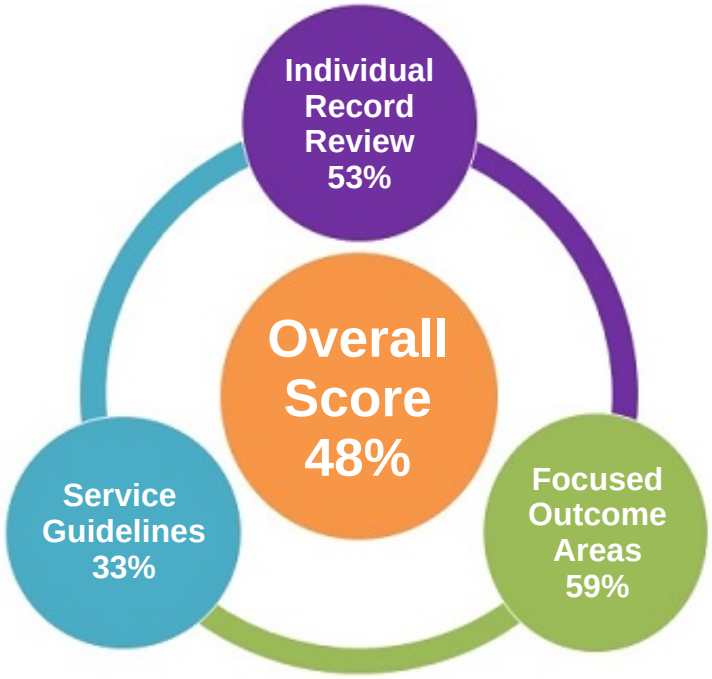
The Georgia Collaborative ASO

Middle Flint Behavioral Health

Crisis Stabilization Unit Quality Review Final Assessment		
Address: Remote Quality Review-940 GA Hwy 96, Warner Robins, GA 31088		
Assessors: Natalee Fritsch, LPC; Jennifer Byrd, LPC, CPCS; Mary Malaguti, RN		
Review Date Range: 7/11/2022 - 7/13/2022	**CSU Type:** Adult (non-BHCC)	**CSU Beds:** 14
Records Reviewed: 15	**Temp Obs Beds:** 0	**Transitional Beds:** 1

The Georgia Collaborative ASO, in partnership with the Department of Behavioral Health and Developmental Disabilities (DBHDD), believes in accessible, high-quality care that leads to a life of recovery and independence. The provider should note any recommendations as an opportunity for quality improvement activities. The review is intended to measure the quality of your organization's systems and practices in adherence to DBHDD policies and standards. The Overall Score is calculated by averaging the categories below.



	Overall Score	IRR	Service Guidelines	FOA
Review Date: 01/31/2022	76%	76%	73%	79%
Review Date: 07/15/2021	89%	87%	89%	91%
FY22 Statewide Average	84%	80%	79%	92%

Note: The FY22 Statewide Averages represent the mean of scores for all reviewed providers.

Summary of Significant Review Findings

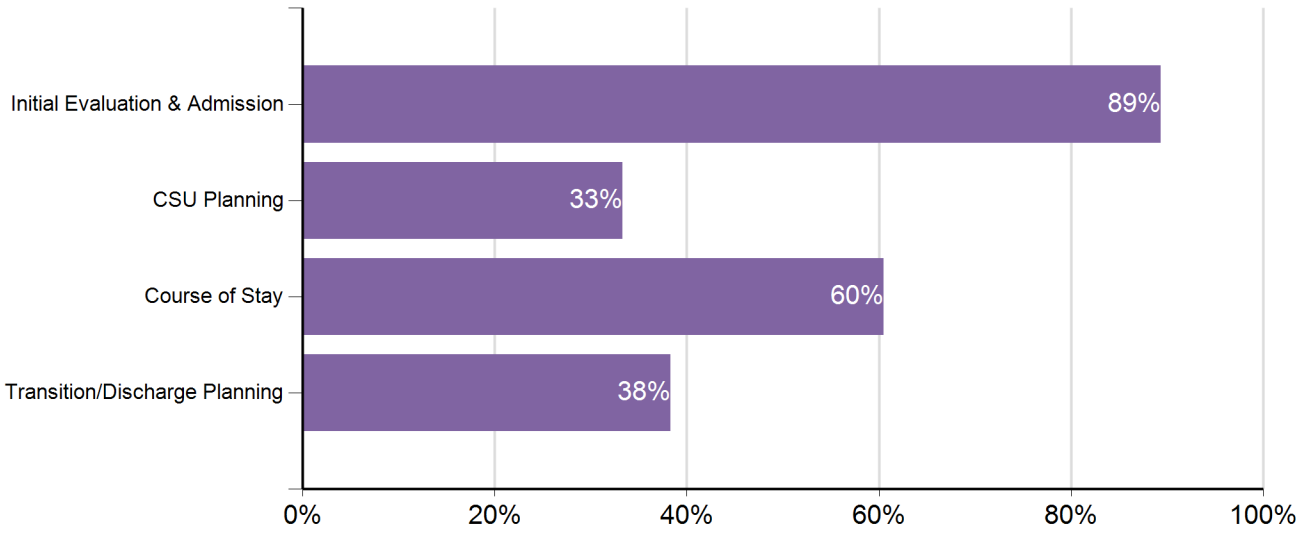
Strengths and Improvements:

- A Remote Quality Review was conducted in response to the COVID-19 pandemic. This is the provider's third Remote Quality review during the COVID-19 pandemic.
- Currently, the Crisis Stabilization Unit (CSU) has resumed their 14 bed capacity rate. During the previous Crisis Stabilization Unit Quality Review (CSUQR), the maximum bed capacity was eight. As of one week prior to the this CSUQR, the bed capacity remained at eight.

Opportunities for Improvement:

- Committee meetings were not being held regularly and meeting minutes were not documented to include the tracking and trending of medication errors, licit and illicit drugs, infection control, and seclusion and restraint episodes. See Service Guidelines for further details.
- Medication errors for missed doses of medications were not documented and reported per the medication notification policy. See Service Guidelines for further details.
- The Columbia-Suicide Severity Rating Scale (C-SSRS) Lifetime/Recent assessment was missing in some records reviewed.
- In all records reviewed, there were no behavioral health assessment of needs, individualized resiliency plans (IRPs), and transition discharge plans.
- Discharge summaries were not entered into the ASO ProviderConnect/batch system.
- Also, in all records reviewed there was no evidence that group skills or group therapy was being offered to the individuals throughout their course of stay.

Individual Record Review



The individual category scores are an average of questions within the category and are for the agency's reference only.

Individual Record Review: 53%

Strengths and Improvements

- The electronic medical record (EMR) alert system was utilized for flagging high risk of suicide individuals, requests for updated documentation, homicidal ideations, etc.
- The date of transfer to a transitional bed was documented by a physician or physician extender in all three applicable records reviewed.
- The following are improvements since the last CSUQR in 01/2022:
  - Discharge summaries documented all the required criteria in majority (14 of 15) of the records reviewed.
  - Majority of applicable charts (four of five) were flagged for high suicide risk.

Opportunities for Growth

Initial Evaluation & Admission:

- The C-SSRS Lifetime/Recent assessment was missing or the ratings did not align with the individuals' histories and presentation, and no explanations for the "yes" responses were documented within six of 15 records reviewed. This is a continued opportunity for improvement noted in the previous CSUQRs in 09/2020, 07/2021 and 01/2022.
    - Three records lacked the crisis intervention assessment where the C-SSRS Lifetime/Recent assessment was located. A stand alone C-SSRS assessment was available within the EMR; however, it was not utilized by staff or completed by staff.
    - One individual's C-SSRS Lifetime/Recent assessment endorsed "no" for self-injurious behaviors; however, the individual self-reported engaging in "cutting."
    - Another individual called the CSU directly in a crisis self-reporting suicidal ideations but upon admission he denied suicidal ideations. The C-SSRS Lifetime/Recent assessment ratings did not align.
    - One individual's C-SSRS Lifetime/Recent assessment indicated a "yes" for the lifetime wish to be dead question; however, no further explanation on the individual's history was provided.

CSU Planning

- Presently, the therapist position is vacant on the CSU. As a result, several clinical services were not being provided and clinical documentation was also not completed. IRPs were missing within all 15 records reviewed. As a direct result, the following was negatively scored:
    - IRPs were not individualized in personalized language;
    - Suicidality was not addressed on the IRP, as applicable (all nine applicable records);
    - Safety issues (i.e., seizure precautions, homicidal ideations) were not addressed on the IRP, as applicable (nine records).
- Treatment team meetings were not documented every 72 hours within four of the 15 records reviewed. For example,
    - One individual's initial treatment team occurred on 04/14/2022 and the following treatment team was not held until 04/18/2022 (4 days later).
    - Another individual's course of stay was from 04/12/2022 - 04/18/2022 with treatment team documentation on 04/13/2022 and 04/14/2022. The next treatment team documentation was for 04/18/2022 (4 days later).
    - One individual's course of stay was from 05/06/2022 - 05/16/2022 with treatment team for 05/09/2022 and 05/10/2022 only. No further treatment team documentation.

Course of Stay

- Verbal orders were not signed within 24 hours in four of six applicable records reviewed. This is an ongoing growth opportunity noted in the previous CSUQRs in 11/2019, 07/2021 and 01/2022.
    - One individual's verbal admit orders on 04/05/2022 had the physician or physician extender's signature; however, the signature lacked a date and time.
    - One nurse practitioner (NP) lacked credentials within the written signature.
    - On 04/24/2022 a verbal order for Ativan 1 mg po x1 time dose was not signed by the prescribing practitioner.
    - Another individual had several verbal medication orders not signed by the prescribing practitioner. For example, on 04/03/2022, Risperdal 0.5 mg po x1 dose, Ativan 0.5 mg po, and admission orders were not signed by the prescriber.
- The Medication Administration Records (MAR) lacked all required criteria in nine of 15 records reviewed. This is an continued area for improvement noted in the previous CSUQRs in 11/2019, 09/2020, 07/2021, and 01/2022.
    - Three MARs for regularly scheduled prescribed medications were missing from the record. MARs for PRN ('pro re nated' as necessary) medications only were present for these three MARS. In addition, several MARs contained illegible staff signatures, credentials and initials.
    - Two records contained medication errors. See Service Guidelines for further details.
- Documentation by the physician or physician extender on the status of the individual daily was missing within three of the 15 records reviewed. Examples included,
    - One individual's course of stay was from 04/19/2022 - 04/22/2022 lacked physician or physician extender documentation on 04/20/2022.
    - Another individual was admitted on 04/12/2022 and documentation by the physician or physician extender was missing on 04/17/2022, the day prior to discharge (04/18/2022).
- Staff interventions in progress notes were not related to interventions on the IRPs due to all 15 records missing an

IRP. In addition, physician and nursing progress notes had goals, interventions and objectives from the individual's outpatient IRPs.

Transition/Discharge Planning

- All records lacked a discharge plan with required criteria (i.e., specific step-down service, clinical benchmarks) due to missing IRPs.
- In five of 15 records reviewed, evidence of discharge planning at the beginning of admission to include identification of the individual's desired outcome and needs, identification of natural supports, risk assessment and safety planning was missing. In all five instances, a behavioral health assessment of needs and a safety/crisis plan was missing within the records. Of note, none of the 15 records reviewed contained a behavioral health assessment of needs. Assessors were able to utilize other assessment tools or treatment team meeting minutes to gather an individual's needs and supports.
- None of the 15 records reviewed contained documentation of consideration of psychiatric medications, the individual's ability to access and afford medication post-discharge, how the medication will be obtained after the five-day supply was exhausted, and how any associated lab work will be accessed and funded. This is an ongoing opportunity for improvement that was noted in the last CSUQR in 01/2022.
    - In all examples, documentation did not demonstrate that a discussion of medication availability, barriers, funding, etc. was had with individuals prior to discharge. All discharge summaries indicated the following blanketed statement: "If [Individual's name] couldn't afford his medications, he can potentially obtain assistance from the following: Medication Assistance Program: AmeriCares (AOP & COP), insurance/ Medicaid/Medicare) (Genoa Pharmacy in WROP 940A GA Hwy 96 WR - 478-352-0916)."
- A discharge summary was not entered into the ASO's ProviderConnect/batch system within the required time following the individual's discharge in all 15 records reviewed. No discharges were on file for this review period. Additionally, majority of initial authorizations were requested during the middle of the individuals stay on the CSU. This is a continued growth opportunity noted in the previous CSUQRs in 11/2019, 09/2020, 07/2021, and 01/2022.
- In all four applicable records reviewed where an individual was identified as homeless, a Need of Supportive Housing (NSH) survey was not completed nor was a referral for necessary residential supports. In 01/2022 this was a noted area for growth.
- Evidence of follow-up and connection to continuing care with the individual post-discharge was lacking in all 10 applicable records reviewed. No documented efforts. This is a continued growth opportunity that was noted in the previous CSUQRs in 11/2019, 09/2020 and 01/2022.
- In the three applicable records reviewed where individuals were in a transitional bed, the individual did not receive daily services from outside of the CSU.
- Documentation lacked collaboration between the provider and the aftercare provider to include: individual's safety plan, who will follow-up with individual and when it will occur, and that the individual's chart was flagged for high suicide risk upon discharge in all five applicable records reviewed. In the previous CSUQRs dated for 09/2020, 07/2021 and 01/2022 this area was noted as an opportunity for improvement.

Focused Outcome Areas

Focused Outcome Areas: 59%

Strengths and Improvements

- Documentation supported individuals were referred to Case Management and other health services (i.e., long-term residential treatment) in all four applicable records reviewed.
- Abnormal Involuntary Movement Scale (AIMS) were completed upon admission. This is a continued strength for the provider.
- Lab work was signed and dated by the physician or physician extender upon review.

Opportunities for Growth

Safety

- Safety/crisis plans were missing or not signed within eight of the 15 records reviewed.
  - Seven safety/crisis plans were missing from records.
  - One individual did not sign the safety/crisis plan.
- Documentation did not support that clinically-appropriate actions or steps were taken and linkages or referrals were made based upon the findings/outcome of the C-SSRS in four of the seven applicable records reviewed. This is a continued growth opportunity that was noted in the previous CSUQRs in 09/2020, 07/2021 and 01/2022.
  - Three records lacked a C-SSRS Lifetime/Recent assessment; therefore, it is unknown if the individuals were in need of linkages or referrals.
  - One individual was assessed as high suicide risk and discharged from the CSU without an aftercare appointment.

Rights

The following were recurring issues noted in the previous CSUQRs in 11/2019, 07/2021 and 01/2022.

- Documentation of rights and responsibilities at the onset of services was not present within five of the 15 records reviewed.
- Documentation of Health Insurance Portability Accountability Act (HIPAA) Privacy and Security Rules were not reviewed with the individual in four of the 15 records reviewed.

Choice

- Documentation lacked identification of individual's known preferences and differences in seven of 15 records reviewed due to a lack of behavioral health assessments, safety/crisis plans, treatment team meetings, and IRPs.

Person-Centered

- Documentation lacked the individual was an active participant in the planning and receiving of services in all 15 records reviewed due to a lack of IRPs.

Community Life

- IRPs were not present in all 15 records reviewed; therefore, it negatively impacted the following areas:
  - Documentation of transition planning throughout service delivery to include specific objectives to be met prior to discharge;
  - Documentation supporting the individual was assisted with setting goals for specific environments where they wish to live, learn, work, and socialize.

Service Guidelines

1	Adult CSU Staffing Requirements Met	No
2	The Crisis Service Center staffing requirements met.	N/A
3	C&A staff requirements met.	N/A
4	The CSU has policies and procedures for identifying and managing individuals at high risk of suicide or intentional self-harm.	Yes
5	Program offerings for the CSU is designed to meet the biopsychosocial stabilization needs of each individual, and a medical and clinical leadership team annually approves the therapeutic content of the program (group therapy/training, individual therapy/training, education support, etc.) This annual review is documented by signature and date of review and by participating leadership.	No
6	Adherence to Medication Notification Policy	No
7	Protocols for Handling Licit and Illicit Drugs present	No

8	Adherence to Safe Storage of Medication Policy			No
9	Infection Control Plan Adherence			No
10	Seclusion & Restraint Policy Adherence			No
11	Therapeutic Blood Level Monitoring			Yes
12	Physician Availability for 3.7-WM			Yes
13	All staff credentialing criteria are met.			No
14	Psychiatrist Available for Consultation			Yes
	# Yes	**# No**	**# NA**	**SCORE**
	4	**8**	**2**	**33%**

Service Guidelines: 33%

Opportunities for Growth

Adult CSU Staffing Requirements

- The Nurse Manager position was vacant throughout this review period. As of 04/27/2022 the Nurse Manager position was open. The Licensed Practical Nurse (LPN) was the identified Nurse Manager in the interim from 05/05/2022 - 06/06/2022. The provider's Chief Nursing Officer (CNO) was the interim Nurse Manager from 06/06/2022 - 07/06/2022. A Nurse Manager was hired as of 07/06/2022. The Nurse Manager was in new hire training the week of 07/04/2022 - 07/08/2022. Day two of the CSUQR was the Nurse Manager's first day on the CSU.
    - Per DBHDD Provider Manual, July 1, 2022, page 206, Staffing Requirements, 2. A CSU must employ a fulltime Nursing Administrator who is a Registered Nurse (RN).
    - Per PolicyStat 01-325, Behavioral Health Provider Certification and Operational Requirements for Certified Crisis Stabilization Units, 1. "Nursing Administrator means a full time employee of the CSU who: a. Is a registered professional nurse; and b. Is responsible for: The management of the nursing staff in the CSU; Effective nursing care systems; and iii. Ensuring continuous quality improvement in care."

Therapeutic Content

- Currently, the medical and clinical leadership team were not approving the therapeutic content of the CSU on an annual basis. Per DBHDD Policy Stat CSU: Program Description, 01-329, 17: "The medical and clinical leadership team annually approves the therapeutic content of program offerings such as (group therapy/training, individual therapy/training, education support, etc.) on the CSU and is documented by signature and date of review and by participating leadership." This is an ongoing opportunity for improvement that was noted in the previous CSUQR in 01/2022.

Presently, the provider does not have documented meeting minutes for any quality improvement, risk management or Medication Oversight Committee meetings since 01/2022. As a direct result, medication errors, handling licit and illicit drugs, safe storage of medications, infection control, and seclusion and restraints have not been tracked and trended for at least six months consecutively.

- During this CSUQR, meeting minutes from the Performance Improvement Meeting were submitted from 03/10/2022; however, the meeting discussed results from a recent survey held in 08/2021. The next meeting was scheduled to be held on 04/26/2022; however, no further meeting minutes were submitted.
- The most recent Medication Oversight Committee meeting minutes submitted were from 05/13/2021.
- As a result of the tracking and trending practices missing, the following policies and procedures in Service Guidelines were negatively scored:
    - Adherence to Medication Notification Policy
    - Protocols for Handling Licit and Illicit Drugs
    - Adherence to Safe Storage of Medications
    - Infection Control Plan Adherence
    - Seclusion and Restraint Adherence
- Assessors recommended the provider update the policies and procedures to specifically state the frequency and

expectations for when all meetings are to be held (i.e., monthly, quarterly, annually).

Adherence to Medication Notification Policy

- During this CSUQR, two records reviewed included six identified medication errors in which the staff initials were missing from the scheduled medications to be administered. These were not identified as medication errors. The policy and procedures for tracking and trending medication errors was not being followed. This is a recurring issue noted in the previous CSUQRs in 11/2019, 09/2020, 07/2021, and 01/2022.
    - Per Policy #:500.60 Reporting of Accidents and Incidents with Follow-up Procedures 5. Monitoring and Reporting of Medication Errors and/or Adverse Medication Reactions: "In addition to the Internal Incident and Accident Report Form, the Medication Error/Adverse Reaction Report must be completed and sent to the Compliance Officer and the Medical Oversight Committee Chairperson for the following Levels O - III."
        - Risperdal 2 mg po qhs x7 days was ordered; however, staff's initials were missing for this scheduled administration of medication on 04/11/2022 and 04/12/2022.
        - On 04/19/2022, Clonidine was administered for high blood pressure and an order to check the individual's blood pressure in 30 minutes. The individual's blood pressure was not documented. In addition, Zyprexa 10 mg, Ativan 2 mg, and Benadryl 50 mg was ordered to be administered either IM/PO on 04/20/2022. The MAR lacked which route these medications were administered. Additionally, there was no documentation of how the medication was administered in a nursing progress note.
            - The abovementioned medication errors were not identified; therefore, Internal Incident Reports and Accident Report Forms were not completed. In addition, the Corporate Compliance Officer was also unable to follow-up on all Critical and Corporate Compliance Investigation Reports within 60 days because these reports were not completed.

Staff Credentialing

- During this CSUQR, six staff credentials were reviewed in which one of the personnel records was not in compliance. The personnel record lacked the Certified Alcohol and Drug Counselor (CADC) certification.
- Assessors also recommended to the provider that once a staff member no longer is employed by a staffing agency and becomes a full time employee another criminal records check is recommended to be completed under the provider.

Crisis Stabilization Unit Site Visit Observations

During the tour of the CSU, the following was noted:

- An external camera and doorbell at the entryway was visible to the nurses station. Permission to enter was granted by a staff from the nurses station.
- The current census was nine with a 14 bed maximum capacity. All bedrooms were single rooms.
- The CSU had 20 security cameras throughout the unit in addition to convex mirrors in the hallways. The nurses station had two monitors for viewing and the CEO had access to the security cameras as well. No security guards were present on the unit.
- Electrical outlets were locked and covered.
- Masks were required by all staff. Masks were optional for the individuals. The CSU provided masks, if requested by the individual.
- The overflow room had a mattress on the floor.
- The dayroom was large and spacious. The television projector was displayed on the entire wall for the individuals to view.
- The restraint room was locked. Restraints were locked in the nurses station. A window was also available for viewing. This room was also located directly across from the nurses station.
- Seclusion room was empty with a security camera and window for viewing. This room was also located directly across from the nurses station.
- The restroom for seclusion and restraint was clean, well lit and had a break-away shower curtain.
- A single bedroom was available for self segregation when an individual feels overwhelmed or overstimulated.
- A wheelchair was available for individuals as needed.
- A pharmacist was onsite daily.
- Medication room was locked. Narcotics were double locked.
- The previous laundering area was converted into a storage area for dirty linens.
- Housekeeping was on the unit daily. The CSU was clean.
- Emergency water and food supply was well stocked and organized.
- The most recent health food score as of 07/07/2022 was 100%.

Opportunities for improvement:

- The floor in the "phone time" room was in need of repair. The chair was in need of repair as well. The phone was not wireless and had a cord attached.
- Staff had difficulty unlocking and opening the restraint room.
- A lightbulb was in need of replacement in the women's shower and in the men's.
- Three restroom stalls were open with no doors or privacy in each of the women's and men's restrooms. Toilet paper was not available in all three stalls. One of the stall's within the women's restroom had toilet paper sitting on the lid of the toilet.
- Ceiling tiles were in need of replacement due to a leak in the roof.
- The thermostat cover was missing in the cafeteria room.

Additional Comments on Practices

Additional strengths and concerns beyond the general scope of the review were discovered by reviewers. Additional issues/practice concerns may have the potential to impact service delivery, quality of care, or may represent a risk to the provider.

- In all records reviewed, there was no evidence that group skills or group therapy was being offered to the individuals throughout their course of stay. Per the weekly group schedule, groups occur daily, Monday through Friday from 3:30 pm - 5:00 pm. Currently, the therapist position is vacant on the CSU. Per staff, clinicians from outpatient services provide clinical services to the individuals on the CSU in the interim (i.e., behavioral health assessments, IRPs, groups, etc.). However, assessors were unable to locate any of the aforementioned clinical documentation during individuals course of stay.
- Nursing and physician assessments lacked the time in and time out within the documentation.
- IRPs were developed by outpatient services while the individual was admitted to the CSU. In addition, physician and nursing progress notes had goals, interventions and objectives identified from the outpatient IRP.
- One individual was receiving multiple services while admitted to the CSU.
- Protected health information (PHI) of another individual was scanned into the EMR of another individual within the sample.
- "No Primary Credential" was listed for two staff members electronic signatures.

Individual Interviews

Individual Interviews Conducted: 0

Due to the COVID-19 pandemic, individual interviews were not conducted.

Quality Improvement Recommendations

Providers are reminded of the responsibility to maintain internal processes which ensure immediate and permanent corrective actions on issues identified during the quality review process. DBHDD may request corrective action plans (CAPs) as quality review findings warrant. Please refer to the comments documentated in each section above for specific information pertaining to the recommendations below.

Recommendations: Current and Prior Review

Individual Record Review - Initial Evaluation & Admission

- Ensure all individuals are assessed for suicide risk at intake (and as needed thereafter) using age-sensitive C-SSRS tools.

Individual Record Review - Course of Stay

- Ensure all verbal orders received by the nurse are signed by the physician or physician extender within 24 hours.
- Ensure each Individual's MAR has a legend that clarifies: Identity of authorized staff initials using full signature and title and reasons that a medication may be not given, is held, or otherwise not received by the Individual.

Individual Record Review - Transition/Discharge Planning

- Ensure there is documentation of consideration of psychiatric medications, the individual's ability to access and afford medication post-discharge, how the medication will be obtained after five-day supply is exhausted, and how any associated lab work will be accessed and funded.
- Ensure discharge summaries are entered into the ASO's ProviderConnect/batch system within 72 hours of discharge.
- Ensure individuals who are identified as homeless, a Need of Supportive Housing (NSH) survey is completed and referral for necessary residential supports.
- Ensure there is evidence in the medical record of follow-up and connection to continuing care.

- Ensure documentation supports that CSU staff have documented collaboration with the aftercare provider.

Focused Outcome Areas - Safety

- Ensure documentation supports that clinically-appropriate actions or steps were taken and linkages or referrals were made based upon the findings/outcome of the C-SSRS.

Focused Outcome Areas - Rights

- Ensure individuals are informed of their rights and responsibilities at the onset of services, supports, and treatment.
- Ensure documentation indicates HIPAA Privacy and Security Rules (as outlined in 45CFR, Parts 160 and 164) are specifically reviewed with individuals.

Compliance with Service Guidelines - Crisis Stabilization Services

- Ensure program offerings for the CSU is designed to meet the biopsychosocial stabilization needs of each individual, and a medical and clinical leadership team annually approves the therapeutic content of the program (group therapy/training, individual therapy/training, education support, etc.) This annual review is documented by signature and date of review and by participating leadership.
- Ensure the Crisis Stabilization Program adheres to their policy which defines requirements and procedures for timely notification to prescribing professional regarding drug reactions, medication problems, medications errors and refusal of medications.
- Ensure the Crisis Stabilization Program adheres to the seclusion and restraint procedures.

Recommendations: Current Review

Individual Record Review - CSU Planning

- Ensure the Individualized Recovery Plan is developed within 72 hours of admission to the CSU.
- Ensure the IRP or NCP's goals/objectives are written using the person's own language, individualized, and specific to the individual.
- Ensure the NCP or IRP addresses the following safety issues including, but not limited to: falls, suicide precautions, flight risk, and infectious/contagious precautions.
- Ensure individuals' plans of care are discussed a minimum of once every 72 hours with the treatment team.
- When the individual is assessed as having any suicide risk, ensure suicidality is addressed on the NCP/IRP.

Individual Record Review - Course of Stay

- Ensure individuals are offered groups on the CSU and individuals participated in one or more therapy/training services such as Individual Counseling, Family and Group Outpatient Services.
- Ensure the physician or physician extender documents the status of the individual daily.
- Ensure staff interventions reflected in the progress notes are related to the staff interventions listed on the treatment plan.

Individual Record Review - Transition/Discharge Planning

- Ensure discharge plans include specific step-down service/activity/supports to meet individualized needs.
- Ensure there is evidence of discharge planning at the beginning of admission and include: identification of the individual's desired outcome and needs, identification of natural supports, risk assessment, and safety planning.

Focused Outcome Areas - Safety

- Ensure documentation shows how providers work with each Individual to develop, document, and implement a safety/crisis plan as needed.

Focused Outcome Areas - Choice

- Ensure individuals' known preferences and differences are followed to the extent possible.

Focused Outcome Areas - Person Centered

- Ensure the individual is an active participant (has a voice) in the planning and receiving of services.

Focused Outcome Areas - Community Life

- Ensure documentation of transition planning is evident throughout service delivery, involves the individual, family, or other supports and includes specific objectives that are to be met prior to decreasing the intensity of the service or discharge.
- Ensure individuals are assisted with identifying after care placement where they wish to live, learn, work, and/or socialize.

Compliance with Service Guidelines - Crisis Stabilization Services

- Ensure the Adult Crisis Stabilization Program meets all staffing requirements.
- Ensure there are protocols for handling of licit and illicit drugs brought into the service setting. This includes confiscating, reporting, documenting, educating, and appropriate discarding of the substances.
- Ensure the Crisis Stabilization Program adheres to the policy and procedure for safe storage of medications.
- Ensure the Crisis Stabilization Program adheres to the Infection Control policy.
- Ensure all staff credentialing criteria are met.