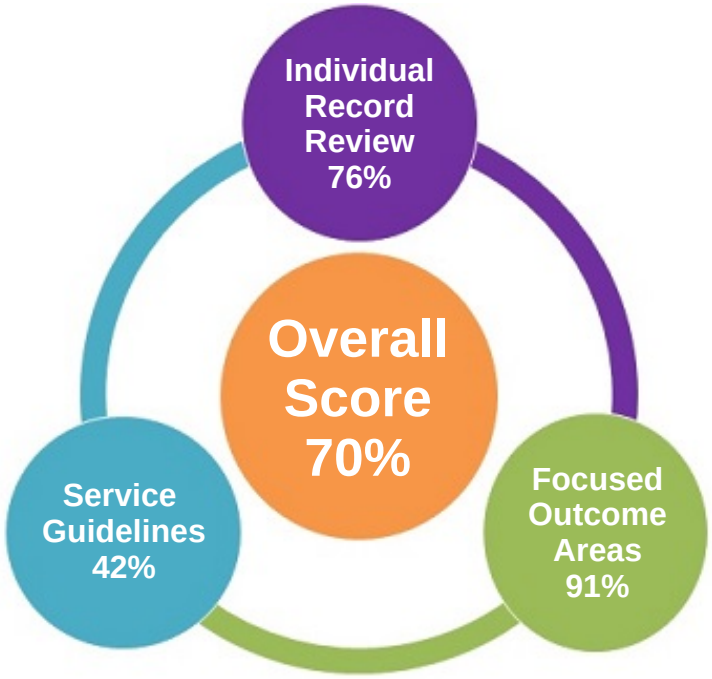
The Georgia Collaborative ASO

Middle Flint Behavioral Healthcare

Crisis Stabilization Unit Quality Review Final Assessment		
Address: 940 GA Hwy 96, Warner Robins, GA 31088		
Assessors: Heather Hewett, LPC; Jennifer Byrd, LPC, CPCS; Ty Barnett, BSN, RN; Edna Bryant, MSN, RN		
Review Date Range: 11/6/2023 - 11/8/2023	**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: 07/11/2022	48%	53%	33%	59%
Review Date: 01/31/2022	76%	76%	73%	79%
FY23 Statewide Average	82%	81%	72%	92%

Note: The FY23 Statewide Averages represent the mean of scores for all reviewed providers.

Summary of Significant Review Findings

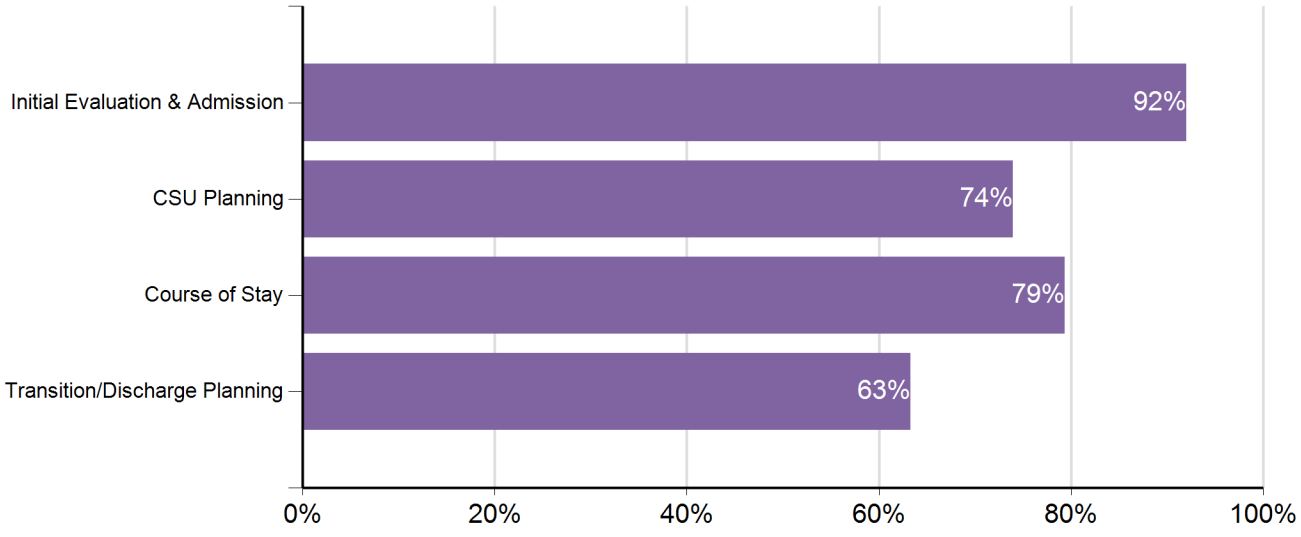
Strengths and Improvements:

- The Crisis Stabilization Unit (CSU) reopened in 05/2023.
- There was evidence that CSU staff were conducting 24-hour chart checks.

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.
- Medication Administration Records (MARs) did not document all required criteria as all were missing staff credentials of one or two staff members.
- There were 11 identified medication errors in four records.
- None of the Individual Resiliency Plans (IRPs) were individualized in personalized language as they were duplicated across records.
- Transition/discharge plans did not include specific step-down services and/or clinical benchmarks.
- None of the records evidenced follow-up and connection to continuing care post discharge.
- None of the applicable records documented that staff collaborated with aftercare providers for individuals assessed at admission to be at risk for suicide.

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: 76%

Strengths and Improvements

- Behavioral Health Assessments (BHAs) documented a Problem List that denoted each presenting issue's status as active, referred, resolved, deferred, or refused.
- Treatment team meetings reflected a multidisciplinary approach and the following was discussed with individuals: today's presenting issues, a rating of how the individual feels they have progressed in their recovery, significant changes in mental status since the last visit (including suicide or homicide risk), and medication compliance.
- Family sessions were conducted by clinical staff via telehealth upon individuals' discharge to confirm there were no weapons in the home, ensure transportation was secured, discuss discharge details, etc.

The following were improvements since the last CSUQR in 07/2022:

- Almost all individuals were assessed for suicide risk.
- All IRPs were developed within 72 hours of admission to the CSU.
- All records evidenced that the individual's plan of care was discussed every 72 hours.
- All records supported that the physician or physician extender and the RN documented the status of the individual daily.
- All records evidenced discharge planning at the beginning of admission.
- Almost all records documented consideration of psychiatric medications, the individual's ability to access and afford medication post discharge, how the medication will be obtained after the supply is exhausted, and how any associated lab work will be accessed and funded.

Opportunities for Growth

Initial Evaluation & Admission

- There was not a nursing assessment to include a review of symptoms, identify physical health needs, and determination of medical clearance for admission to the CSU within one hour of admission in four records.
    - One individual's admission orders were signed on 08/18/2023 at 2:59pm, and the initial nursing assessment was completed at 5:19pm.
    - Another individual's orders for admission were given on 09/12/2023 at 3:22pm, while the initial nursing assessment was completed at 5:42pm.
    - A third individual's admission orders were signed on 08/13/2023 at 2:00pm, and the initial nursing assessment was completed 3:42pm.
    - Lastly, one order for admission was given on 09/01/2023 at 1:30pm; however, it could not be determined if the initial nursing assessment completed on 09/01/2023 occurred within one hour as the assessment did not include time in/out, vital signs were completed on 09/03/2023 at 8:41am, and the staff signed the assessment on 10/04/2023 at 10:41am.

CSU Planning

- None of the 15 IRPs were individualized in personalized language as they were duplicated across records. This is a reoccurring issue from the last CSUQR in 07/2022. These IRPs addressed suicidal ideation, need for housing, and unemployment regardless of whether or not the individual presented with these issues.
- Safety issues were not addressed within four of eight applicable IRPs. This is a reoccurring issue from the last CSUQR in 07/2022.
    - An individual was admitted for threatening to stab a peer with scissors during outpatient group services; however, this was not addressed on the IRP.
    - One individual presented with aggression upon admission, yet this was not addressed on the IRP.
    - Another individual was admitted on an involuntary status for being aggressive with hospital staff; however, this was not addressed on the IRP.
    - Lastly, one individual was identified as a fall risk due to unsteady gait and seizure precautions, yet this was not addressed on the IRP.

Course of Stay

- One of four applicable records contained verbal orders that were not signed within 24 hours. This is a recurring issue noted in previous CSUQRs in 7/2022, 01/2022, 07/2021, and 11/2019. On 08/18/2023, telephone orders for medications were taken at 4:00pm; however, they were never signed by the prescriber. On the same day, a telephone order clarification was documented at 5:35pm and was also never signed by the prescriber.
- The MARs did not reflect all required criteria within 13 of 15 records. This is a recurring issue noted in previous CSUQRs in 7/2022, 01/2022, 07/2021, and 11/2019.

    - In all 13 records, one or both of two staff members' credentials were missing from the MAR, some signatures were illegible, and medications were held without documented explanation or reason.
    - Additionally, 11 medication errors were identified within four records. See Service Guidelines for further details.
- Non-medical progress notes did not document progress toward IRP goals/objectives within four of 13 applicable records. These group progress notes contained goal/objective progress statements that were either written in vague language or did not have progress statements at all.

Transition/Discharge Planning

- Fourteen of 15 transition/discharge plans did not include a specific step-down service and/or clinical benchmarks to meet individualized needs. This is a reoccurring issue from the last CSUQR in 07/2022.
    - None of the transition/discharge plans documented clinical benchmarks.
    - Six of the transition/discharge plans documented vague step-down services including "WROP [Warner Robins Outpatient]," "Non-Intensive OP [Outpatient]," and "AOP [Adult Outpatient]."
- Four of five individuals identified as homeless did not have a completed Need of Supportive Housing (NSH) survey within the record nor a referral for necessary residential supports. This is a recurring issue noted in previous CSUQRs in 7/2022 and 01/2022.
- None of the 13 applicable records evidenced staff follow-up and connection to continuing care with the individual within five to seven days post discharge. There were no documented efforts. This is a recurring issue noted in previous CSUQRs in 7/2022, 01/2022, 09/2020, and 11/2019.
- Within the only applicable record where an individual was in a transitional bed, there was no evidence that the individual was receiving services from outside of the CSU. This is a reoccurring issue from the last CSUQR in 07/2022.
- Five individuals were assessed to have recent suicidal ideation, and two records were not flagged for high risk for suicide.
- None of the five applicable records supported that CSU staff documented collaboration with the aftercare provider to include: individual's safety plan, who will follow-up with the individual and when it will occur, and that the individual's chart is flagged for high suicide risk upon discharge. This is a recurring issue noted in previous CSUQRs in 7/2022, 01/2022, 07/2021, and 09/2020.

Focused Outcome Areas

Focused Outcome Areas: 91%

Strengths and Improvements

- Personal Safety Interviews were completed in records, which helps to potentially prevent seclusion and restraint episodes.
- There was evidence that physicians and physician extenders signed off on lab results.
- Abnormal Involuntary Movement Scale (AIMS) assessments were completed within initial nursing assessments.

The following were improvements since the last CSUQR in 07/2022:

- Almost all records contained safety/crisis plans that were developed, as needed, that directs, in advance, the individual's desires/wishes/plans/objectives in the event of a crisis.
- All records supported that clinically appropriate actions or steps were taken and linkages or referrals were made based upon the findings/outcome of the Columbia-Suicide Severity Scale (C-SSRS).
- All individuals/guardians signed formal acknowledgement of rights and responsibilities at the onset of services, supports, and treatment.
- All records evidenced that Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules were reviewed with the individual.

Opportunities for Growth

Rights

- Release of information (ROI) forms did not contain all required components within four of eight records. In all instances, staff documented speaking with family and friends of individuals without completing a ROI form.

Person-Centered

- Two of four applicable records did not demonstrate that the IRP was reassessed based upon changing needs, circumstances, and/or response by the individual.
  - One individual's IRP was not updated after being sent to the emergency room.
  - Another individual's IRP was also not updated after being sent to the emergency room. Additionally, this individual's medical condition was declining throughout the CSU stay.

Community Life

- Documentation did not support that the individual was assisted with setting goals for specific environments where they wish to live, learn, work, and/or socialize within five of 14 applicable records. This is a reoccurring issue from the last CSUQR in 07/2022. These five individuals were homeless and their IRPs were not personalized to include a goal to address homelessness.

Service Guidelines

1	Adult CSU Staffing Requirements Met	Yes
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**
	5	**7**	**2**	**42%**

Service Guidelines: 42%

Opportunities for Growth

Therapeutic Content

- The medical and clinical leadership team were not approving the therapeutic content of the CSU on an annual basis. This is a recurring issue noted in previous CSUQRs in 7/2022 and 01/2022. While a document was submitted saying that a "curriculum was reviewed and approved by licensed clinical staff to be utilized in group therapy/training, individual therapy training and as educational support for individuals admitted into the crisis stabilization unit," there was no narrative of what trends were discussed, what changes were made, and what was approved by staff.
    - Per Department of Behavioral Health and Developmental Disabilities (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."
- The CSU's daily schedule and group schedule submitted to the assessors did not align with each other nor did they align with the group schedule displayed within the CSU common area.

The CSU Leadership team and the Medical Oversight team met monthly and quarterly, respectively. However, meeting minutes did not reflect tracking and trending of identified risk or issues with disposition or discussion of outcome and corrective action recommendations to include follow up. Policies did not reflect the current committees. As a direct result, medication notification, handling licit and illicit drugs, safe storage of medications, infection control, and seclusion and restraints have not been tracked and trended.

- 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).
- Assessors also recommended the pharmacist participate in discussion surrounding medication errors, safe storage of medication, etc.

Adherence to Medication Notification Policy

- During this CSUQR, four records reviewed identified 11 medication errors in which staff initials were missing from the scheduled medications to be administered. This is a recurring issue noted in previous CSUQRs in 7/2022, 01/2022, 07/2021, 09/2020, and 11/2019. These were not identified as medication errors by agency staff. The policy and procedures for tracking and trending medication errors was not being followed.
    - One individual's MAR reflected five medication errors. On 09/18/2023 at 9:00am, Haldol 7.5mg po bid was not administered. Additionally, Haldol 7.5mg po bid was ordered twice daily but only given once for four days (09/16/2023 to 09/20/2023).
    - Another individual's MAR reflected Trazodone 50mg was not administered as ordered on 08/30/2023 at 9:00pm.
    - Three medication errors were identified in another record as Librium 25mg po as part of a detox protocol was not administered on 08/15/2023 at 9:00am, 1:00pm, or 5:00pm.
        - The MAR did not indicate that medications were held. Additionally, documentation did not reflect

Clinical Institute Withdrawal Assessment for Alcohol (CIWA) assessments to indicate a hold for medication.
    - Two medication errors were documented in a record as Coreg 6.25mg (used to treat high blood pressure and heart failure) was not administered as ordered on 09/07/2023 at 9:00pm or 09/08/2023 at 9:00am.
        - The medication was ordered on 09/07/2023 at 1:16pm.
        - The medication was discontinued on 09/08/2023 at 1:30pm per agency staff due to no availability on the agency's formulary. Documentation did not reflect that nursing staff or the pharmacist communicated with the prescriber regarding the availability of the medication or attempts to obtain it.
            - 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."
                - 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.
- The current policy did not reflect current staff procedures as CSU Leadership meetings did not document evidence of discussing the Investigative Summary Report or the Continuous Quality Improvement Committee per agency policy. Additionally, the policy had not been updated since 10/21/2021.
- While the CSU Leadership monthly meetings appeared to be discussing medication errors, there was nothing listed under "QI" as having been discussed. There was no other documentation evidencing discussion of medication errors on a regular basis.

Adherence to Safe Storage of Medication Policy

- The temperature parameters listed in the agency policy was 36 degrees to 46 degrees Fahrenheit; this does not align with the DBHDD Provider Manual. This is a reoccurring issue from the last CSUQR in 07/2022. The correct range is 36 degrees to 41 degrees Fahrenheit.
- Additionally, medication refrigerator temperatures were out of range as daily logs indicated:
    - For the month of May 2023, the temperature log was out of range for 30 days (48-79 degrees Fahrenheit).
    - For the month of June 2023, the temperature log was out of range for 15 days (34-74 degrees Fahrenheit).
    - For the month of July 2023, the temperature log was out of range for 15 days (18-78 degrees Fahrenheit).
    - For the month of August 2023, the temperature log was out of range for six days (33-42 degrees Fahrenheit).
    - For the month of September 2023, the temperature log was out of range for 12 days (33-42 degrees Fahrenheit).
    - For the month of October 2023, the temperature log was out of range for 25 days (35-47 degrees Fahrenheit).
- The policy needs to be updated to reflect corrective action protocol when temperatures are out of range.
- It is recommended that temperature parameters are monitored and discussed in the agency's designated committee.

Infection Control Plan Adherence

- The infection control policy submitted to the assessors included a chart of specific infections and did not consist of protocols when infections are identified and how the infection incident reports will be reviewed, tracked, and trended. This is a reoccurring issue from the last CSUQR in 07/2022.
- CSU Leadership meeting minutes stated "Infection Control;" however, it only noted, "education will be given to staff about upcoming flu season."

Seclusion & Restraint Policy Adherence

- The current policy and procedure is unclear and convoluted regarding where incidents will be tracked and trended. This is a recurring issue noted in previous CSUQRs in 7/2022 and 01/2022. For example, Seclusion and Restraint policy > Quality Assurance Plan > Continuous Quality Improvement Committee > CSU Leadership Meeting > "QI" (which was blank). There was no documented evidence that seclusion and restraint episodes were being reviewed.
- Staff reported a seclusion occurred in July 2023; however, meeting minutes from August 2023 did not indicate a review of this episode.
- Additionally, the policy was last updated on 01/17/2019.

Staff Credentialing

- During this CSUQR, five staff credentials were reviewed in which one of the personnel records was not in compliance. This is a reoccurring issue from the last CSUQR in 07/2022. The personnel record of this supervisee/trainee (S/T) lacked an attestation form that included all required criteria. Specifically, the attestation did not specify which licensure discipline the staff member is working toward nor did it list a projected licensure examination date. It was confirmed that this information was not documented anywhere else within the personnel file.

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.
- There were two waiting areas for individuals to remain until they can be assessed. The second waiting area was used for individuals that present with aggression, suicidal ideation, etc.
- The current census was six with a 14 bed maximum capacity. All bedrooms were single rooms.
- The CSU had 23 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. Technicians serve as security guards on the unit.
- Convex mirrors were located in the corners of halls throughout the building.
- Electrical outlets were locked and covered.
- The holding 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. There were puzzles available to individuals.
- The group room had a dry erase board with positive affirmations written on it by individuals. The group schedule was posted within the dayroom.
- 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.
- The outside area was sunny with various chairs and benches and enclosed with four high brick walls.
- A pharmacist was onsite six or seven days per week.
- Medication room was locked. Narcotics were double locked.
- Housekeeping was on the unit daily.
- Emergency water and food supply was well stocked and organized.
- Food is brought in from Houston Medical Center's dietary department, where nutritionists are consulted on dietary restrictions and needs.
- The most recent health food score as of 09/29/2023 was 100%.

Since the previous review on 7/11/2022, the following improvements were noted:

- All new toilets, ceiling lights, anti-ligature sinks and doorknobs, wall/door paint, and furniture were replaced throughout the building.
- Thermostat controls were placed near the ceiling, out of reach of individuals, and controlled via phone.
- The "phone time" room is now a private phone booth complete with speakerphone capabilities with no phone cords.
- The restraint room door opened without difficulty.
- All bathroom lights were operable.
- All bathroom stalls were equipped with privacy shower curtains.
- There was no evidence of stained ceiling tiles.

Opportunities for improvement:

- Toilet paper continued to not be available in all bathroom stalls.
- A surge protector power strip was located directly under the sink in the bio-hazard room.
- Dried brown and red fluids were found within the seclusion room on the door, windowsill, and floor.

Additional Comments on Practices

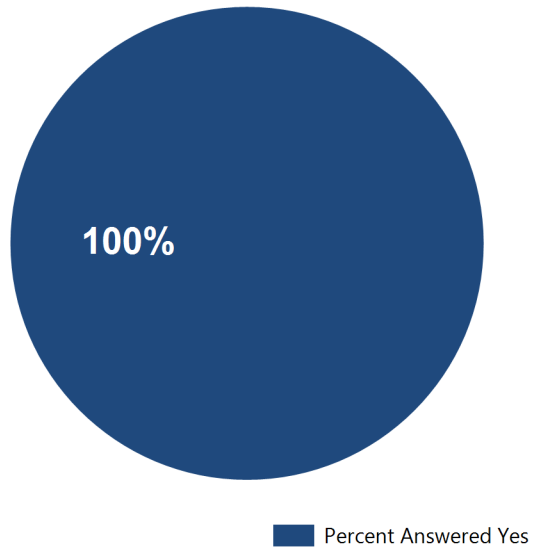
Additional strengths and concerns beyond the general scope of the review were discovered by reviewers. Additional issues/practice concerns may have the potential to impact service delivery, quality of care, or may represent a risk to the provider.

- While the CSU has Policy 5-SD.057 which is their suicide prevention, screening, intervention, and monitoring policy; it appeared that the policy was written for individuals served in the community. The provider was encouraged to create a suicide policy specifically for individuals served within the CSU setting. Additionally, the current policy has not been updated since 7/10/2019.
- Within one record, "Refused" was written in for the individual's signature on rights and Health Insurance Portability and Accountability Act (HIPAA) documentation. The provider was encouraged to document at least a second attempt to have the individual sign their rights and HIPAA paperwork.
- All IRPs reflected "(if unavailable) verbal consent" despite some being signed by the individual.
- Some BHA documents listed the assessor's name and the co-signer's name under signature history with only the co-signer's electronic signature. The assessor's electronic signature should also be reflected within the document. Additionally, a nursing progress note documented one staff member's name at the top with a different staff member's electronic signature at the bottom.
- A licensed professional counselor (LPC) and an S/T were documented as ordering CSU, Medication Administration, Nursing Assessments, and Psychiatric Treatment; however, an LPC and S/T cannot order these services per DBHDD guidelines.
- Nursing assessments and daily physician notes did not have time in/out documented. This is a reoccurring issue from the last CSUQR in 07/2022.
- While suicidality was addressed on the IRP, the language was identical across all IRPs and was not personalized to the individual, "[Ind] will comply with safety plan when experiencing suicidal/self-harm/homicidal ideation to avoid harm to self or others."
- Some group and nursing progress notes were signed late. Examples included:
    - One group session occurred on 08/22/2023 and was signed by staff on 09/12/2023, 21 days after the individual discharged.
    - One nursing assessment occurred on 08/24/2023 and was signed off by staff on 08/29/2023, the day the individual discharged.
- Additionally, some physician assessment progress notes were signed before the session ended; for example, an initial physician assessment was completed on 08/21/2023 from 3:00pm-3:30pm and was signed by staff the same day at 3:01pm.
- One individual was morbidly obese with a body mass index (BMI) of 32; however, the individual was documented as having no medical issues, and the following were not completed upon intake: nutritional assessment and BMI management screening ("Exclusion from Screening Reason" was blank).
- Within a physician progress note for one female individual, it was noted "his mood is good."
- MAR forms did not include prompts for staff credential(s) with their name.

Individual Interviews

Individual Interviews Conducted: 3

Individual Interviews are not calculated into the Overall Score



All three individuals reported:

- They can access appointments, provider staff, and other agency supports in a timely manner when requested.
- They feel supported in moving toward desired goals and dreams.
- They feel they are treated with respect and dignity by staff.

When asked what this agency does exceptionally well, individuals shared:

- *"I have been here for two days, and these people have been nothing but the best."*
- *"Groups are amazing."*
- *"I've been here three days. I feel like I am getting better each day. The attentiveness of staff has been great. They handled a little drama very well and still paid attention to the other patients. They have been very attentive to my medical needs. They followed up each day and adjusted meds as needed."*
- *"This facility has far exceeded my expectations."*
- *"I like this facility. I'm more myself. When I leave here, I'm going to a new place. That's my goal to go some where new and just take care of myself and stay sober."*
- *"They talk to you here with wisdom and encouragement."*
- *"A lot of things are positive here, and I feel like I am learning a lot."*
- *"I like the food here, it is delicious. They give you a variety."*
- *"They way the treat us and each other is phenomenal. Other places treat you like a disease but here they treat like you are human."*

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 documented in each section above for specific information pertaining to the recommendations below.

Recommendations: Current and Prior Review

Individual Record Review - CSU Planning

- 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.

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 discharge plans include specific step-down service/activity/supports to meet individualized needs.
- 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 - Community Life

- 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 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 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 the Crisis Stabilization Program adheres to the seclusion and restraint procedures.
- Ensure all staff credentialing criteria are met.

Recommendations: Current Review

Individual Record Review - Initial Evaluation & Admission

- Ensure within one hour of admission, there is a nursing evaluation to include review of symptoms, identification of physical health needs, and determination of medical clearance for admission to the CSU/BHCC.

Individual Record Review - Course of Stay

- Ensure non-medical progress notes consistently contain documentation of the individual's progress (or lack of) toward specific goals/objectives on the treatment plan.

Individual Record Review - Transition/Discharge Planning

- Ensure the medical record is flagged for high risk of suicide if the individual was assessed to have a history of suicidal ideation or behavior, or has exhibited recent suicidal ideation.

Focused Outcome Areas - Rights

- Ensure all releases of information contain all required components.

Focused Outcome Areas - Person Centered

- Ensure plans are re-assessed and based upon any changing needs, circumstances and/or response by the individual.

Additional Recommendations

- Ensure individuals in a transitional bed receives services from outside of the CSU. This was a reoccurring issue from the previous CSUQR on 07/11/2022.

Providers have the opportunity to appeal review findings for up to ten (10) business days following notification that their written Final Assessment has been saved to the Collaborative's website. For appeals procedures and submission requirements, access the Georgia Collaborative's website to review the appeals process in the Quality Management section of the Provider Handbook and for a current version of the Review Appeal Form at this link: https://www.georgiacollaborative.com/providers/behavioral-health-providers/