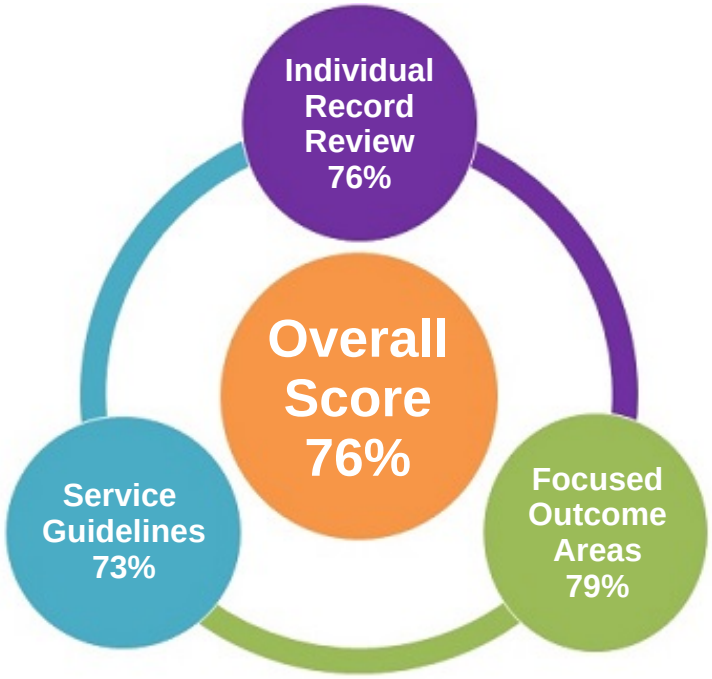
The Georgia Collaborative ASO

Middle Flint Behavioral Health

Crisis Stabilization Unit Quality Review Final Assessment		
Address: Remote Quality Review, 940 GA Hwy 96, Warner Robins, GA 31088		
Assessors: Jennifer Byrd, LPC, CPCS; Natalee Fritsch, LPC; Dorian Milam, RN		
Review Date Range: 1/31/2022 - 2/2/2022	**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: 07/15/2021	89%	87%	89%	91%
Review Date: 09/14/2020	83%	74%	90%	84%
FY21 Statewide Average	84%	80%	81%	90%

Note: The FY21 Statewide Averages represent the mean of scores of all reviewed providers. Due to the COVID-19 pandemic, several reviews were postponed or conducted remotely (rather than on site). Additionally, reviews conducted in FY20 (July 1, 2019 to June 30, 2020), may have had points removed from the Overall Score due to identified Quality Risk Items; therefore, caution should be taken when comparing scores across fiscal years.

Summary of Significant Review Findings

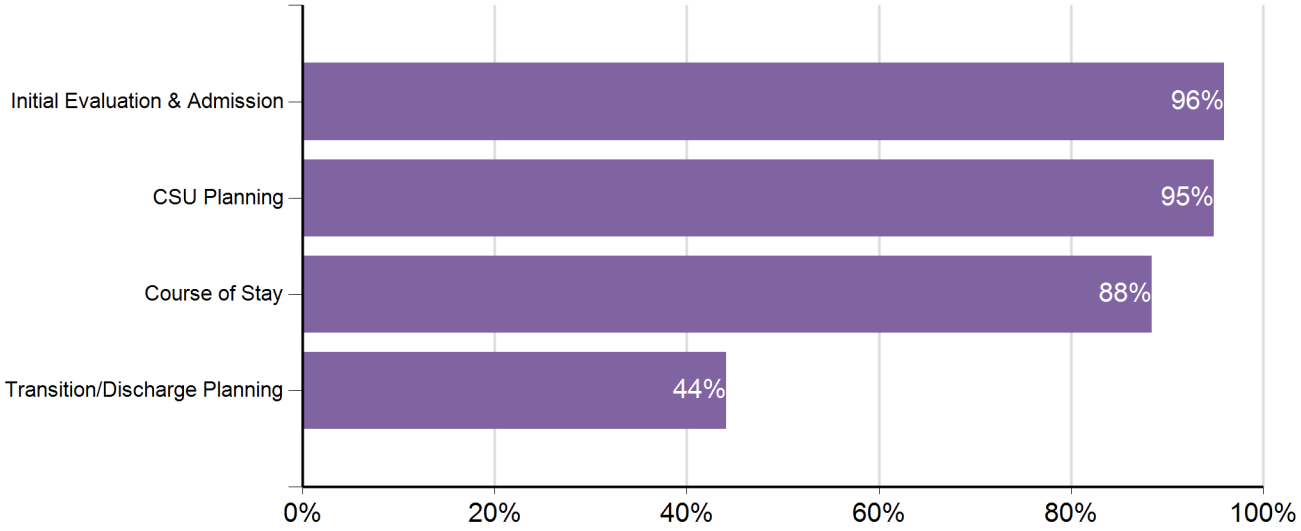
Strengths and Improvements:

- A Remote Quality Review was conducted in response to the COVID-19 pandemic. This is the provider's second Remote Quality review during the COVID-19 pandemic.
- Currently, the Crisis Stabilization Unit (CSU) has adjusted the 14 bed admission rate to an eight bed maximum capacity due to staffing issues.
- Upon admission individuals were screened for symptoms of COVID-19.
- Records included detailed documentation when the individual refused to attend treatment team or a prescribed medication.
- Four of the five staff members' credentialing documentation contained all required Standard Training Requirements (STRs) and supervision attestations, as applicable.
- The initial physician assessments and comprehensive nursing assessments contained documentation of time in and time out. This is an improvement from the previous Crisis Stabilization Unit Quality Review (CSUQR) in 07/2021.

Opportunities for Improvement:

- Medication errors for missed doses of medications were not being documented and reported per the medication notification policy.
- One record did not include all required documentation for two identified seclusion episodes.
- The Columbia-Suicide Severity Rating Scale (C-SSRS) Lifetime/Recent ratings did not coincide with the individuals' presenting circumstances.
- Verbal orders were not signed by the physician within 24 hours and when they were signed they did not include the date and time of the physician's signature.
- Medication Administration Records (MARs) lacked all required criteria.
- Discharge summaries did not include all required criteria.
- Documentation regarding how an individual will obtain prescribed medications and lab work post-discharge was missing.
- Discharge summaries were not entered into the ASO’s ProviderConnect/batch system within 72 hours of discharge.
- Charts were not flagged for those individuals assessed with a high suicide risk. In addition, documentation lacked collaboration between the provider and the aftercare provider for those individuals assessed with a high suicide risk.
- Individual's rights and responsibilities and Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules were not completed at the onset of services.
- One staff member's credentialing documentation did not meet the STR due to missing a Department of Behavioral Health and Developmental Disabilities (DBHDD) approved criminal records check.

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

- Records contained documentation of nursing staff providing group education to the individuals as it related to individuals physical health needs and medications.
- All records included a comprehensive nursing assessment that was completed within one hour of admission.
- The following are continued strengths from the previous CSUQR in 07/2021:
  - In all applicable records, suicidality was addressed on the Individualized Recovery Plans (IRPs).
  - All individuals' plan of care was discussed every 72 hours.
  - All records included documentation where the individual was offered the opportunity and/or were present for the plan of care discussion.

Opportunities for Growth

Initial Evaluation and Admission

- While all records reviewed utilized the C-SSRS to assess for suicide risk, there were three records where the ratings did not coincide with the individuals' presenting circumstances. This was an ongoing area for improvement that was noted in the previous CSUQRs in 09/2020 and 07/2021. Examples included:
  - One individual was admitted to the CSU for suicidal ideations and an attempt to walk into traffic; however, the C-SSRS questions were scored "no". Additionally, the C-SSRS was completed upon discharge.
  - Another individual reported during the initial assessment he was experiencing suicidal thoughts; however, the C-SSRS was scored "no".

CSU Planning

- In one applicable record reviewed, the IRP was not reviewed/updated following three episodes of seclusion. See Service Guidelines for additional information.

Course of Stay

- Verbal orders were not signed within 24 hours in four of seven applicable records. In majority of these instances, the physician or physician extender signed the verbal order; however, the date and time of the signature was missing. One record contained a verbal order for Seroquel, Haldol, and Benadryl on 11/27/2021 that was not signed by the physician. This was an ongoing area for improvement that was noted in the previous CSUQRs in 11/2019 and 07/2021.

- MARs lacked all required criteria in five of 15 records. This was an ongoing area for improvement that was noted in the previous CSUQRs in 11/2019, 09/2020 and 07/2021. In reviewing the MARs, there were several issues noted during this CSUQR:
    - Staff signatures, credentials, and initials were illegible.
    - There was one record that contained one medication error. See Service Guidelines for additional information.

Transition/Discharge Planning

- The discharge summary did not include the required documentation in nine of 15 records. The majority of records reviewed did not include the individual's Strengths, Needs, Abilities, and Preferences (SNAPs) within the discharge summary. Additional examples included:
    - One discharge summary did not indicate the living situation of the individual at the time of discharge.
    - Another record included a date and time of a follow-up appointment; however, it did not specify the agency, address of the appointment, or telephone number.
    - One individual was discharged with medications to a long-term residential program but was not given a follow-up appointment with a mental health provider.
- None of the 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. In all examples, documentation did not demonstrate that a discussion of medication availability was had with individuals prior to discharge.
- None of the discharge summaries were entered into the ASO’s ProviderConnect/batch system within the required 72 hour timeframe. In the majority of records, discharge summaries were not entered into the system at all. This was an ongoing area for improvement that was noted in the previous CSUQRs in 11/2019, 09/2020 and 07/2021.
- One individual was identified as homeless in which a Need of Supportive Housing (NSH) survey was not completed.
- In all of the 14 applicable records reviewed documentation lacked evidence of follow-up and connection to continuing care with the individual post-discharge. This was an ongoing area for improvement that was noted in the previous CSUQRs in 11/2019 and 09/2020.
- In three of 11 applicable records, individuals who were assessed to have a history of suicidal ideation and/or behavior and had exhibited recent suicidal ideation did not have their chart flagged for high risk of suicide. This was an ongoing area for improvement that was noted in the previous CSUQR in 07/2021.
- Documentation did not support that CSU staff documented collaboration with the aftercare provider to include: individual’s safety plan, who would follow-up with the individual and when it will occur, and that the individual’s chart was flagged for high suicide risk upon discharge in all 11 applicable records. This was an ongoing area for improvement that was noted in the previous CSUQRs in 09/2020 and 07/2021.

Focused Outcome Areas

Focused Outcome Areas: 79%

Strengths and Improvements

- Baseline Abnormal Involuntary Movement Scales (AIMS) were completed upon admission.
- Laboratory results were present within the record with the staff member's initials and date of the reviewed results.
- Collaboration with the Community Support Team (CST) was documented in the treatment team meeting notes for several individuals.
- All records included a crisis/safety plan that was completed upon admission.
- Releases of information (ROIs) contained all required components in all applicable records reviewed. This was a continued strength from the previous CSUQR in 07/2021.

Opportunities for Growth

Whole Health

- Documentation did not support that individuals were referred to Case Management and other health services when indicated in six of 12 applicable records. This was an ongoing area for improvement that was noted in the previous CSUQRs in 09/2020 and 07/2021. Examples included:
  - Three records identified individual's who were in need of a dental referral. One individual was prescribed medications for a toothache during the course of stay, while another individual had a cavity and a chipped front tooth.
  - Another individual did not have stable housing and could have benefited from a Case Management referral.
  - One record did not have any documented referrals to either Case Management, CST or any other additional resources even though the individual had five previous CSU admissions.

Safety

- 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 nine of 11 applicable records. This was an ongoing area for improvement that was noted in the previous CSUQRs in 09/2020 and 07/2021.

Rights

The following were recurring issues noted in the previous CSUQRs in 11/2019 and 07/2021:

- Eleven individuals were not presented with nor did they sign formal acknowledgement of their rights and responsibilities at the onset of services.
- Documentation of HIPAA Privacy and Security Rules was not reviewed with the individual in ten records.

Person-Centered

- Documentation did not demonstrate the IRP was reassessed based upon any changing needs, circumstances and/or response by the individual in two of seven applicable records. Examples included:
  - One individual was identified as having dental issues during his course of stay and was placed on seizure precautions but the IRP was not updated.
  - The IRP was not updated following three episodes of seclusion.

Service Guidelines

Program Offerings		
1	Adult CSU Staffing Requirements Met	Yes
2	The Crisis Service Center staffing requirements met.	N/A
3	The Adolescent/Youth CSU has an independently licensed/credentialed practitioner (or a supervised S/T) on staff and available to provide individual, group, and family therapy.	N/A
4	C&A Minimum Staff Present	N/A
5	C&A Staff Ratio Met	N/A
6	The CSU has policies and procedures for identifying and managing individuals at high risk of suicide or intentional self-harm.	Yes
7	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
8	C&A Nursing Staff Ratio increases based on need	N/A
9	Adherence to Medication Notification Policy	No

10	Protocols for Handling Licit and Illicit Drugs present			Yes
11	Adherence to Safe Storage of Medication Policy			Yes
12	Infection Control Plan Adherence			Yes
13	Seclusion & Restraint Policy Adherence			No
14	Therapeutic Blood Level Monitoring			Yes
15	Model/Curriculum for SU treatment (Non-scored)			Yes
Staff Training				
16	Physician Availability for 3.7-WM			Yes
17	Psychiatrist Available for Consultation			Yes
18	C&A Psychiatrist (Non-scored)			N/A
	# Yes	**# No**	**# NA**	**SCORE**
	8	**3**	**5**	**73%**

Service Guidelines: 73%

Strengths and Improvements

- The medication temperature log was completed daily without missing any dates per the agency's safe storage of medication policy.
- The agency utilized a glucometer that does not require calibration.

Opportunities for Growth

Adherence to Medication Notification Policy

The following was a recurring issue noted in the previous CSUQRs in 11/2019, 09/2020 and 07/2021:

- During this CSUQR, one record reviewed included one identified medication error in which the staff initials were missing from the scheduled medications to be administered. These errors were not identified as medication errors. The Incident Report Form was not completed; therefore, the medication errors were not tracked in the Medical Oversight Committee.
    - Per Policy #6-MM.028, E. Medication Administration and Supervision of Self-Administration- E. "All medication errors, refusal of medications, and/or adverse reactions will be recorded on the MAR and in the client record; immediately reported to the physician and nurse supervisor; and the Corporate Compliance Officer will be notified via an Incident and Accident Report Form and Safety Plan per the Policy #4-CQA.022, "Reporting of Accidents and Incidents with Follow-up Procedures."
- Per Policy #6-MM.036, Medication Utilization Review, C: "The Medical Oversight Committee will audit for adherence to guidelines and criteria and report trends to the Medical/Clinical Committee."
    - Per the Medical Oversight Committee meeting minutes, the aforementioned medication errors were not discussed.
    - The Medical Oversight Committee meets every other month but there were no meetings held between 05/2021 and 10/2021.

Seclusion and Restraint Policy Adherence

- During the course of stay for one individual (11/22/2021 to 11/29/2021) he was placed into seclusion on three separate instances on 11/24/2021, 11/27/2021, and 11/29/2021 (day of discharge). The individual presented with homicidal ideations towards staff. The individual was placed into seclusion for 51 minutes the morning of discharge. The individual was released from the CSU two hours after being in seclusion.
- The CSU staff did not adhere to the following policy: #7-CSU.003, Seclusion and Restraint and DBHDD PolicyStat 01-351: Use of Seclusion or Restraint in Crisis Stabilization Services. The following documentation was missing for each identified seclusion episode:
    - 11/27/2021: The findings of the individual's care were not communicated to the individual's treatment team. Additionally, it is unclear from the documentation whether or not the individual was released from seclusion between 8:05am (when meds were given) and 9:08am when the seclusion is renewed.
    - 11/29/2021: The record did not contain any documentation required for this seclusion episode. Documentation missing included:
        - The Nursing Evaluation and Physician/LIP Order Form for Seclusion and Restraint in Crisis Stabilization Services.
        - Seclusion and Restraint Monitoring Form for Crisis Stabilization Services.
        - Debriefing with the Individual Following Use of Seclusion and Restraint in Crisis Stabilization Services.
        - Findings were not communicated to the treatment team.
        - Debriefing with the Involved Staff Following Use of Seclusion or Restrain in Crisis Stabilization Services.
- Additionally, there was no documentation to support that CSU staff followed up with the individual after they were discharge on 11/29/2021. The individual was given a seven day supply of medications; however, they were given an appointment for medication management on 12/20/2021 almost one month after he was discharged.

Program Offerings

- 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."

Crisis Stabilization Unit Site Visit Observations

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

- A keycard was required for entry into the building. In order to access the facility, individuals and visitors ring a door bell which was monitored by a camera.
- The assessment room had a security camera and two chairs that were bolted to the floor. The window had a privacy screen. The waiting area was clean, nicely furnished and had informational materials for individuals.
- A holding room was attached to the assessment room. The holding room had a mattress on the floor. There was also a camera in this room that was monitored in the nurses station.
- All CSU staff had access to the 26 live cameras. It was also visible within the nurses station.
- Outlets throughout the unit had protective covers to prevent unauthorized use.
- The individual's rights and privacy practices were located in the day room entryway.
- A locked separate room was present for individuals to have phone time. The phone was not wireless.
- The day room had weighted furniture. A projector was recently placed in the day room to replace the television.
- The outdoor area had two bolted benches. The area was free of debris.
- The hallways were well lit and floors were clean.
- All rooms contained single beds, which were bolted to the floor.
- The emergency food and water supply were all within the appropriate expiration dates.
- An industrial laundry room was for staff only. Staff wash all laundry on the unit.
- Thermostats have recently been changed over to Wi-Fi thermostats and are not within reach of the individuals.
- Restrooms were equipped with breakaway shower curtains and ligature free towel hooks. The restrooms were clean and contained tamper resistant mirrors.
- The seclusion room was furnished with a mattress; it was monitored through a window. A shower and bathroom were adjacent.
- The restraint room had a bed that was bolted to the floor and was in view of the nurses station.
- Only lab samples were held in the laboratory refrigerator.
- The glucometer on the unit does not require calibration.
- The refrigerator in the medication room was locked. Controlled medications were double locked.
- The CSU no longer served frozen dinners and they now have access to a dietician. An outside provider handles all dietary restrictions. The most recent health food score was 100 as of 5/2021. All furniture in the cafeteria was bolted to the floor.

Areas for improvement:

- Walls and door frames were in need of re-painting.
- The molding in the day room was missing.
- The phone available to the individuals had a cord attached.
- A lightbulb was out on the men's shower.

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.

- Interchanging pronouns were documented within several individuals' records.
- Although paper admission orders to the CSU were signed by the physician within 24 hours, the majority of service orders were signed late within the electronic medical record (EMR). For example, one individual was admitted on 11/22/2021 and discharged on 12/01/2021 but the service orders were not signed by the physician until 12/13/2021.

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 discharge summaries are entered into the ASO's ProviderConnect/batch system within 72 hours of discharge.
- Ensure there is evidence in the medical record of follow-up and connection to continuing care.
- 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.
- Ensure documentation supports that CSU staff have documented collaboration with the aftercare provider.

Focused Outcome Areas - Whole Health

- Ensure documentation supports referrals are made when to Case Management and other health services when indicated.

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 all individuals are informed of their rights and responsibilities evidenced by the individual's or legal guardian signature on notification.
- 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 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.

Recommendations: Current Review

Individual Record Review - CSU Planning

- Ensure the NCP or IRP is reviewed with the treatment team and updated following an episode of seclusion or restraint.

Individual Record Review - Transition/Discharge Planning

- Ensure Discharge Summaries include required documentation.
- 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 individuals who are identified as homeless, a Need of Supportive Housing (NSH) survey is completed and referral for necessary residential supports.

Focused Outcome Areas - Person Centered

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

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 the seclusion and restraint procedures.