressed suicidality.
Beginning Compliance	SWSH	12.3.09. The hospital tracks suicidal gestures but not effectiveness or implementation of interventions.
Beginning Compliance	WC GRH	10.21.09. Effectiveness of interventions with individuals at risk of suicide was not consistently documented. Key indicators to determine effectiveness of interventions were not found.

OUTCOME 7: Assessment of risk of suicide is benchmarked according to generally accepted professional standards.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
1.2010	All Hospitals	Hospitals were audited against the Policy Directive for Suicide Risk Screening and Assessment of Individuals in State Hospitals and State-Operated Crisis Stabilization Programs., adopted at the Departmental level and implemented at each hospital effective November, 2009

ISSUE SUBSTANTIAL COMPLIANCE: Prevention of Harm to Others (Patient on Patient Assault)
A. Protection From Harm, Item I. c.
V. E. Patient on Patient Assault

c. Create or revise, as appropriate, and implement thresholds for indicators of incidents, including, without limitation, patient injury, patient-on-patient assaults, self-injurious behavior, falls, and suicide attempts, that will initiate review at the unit/treatment team level and review by supervisors consistent with generally accepted professional standards and policy, regulation, and law; whenever such thresholds are reached, the treatment team shall review patient incidents and document in the patient medical record the rationale for changing/not changing the patient's current treatment regimen;

OUTCOME1: Common thresholds for indicators of incidents will be used system wide.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Moderate Compliance 1	CSH	1.7.10. Common thresholds were noted. The hospital is beginning to implement the new Risk Management policy and review process. There is not a current system to conduct fidelity checks of this process. Incidents are reported and reviewed by various committees.
Not Compliant	EC GRH	12.15.09. Common thresholds were not noted. The campuses are beginning to implement the new Risk Management policy and review process.
Partial Compliance	GRH/Atl	11.19.09. Common thresholds have been established and procedures were in place. There is not a current system to conduct fidelity checks of this process.
Moderate Compliance 1	GRH/Sav	10.28.09. Thresholds for incidents have been established and procedures recently put in place. The Psychology Chief is notified and will review any incident of patient on patient assault A Behavior Specialist will review new admissions and involve the Psychology Chief when indicated.
Moderate Compliance 1	NW GRH	11.12.09. Training is completed. Thresholds for incidents have been established and procedures recently put in place for review of patient to patient assaults.
Partial Compliance	SWSH	12.3.09. Common thresholds have been established and procedures were in place. There is not a current system to conduct fidelity checks of this process. Incidents were trended and reviewed by the Risk Management Committee.
Beginning Compliance	WC GRH	10.21.09. Thresholds for indicators of incidents have been set through the Risk Management department of the hospital. Data required to track indicators is incomplete. Fidelity checks in this area were not found.

PART III: ISSUES TO BE IN SUBSTANTIAL COMPLIANCE WITHIN ONE YEAR OF 1.15.09
SYSTEM-WIDE PLAN OF IMPLEMENTATION AND REPORT OF COMPLIANCE filed 9.15.09
ISSUE SUBSTANTIAL COMPLIANCE: Prevention of Harm to Others (Patient on Patient Assault)

OUTCOME 1: Propensity for harm to others is identified formally and informally.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Partial Compliance	CSH	1.7.10. Formal screenings are not consistently seen in all mental health and DD records, primarily patients at CSH for a number of years. Assignment of the level of risk is not consistently seen except in forensics.
Beginning Compliance	EC GRH	12.15.09. Initial screenings and assessments of propensity for patient on patient assault were completed by the physician, but did not include an assignment of the level of risk.
Moderate Compliance	GRH/Atl	11.19.09. GRH/Atl has a nice tracking and trending system for completion of screening and development of treatment and behavior plans. Informal and formal screenings were completed as needed.

2		
Beginning Compliance	GRH/Sav	10.28.09. Formal screenings and assessment of propensity for patient on patient assault was not always apparent when indicated. A process for assessment of these concerns was limited.
Partial Compliance	NW GRH	11.12.09. Initial screenings and assessments of propensity for patient on patient assault were completed by the physician, but did not include an assignment of the level of risk.
Partial Compliance	SWSH	12.3.09. Initial screenings and assessments of propensity for patient on patient assault were completed on admission. There were 17 patient-to-patient assaults reported in September/October 2009, and 38% of these patients' care plans were updated or revised.
Beginning Compliance	WC GRH	10.21.09. Formal screenings and assessment of propensity for patient on patient assault was not consistently seen. Numerous patient to patient assaults have been documented. Staff approaches were generally reactive.

OUTCOME 2: Pursuant to assessment of risk, an individual plan regarding propensity for patient on patient assault is developed, documented and implemented.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Moderate Compliance 2	CSH	1.7.10. When issues were identified these issues were addressed in safety plans and/or treatment plans. Standard Operating Procedures which provide practical guides to address aggression and other challenging behaviors are utilized in forensic services. Patient on Patient assault data is tracked, trended and reported to QI.
Beginning Compliance	EC GRH	12.15.09. A number of incidents were documented. Treatment plans did not consistently address the issue. Behavior Support or Self-Management plans were not seen consistently. Fidelity checks were not done.
Moderate Compliance 2	GRH/Atl	11.19.09. Behavior support plans were detailed and individualized. Plans were noted for a number of patients with a propensity for harm. Plans were reviewed by the treatment teams. Data is aggregated and trended on most but not all of the plans. QI tracks the number of consumers with positive screenings and number of plans submitted.
Beginning Compliance	GRH/Sav	10.28.09. Sixteen patients currently have Behavior Support Plans (BSP's) to address patient on patient concerns. These BSP's were detailed and contain very individualized interventions. Staff has not consistently implemented these plans. Follow-up to identified issues and review of the effectiveness of the plans were not often found in documentation.
Moderate Compliance 2	NW GRH	11.12.09. Self-Management plans were in place, detailed and contain individualized interventions. Behavior data was compiled and forwarded for review and monitoring of effectiveness.
Beginning Compliance	SWSH	12.3.09. A number of incidents were documented. Behavior support plans were not consistently in place after multiple incidents of patient on patient altercations. Tracking and trending of incidents was conducted retrospectively. Fidelity checks were not done.
Not Compliant	WC GRH	10.21.09. Numerous incidents of patient on patient assault were documented. Data and information related to all these incidents was noted however, individual plans that were responsive to situations were not found. Incidents were not tracked, trended, or utilized to develop interventions to address this area. Debriefing of assaults was not found.

OUTCOME 3: Therapeutic programming supports an individual to safely address thoughts and feeling regarding propensity to harm others.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Beginning Compliance	CSH	1.7.10. Documentation in patient records does not consistently show that therapeutic programming supports an individual to work on issues behind propensity to harm others. In forensic services, documentation indicated that multiple groups were cancelled. Patient crowding in small areas and inactivity were noted.
Beginning Compliance	EC GRH	12.15.09. Treatment groups were not consistently conducted due to staff shortages. Poor attendance at programming, consumer crowding in small areas of the forensic areas and inactivity were noted. Documentation in patient records does not show that therapeutic programming supports an individual to work on issues behind propensity to harm others.
Moderate Compliance 2	GRH/Atl	11.19.09. Programming and documentation of programming address supportive interventions. Treatment mall activities were assigned based on treatment plans and the patient's functional level. Treatment plans contain specific groups for specific goals.
Beginning	GRH/Sav	10.28.09. Sixteen individualized BSP's have been developed. Interventions in relation to these BSP's have not consistently been implemented.

Compliance		Documentation in patient records does not show that therapeutic programming supports an individual to work on issues behind propensity to harm others.
Partial Compliance	NW GRH	11.12.09. Treatment groups and activities were assigned according to the treatment plan and functional level. Documentation does not fully reflect all areas of outcomes.
Partial Compliance	SWSH	12.3.09. Programming and documentation of programming address supportive interventions. Treatment mall activities were assigned based on treatment plans and the patient's functional level.
Not Compliant	WC GRH	10.21.09. Patients were expected to attend activities in the Treatment Mall. Activities and groups were not clearly tied to the patient's treatment plan. Documentation was limited and does not reflect therapeutic support of patients. Documentation did indicate that the patients were bored and were not engaged in activities at the time.

OUTCOME 4: If propensity to harm others persists, clinical consultation is sought.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Moderate Compliance 1	CSH	1.7.10. Clinical consultation is noted with appropriate revision of plans when indicated. The Medical Director reviews high risk patients at least weekly and as a part of the Program Review Committee.
Not Compliant	EC GRH	12.15.09. A number of patient on patient assaults were documented and many times the same patients were involved in these assaults/altercations. Neither consultation nor plans were consistently documented. Documentation indicates that staff approach was generally reactive. Review of high risk patients is not documented consistently.
Moderate Compliance 1	GRH/Atl	11.19.09. Hospital standard operating procedures (SOP) list thresholds in relation to what is to occur in the event of multiple episodes of patient on patient assault involving an individual patient. The SOP describes steps for consultation. Documentation does reflect that the SOP has been fully implemented. Status of high risk patients is reported at the morning rounds.
Beginning Compliance	GRH/Sav	10.28.09. Newly implemented hospital standard operating procedures (SOP) list thresholds in relation to what is to occur in the event of multiple episodes of patient on patient assault involving an individual patient. The SOP describes steps for consultation. Documentation did not reflect that the SOP has been fully implemented.
Partial Compliance	NW GRH	11.12.09. Individual plans were in place and implemented which included consultation with the Chief Medical Officer, appropriate professionals and the Regional Hospital Administrator.
Not Compliant	SWSH	12.3.09. A number of patient on patient assaults were documented and many times the same patients were involved in these assaults/altercations. Neither consultation nor plans were consistently documented. Documentation indicates that staff approach was generally reactive.
Not Compliant	WC GRH	10.21.09. Numerous patient on patient assaults were documented and many times the same patients were involved in these assaults. Neither consultation nor plans were consistently documented. Patients were often staffed in the Safety Meeting after an altercation has occurred. Documentation indicates that staff approach was generally reactive.

OUTCOME 5: Standard operating procedures for propensity to harm others are implemented.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
1.2010	All Hospitals	Hospitals were audited against the Policy Directive for Suicide Risk Screening and Assessment of Individuals in State Hospitals and State-Operated Crisis Stabilization Programs., adopted at the Departmental level and implemented at each hospital effective November, 2009

OUTCOME 6: Professional and direct care staff are trained in interventions to address propensity for harm to others

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Moderate Compliance 1	CSH	1.7.10. 100% of staff has Mandt certification. Staff is observed on the units by Mandt instructors to evaluate competency. Actions are evaluated during the Code Yellow review. Ongoing fidelity checks of staff performance needs to be aggregated, tracked and trended.

Partial Compliance	EC GRH	12.15.09. 98% of applicable staff has Mandt certification. There is no evidence of documented ongoing competency checks. There is documentation of observations of staff during care activities.
Beginning Compliance	GRH/Atl	11.19.09. 82% of applicable staff has Mandt certification. There is no evidence of documented ongoing competency checks.
Beginning Compliance	GRH/Sav	10.28.09. 90% of the staff has Mandt certification; however real time observation has not been implemented.
Beginning Compliance	NW GRH	11.12.09. Mandt training is completed, however, documentation of interventions do not consistently reflect competency in this area. There is not documentation of observations of staff during care activities.
Moderate Compliance 1	SWSH	12.3.09. 99% of staff is currently trained in Mandt. Competency checks were done but not aggregated, tracked and trended.
Beginning Compliance	WC GRH	10.21.09. Virtually all staff has current Mandt certification, however, there was no documentation of observations of staff during care activities.

OUTCOME 7: Effectiveness of interventions with individuals who have a propensity for harm to others is documented and aggregated

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Moderate Compliance 2	CSH	1.7.10. Tracking and trending of key indicators is noted. The Program Review Committee reviews all incidents and evaluates effectiveness of interventions.
Beginning Compliance	EC GRH	12.15.09. Tracking and trending of number of assault incidents and restraint/seclusion was noted. Effectiveness of individual interventions and plans is not aggregated and trended. This information is not being utilized to inform care for individuals and units.
Moderate Compliance 1	GRH/Atl	11.19.09. Tracking and trending was noted. Trending reflects that consumer to consumer incidents have gone up on some units in recent months. This information was being utilized to inform care for individual patients or units.
Beginning Compliance	GRH/Sav	10.28.09. Indicators of use of restraint or seclusion and incidents of assaults were trending downward over the past several months however, indicators that relate to the effectiveness or lack of effectiveness have not been assessed.
Beginning Compliance	NW GRH	11.12.09. Quality indicators that reflect the use of restrictive interventions was trending downward over the past several months however, effectiveness of the plans was not tracked.
Beginning Compliance	SWSH	12.3.09. Interventions were consistently documented, however assessment of effectiveness of interventions was not apparent. Indicators that reflect effectiveness of interventions had not been assessed.
Beginning Compliance	WC GRH	10.21.09. Interventions were consistently documented, however assessment of effectiveness of interventions was not apparent.

OUTCOME 8: Assessment of propensity for patient on patient assault is benchmarked according to generally accepted professional standards.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
1.2010	All Hospitals	Hospitals were audited against the Policy Directive for Suicide Risk Screening and Assessment of Individuals in State Hospitals and State-Operated Crisis Stabilization Programs., adopted at the Departmental level and implemented at each hospital effective November, 2009

OUTCOME 9: Propensity for patient on patient assault is re-assessed.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
1.2010	All Hospitals	Hospitals were audited against the Policy Directive for Suicide Risk Screening and Assessment of Individuals in State Hospitals and State-Operated Crisis Stabilization Programs., adopted at the Departmental level and implemented at each hospital effective November, 2009; Policy Directive processes will

		further determine specific assessments and intervals for use. Procedures are currently in flux.

OUTCOME 10: Propensity for sexual violence is assessed based on direct or collateral history.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Partial Compliance	CSH	1.7.10. Assessment of propensity for sexual violence was generally noted and goals were found for same. Standard Operating Procedures were noted. Follow-up and fidelity checks were not noted.
Beginning Compliance	EC GRH	12.15.09. Assessment of propensity for sexual violence was limited or inconsistently found. Goals related to same were not evidenced in documentation at the Augusta campus. Follow-up and fidelity checks were not noted. Some behavior support plans were found for specific patients at the Gracewood campus.
Beginning Compliance	GRH/Atl	11.19.09. Assessment of propensity for sexual violence was limited or inconsistently found. Goals related to same were not evidenced in documentation. Follow-up and fidelity checks were not noted. Some behavior support plans were found for specific patients, but not consistently when indicated.
Not Compliant	GRH/Sav	10.28.09. Assessment of propensity for sexual violence was limited or inconsistently found. Goals related to same were not evidenced in documentation. Follow-up and fidelity checks were not noted.
Beginning Compliance	NW GRH	11.12.09. Screenings were documented in a narrative, so it was difficult to determine if all patients were screened upon admission. Individual incidents were reported on internal incident reports.
Beginning Compliance	SWSH	12.3.09. Assessment of propensity for sexual violence was limited or inconsistently found. Goals related to same were not evidenced in documentation. Follow-up and fidelity checks were not noted. A behavior support plan was found for a specific patient, but plans were not found consistently when patients had incidents of a sexual nature.
Not Compliance	WC GRH	10.21.09. Assessment of propensity for sexual violence was inconsistently found. Plans were not in place when indicated. Follow-up was not evidenced and fidelity checks were not found.

OUTCOME 11: Propensity to be harmed by others [propensity for victimization] is identified formally and informally.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Partial Compliance	CSH	1.7.10. Formal and informal screenings were generally found.
Not Compliant	EC GRH	12.15.09. Neither formal or informal screening nor assessment of propensity for harm by others was noted in the patient records reviewed.
Not Compliant	GRH/Atl	11.19.09. Neither formal or informal screening nor assessment of propensity for harm by others was noted in the patient records reviewed.
Not Compliant	GRH/Sav	10.28.09. Neither formal or informal screening nor assessment of propensity for harm by others was noted in the patient records reviewed.
Not Compliant	NW GRH	11.12.09. Neither formal or informal screening nor assessment of propensity for harm by others was noted in the patient records reviewed.
Not Compliant	SWSH	12.3.09. Neither formal or informal screening nor assessment of propensity for harm by others was noted in the patient records reviewed.
Not Compliant	WC GRH	10.21.09. Neither formal or informal screening nor assessment of propensity for harm by others was noted in the patient records reviewed.

OUTCOME 12: An individual plan regarding propensity to be harmed by others [propensity for victimization] is developed, documented and implemented.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Partial Compliance	CSH	1.7.10. Interventions were generally noted to address propensity to be harmed by others. Levels of observation were increased; however formal plans were not always noted. Fidelity checks were not documented. CSH staff was aware of patient observation levels and physician orders for observations

		were clear.
Not Compliant	EC GRH	12.15.09. This area was not identified clearly in the assessment process; therefore plans were not evidenced in the records reviewed.
Not Compliant	GRH/Atl	11.19.09. This area was not identified clearly in the assessment process; therefore plans were not evidenced in the records reviewed.
Not Compliant	GRH/Sav	10.28.09. This area was not identified clearly in the assessment process; therefore plans were not evidenced in the records reviewed.
Not Compliant	NW GRH	11.12.09. This area was not identified clearly in the assessment process; therefore plans were not evidenced in the records reviewed.
Not Compliant	SWSH	12.3.09. This area was not identified clearly in the assessment process; therefore plans were not evidenced in the records reviewed.
Not Compliant	WC GRH	10.21.09. This area was not identified clearly in the assessment process; therefore plans were not evidenced in the records reviewed.

OUTCOME 13: Therapeutic programming supports individuals in need of protection from harm.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Partial Compliance	CSH	1.7.10. Individual and group programming did not consistently support individuals who are vulnerable to harm. Consumers are grouped according to functional levels generally.
Not Compliant	EC GRH	12.15.09. Individual and group programming did not fully support individuals who are vulnerable to harm.
Beginning Compliance	GRH/Atl	11.19.09. Individual and group programming did not fully support individuals who are vulnerable to harm. A new unit has been opened to remove aggressors from the patient population.
Not Compliant	GRH/Sav	10.28.09. Individual and group programming did not fully support individuals who are vulnerable to harm.
Not Compliant	NW GRH	11.12.09. Individual and group programming did not fully support individuals who are vulnerable to harm.
Not Compliant	SWSH	12.3.09. Individual and group programming did not fully support individuals who are vulnerable to harm.
Not Compliant	WC GRH	10.21.09. Individual and group programming did not fully support individuals who are vulnerable to harm.

ISSUE SUBSTANTIAL COMPLIANCE: Implementation of Emergency Medical Codes Consistent with Generally Accepted Professional Standards (GAPS)
D. Medical and Nursing Care, Item 14

14. Establish an effective medical emergency preparedness program, including competency-based staff training; require staff familiarity with emergency supplies, their operation, maintenance and location; and conduct sufficient practice drills to attain adequate performance when confronted with an actual emergency.

OUTCOME 1: Emergency medical codes are conducted correctly and efficiently.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Partial Compliance	CSH	1.7.10. An emergency preparedness program has been established. Drills were conducted as required. Follow-up of issues identified is documented. Drill performance data is not aggregated and reported to QI.
Partial Compliance	EC GRH	12.15.09. An emergency preparedness program has been established. Drills were conducted as required. Follow-up of issues identified was inconsistently aggregated and reported to QI.
Moderate Compliance 2	GRH/Atl	11.19.09. An emergency preparedness program has been established to include competency based staff training. Drills were conducted as required. Follow-up to issues identified was documented. Drill performance data was aggregated and reported to QI.
Substantial Compliance	GRH/Sav	10.28.09. An emergency preparedness program has been established to include competency–based staff training. Staff was familiar with equipment and drills were conducted as required. Drill performance data was aggregated, tracked and trended.
Moderate Compliance 2	NW GRH	11.12.09. Trainings were completed and emergency drills were conducted. Drill performance data was aggregated and reported to QI.
Partial Compliance	SWSH	12.3.09. An emergency preparedness program has been established. Drills were conducted as required. Follow-up of issues identified were not consistently documented and reported to QI. SWSH has very recently hired a QI director.
Beginning Compliance	WC GRH	10.21.09. Assessment of drills related to accuracy and efficiency has produced performance related issues of concern. Follow-up to these issues was not always documented.

OUTCOME 2: All full time and hourly professional medical and direct patient care staff is fully trained.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Partial Compliance	CSH	1.7.10. 94% of staff has completed CPR trainings. 94% of staff had completed first aid training. Emergency drills were conducted, but there is not a mechanism in place to assure that all staff has participated in a drill as required.
Partial Compliance	EC GRH	12.15.09. 99.2% of staff has completed CPR trainings. 99.4% of staff had completed first aid training. Emergency drills were conducted, but there is not a mechanism in place to assure that all staff has participated in a drill as required.
Moderate Compliance 1	GRH/Atl	11.19.09 93% of staff have completed CPR training, 99% of staff have completed First Aid training. The agency has begun to collect data on individual staff participation in an emergency drill, but the data is currently incomplete.
Moderate Compliance 2	GRH/Sav	10.28.09. At least 90% of staff was trained in CPR. Drills were conducted as required. Documentation was maintained.
Partial Compliance	NW GRH	11.12.09. At least 95% of staff has completed CPR and First Aid training. Emergency drills were completed, but there was not a mechanism in place to assure that all staff has participated in a drill as required.
Partial Compliance	SWSH	12.3.09. At least 99% of staff has completed CPR and First Aid training. Emergency drills were conducted, but there was not a mechanism in place to assure that all staff has participated in a drill as required.
Partial	WC GRH	10.21.09. While most staff has CPR and First Aid certification, a record of specific staff participants in mock codes has not been kept and not all staff

Compliance		has participated in mock drills.

OUTCOME 3: Notification mechanisms ensure timely response to emergencies.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Substantial Compliance	CSH	1.7.10. Notification mechanisms are in place.
Substantial Compliance	EC GRH	12.15.09. Notification mechanisms are in place.
Substantial Compliance	GRH/Atl	11.19.09. Notification mechanisms are in place.
Substantial Compliance	GRH/Sav	10.28.09. Notification mechanisms are in place.
Substantial Compliance	NW GRH	11.12.09. Drill evaluations were completed and remedial actions were taken as needed if timeliness of response was an issue.
Substantial Compliance	SWSH	12.3.09. Notification mechanisms are in place.
Beginning Compliance	WC GRH	10.21.09. Documentation of drills indicates issues related to the timeliness of response.

OUTCOME 4: Supplies and equipment are available and in working order.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Substantial Compliance	CSH	1.7.10. Emergency equipment was available and in working order.
Substantial Compliance	EC GRH	12.15.09. Emergency equipment was available and in working order.
Substantial Compliance	GRH/Atl	11.19.09. Emergency equipment was available and in working order.
Substantial Compliance	GRH/Sav	10.28.09. Emergency equipment was available and in working order.
Substantial Compliance	NW GRH	11.12.09. Emergency equipment was available and in working order.
Substantial Compliance	SWSH	12.3.09. Emergency equipment was available and in working order.
Substantial Compliance	WC GRH	10.21.09 Emergency equipment was available and in working order.

OUTCOME 5: Emergency codes are evaluated.

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Partial Compliance	CSH	1.7.10. Emergency code drills were evaluated. Data regarding follow-up of individual issues is documented, but not aggregated, trended or reported to QI.
Beginning Compliance	EC GRH	12.15.09. Emergency code drills were evaluated and data was trended by numbers, but not by type of deficiency. Fidelity checks were not noted.

Moderate Compliance 2	GRH/Atl	11.19.09. Emergency code drills were evaluated and data was trended. Findings were reviewed and remedial actions were taken as needed.
Moderate Compliance 1	GRH/Sav	10.28.09. Codes were documented and aggregated according to the required elements. Fidelity checks were conducted. Findings were reviewed but not trended or tracked.
Moderate Compliance 2	NW GRH	11.12.09. Emergency code drills were evaluated and data was trended. Findings were reviewed and remedial actions were taken as needed.
Beginning Compliance	SWSH	12.3.09. Emergency codes were documented and issues were listed however, follow-up to identified issues was not documented or reflected in the hospital's quality improvement processes. Fidelity checks were not noted.
Beginning Compliance	WC GRH	10.21.09. Emergency codes were documented and issues were listed however, follow-up to identified issues was not documented or reflected in the hospital's quality improvement processes. Fidelity checks were not noted.

OUTCOME 6: Supplies and equipment are standardized throughout all hospitals

1.15.10 STATUS	FACILITY SUMMARY	AUDIT END DATE FINDINGS
Substantial Compliance	CSH	1.7.10. Supplies and equipment are standardized.
Substantial Compliance	EC GRH	12.15.09. Supplies and equipment are standardized.
Substantial Compliance	GRH/Atl	11.19.09. Supplies and equipment are standardized.
Substantial Compliance	GRH/Sav	10.28.09. Supplies and equipment are standardized.
Substantial Compliance	NW GRH	11.12.09. Supplies and equipment are standardized.
Substantial Compliance	SWSH	12.03.09. Supplies and equipment are standardized.
Substantial Compliance	WC GRH	10.21.09. Supplies and equipment are standardized.