The Georgia Collaborative ASO

DeKalb Community Service Board dba Claratel

Crisis Stabilization Unit Quality Review Final Assessment		
Address: **450 Winn Way, Decatur, GA, 30030**		
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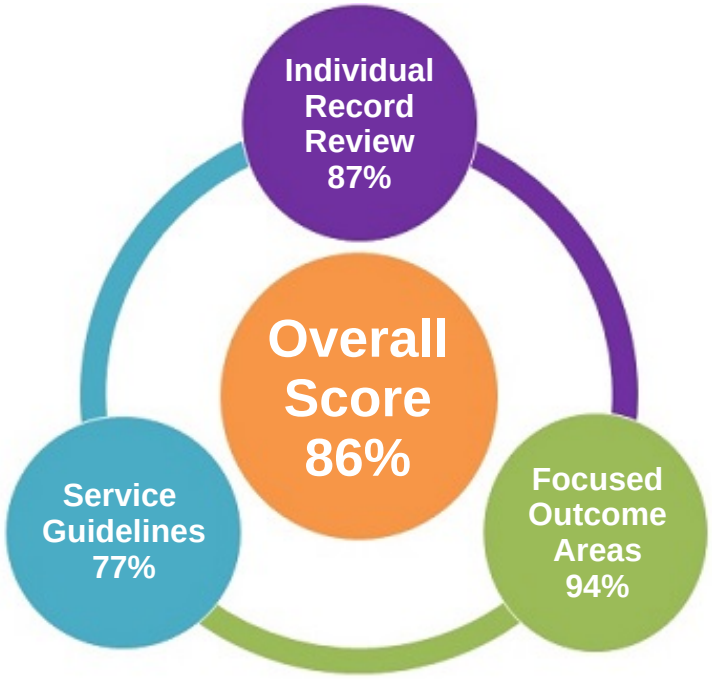
Review Date Range: **7/21/2025 - 7/24/2025**	CSU Type: **BHCC**	CSU Beds: **36**
Individual Records Reviewed: **20**	Temp Obs Beds: **6**	Transitional Beds: **0**
Staff Records Reviewed: **5**	Current Review Frequency: **Annual**	

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: 07/15/2024	87%	90%	77%	93%
Review Date: 01/25/2024	93%	97%	85%	96%
FY25 Statewide Average	89%	89%	82%	95%

Note: The FY25 Statewide Averages represent the mean of scores for all reviewed providers.

Summary of Significant Review Findings

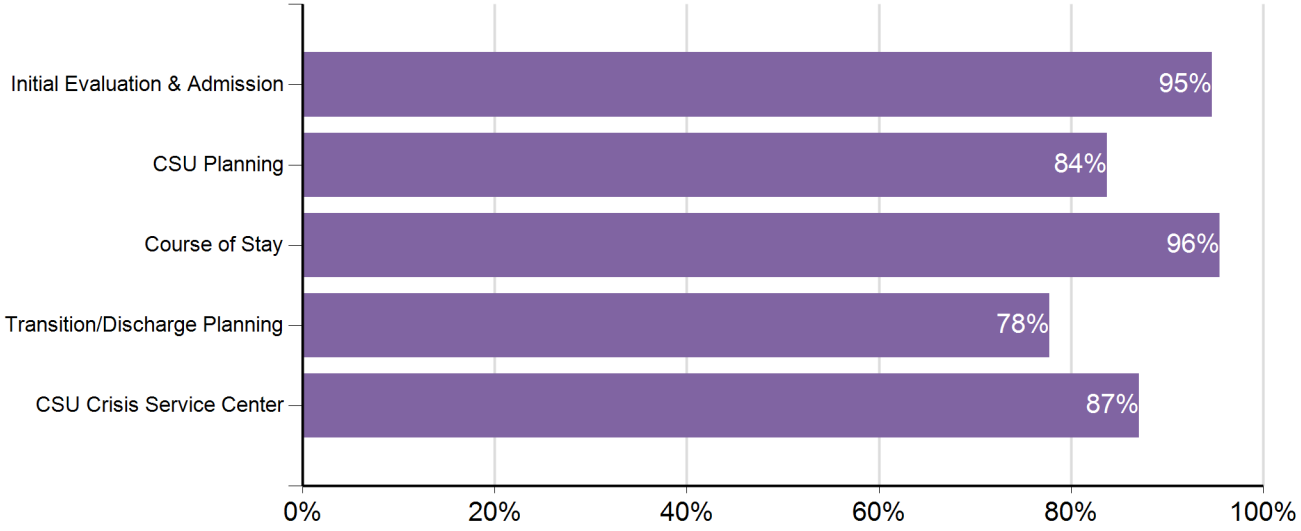
Strengths and Improvements:

- The electronic medication administration record (eMAR) contained a comment section and caption bubbles where the nurse was able to write follow-up comments regarding the effectiveness of the medication and other pertinent information such as an anxiety rating scale or the reason the medication was given.
- The eMAR was clear and easy to understand. Lab results and vital signs were easily accessible. "Additional Instructions" provided comprehensive directives to address refusal of medication, i.e., "Check for cheeking. Cannot refuse meds. If refuses, call provider for involuntary medication order. He is involuntary status."
- Medication counseling was provided to the individual by the pharmacist and was documented in a non-billable progress note. This continued to be a strength for the provider.
- Baseline Abnormal Involuntary Movement Scales (AIMS) were completed upon admission in all records.
- Documentation indicated individuals were assisted at discharge with transitioning to ongoing treatment care options. For example, individuals were assisted with placement at long-term residential treatment programs.

Opportunities for Improvement:

- The Behavioral Health Crisis Center (BHCC) did not have a certified peer specialist (CPS) scheduled seven days a week.
- The Crisis Service Center (CSC) did not have a fully licensed clinician on staff at all times.
- In one of five staff members' credentialing reviewed, documentation did not contain all required standard training requirements.
- Discharge summaries must be entered into the ASO's ProviderConnect/batch system within the required timeframe.
- Treatment team meetings must be held every 72 hours.

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: 87%				*Indicators scoring below 80%*
CSU Planning - 84%	**Yes**	**No**	**NA**	**%**
IRP/NCP addresses safety issues.	6	2	7	75%
Plan of Care discussed every 72 hours.	6	9	0	40%
Transition/Discharge Planning - 78%	**Yes**	**No**	**NA**	**%**
A discharge summary was entered into the ASO's ProviderConnect/ batch system within the required time following the individual's discharge.	3	12	0	20%
Individuals who are identified as homeless, a Need of Supportive Housing (NSH) survey is completed and referral for necessary residential supports.	1	2	12	33%

Is there evidence in the medical record of follow-up and connection to continuing care within 5 to 7 days post discharge.	2	5	8	29%
If the individual/youth was assessed to have recent suicidal ideation (within the last four months), their record has been flagged for high risk of suicide.	1	4	10	20%
Documentation supports that CSU staff have documented collaboration with 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 is flagged for high suicide risk upon discharge.	2	1	12	67%
CSU Crisis Service Center - 87%	**Yes**	**No**	**NA**	**%**
Documentation of attempts to de-escalate the crisis were contained within the medical record.	3	1	1	75%
For individuals seen in the Crisis Service Center but not admitted to the CSU, there is documentation of a discharge plan that includes linkage to appropriate after-care/follow-up services.	1	1	3	50%

Individual Record Review

Strengths and Improvements

- All individualized recovery plans (IRPs) were developed within 72 hours of admission.
- The provider followed their policy, along with completing Department of Behavioral Health and Developmental Disabilities (DBHDD) policy, for the one individual who was placed in seclusion and restraints. Seclusion and restraint was also listed on the individual's IRP.

The following were improvements from the previous Crisis Stabilization Unit Quality Review (CSUQR) in July 2024:

- Documentation reflected alternatives were explored for individuals who were discharged to homeless shelters. One individual was provided with resources to a long-term treatment program for substance abuse, but chose a homeless shelter instead of long term treatment.
- Licensed clinicians and medical staff at the Crisis Service Center completed crisis assessments within 24 hours, as clinically necessary.

Opportunities for Growth

CSU Planning

- IRPs did not address safety issues in two applicable records.
  - An individual who was admitted with homicidal ideations did not have this listed on their IRP.
  - An individual who had fall risk precautions ordered by the nurse practitioner (NP), did not have fall risk listed on their IRP.
- Treatment team was not held every 72 hours in nine of 15 records.
  - Additionally, treatment team documentation continued to contain duplicated/vague language in almost all records: "Client agrees with the current treatment plan as discussed with treatment team members" without further documentation as to the individual's progress/lack of progress, modifications to the IRP, etc.
  - This issue was identified in the previous review (7/2024).
  - Of note, one individual was documented as sleeping during the treatment team meeting. However, documentation detailed an active intervention in which the individual was engaged with the case manager (even though the note documented the individual was asleep during the treatment team meeting).
  - Content within the notes listed various multi-disciplinary team members were present, but the intervention only detailed the discussion between the individual and a case manager.
  - Treatment team notes in one record all stated "client agrees with the current treatment plan as discussed with treatment team members" with no further details or specifics including the treatment team meeting held the day of discharge.

Transition/Discharge Planning

- Discharge summaries were not entered into the ASO's ProviderConnect/batch system within the required 48 hour timeframe in 12 records.
- Two of three applicable individuals who identified as homeless did not have a Need of Supportive Housing (NSH) survey.
- Five records lacked evidence of follow-up and connection to continuing care within five to seven days post discharge. In all instances, there was no documentation to support contact with individuals was attempted and/or completed.
- Four of five applicable records were not flagged for high risk of suicide for individuals who were assessed to have suicidal ideation (SI) upon admission. For example, an individual who was admitted to the Crisis Stabilization Unit (CSU) in April 2025 presented with SI with a plan. The EMR was flagged as moderate risk only.
- Documentation lacked 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 was flagged for high suicide risk upon discharge in one of three applicable records in which the individual presented with suicidal ideation at admission.

Crisis Service Center

- In one record, there was no documented attempts to de-escalate an individual who presented in crisis nor was there documentation within their record showing there was any linkage to appropriate aftercare/follow-up services. The individual was seen in the CSC but not referred to the CSU for continued observation. There was no documentation regarding what was arranged for the individual upon discharge from the CSC.

Focused Outcome Areas

Focused Outcome Areas: 94%

Strengths and Improvements

- Documentation supported individuals were referred to Case Management (CM) and other health services when the need was indicated in 100% of records.
- Documentation demonstrated individuals' known preferences at discharge were followed to the extent possible. Examples included individuals who were discharged to their preferred outpatient facilities, long-term residential programs, and private practice.
- Documentation reflected individuals were educated on risk and benefits of all medications prescribed in 93% of records. This was an improvement from 60% in the previous CSUQR in July 2024.

Service Guidelines

1	Adult CSU Staffing Requirements Met	No
2	The Crisis Service Center staffing requirements met.	No
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.	Yes
6	Adherence to Medication Notification Policy	Yes
7	Protocols for Handling Licit and Illicit Drugs present	Yes
8	Adherence to Safe Storage of Medication Policy	Yes
9	Infection Control Plan Adherence	Yes
10	Seclusion & Restraint Policy Adherence	Yes
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**
	10	**3**	**1**	**77%**

Service Guidelines: 77%

Strengths and Improvements

- The Safe Storage of Medications policy and procedures were followed in it's entirety (i.e., daily temperature logs were completed and temperature logs were within range), an improvement from the last CSUQR in July 2024.
- The provider followed their policy, along with completing DBHDD requirements, when it came to the one individual who was placed in seclusion and restraints. Seclusion and restraint was also listed on the individual's IRP.

Opportunities for Growth

Adult CSU Staffing Requirements

- The BHCC did not have a CPS on site seven days per week between the hours of 8:00am-10:00pm. The months of March and May were missing 10 hours total, while the months of April and June were missing eight hours total.
    - Per the DBHDD Provider Manual, April 1, 2025, page 226, 8, "A CSU that functions as a component of a BHCC must employ a full-time peer specialist (MH, CPS-AD) during the hours of 8:00am and 10:00pm."

Crisis Service Center Staffing Requirements

- The CSC did not have a fully licensed clinician on staff at all times. The provider has one fully licensed clinician who is part-time. In April and June 2025, the clinician was on-site a total of 27 hours, and was not on-site in the month of May. The provider does not have a current waiver for a fully licensed behavioral health clinician.
    - Per the April 1, 2025, DBHDD Provider Manual, page 223, A, 1, "At minimum, staff must include a fully licensed behavioral health clinician onsite at all times."

Staff Credentialing

- During this CSUQR, five personnel records were reviewed for credentialing. All staff reviewed were registered nurses (RNs).
    - One RN was missing evidence of current certification in cardiopulmonary resuscitation (CPR).
    - Although it did not impact scoring, it is noted four of the five staff reviewed were hired prior to completion of a DBHDD-approved background check. For example, an RN was hired in April 2022 but the DBHDD-approved background check was not completed until October 2023.

Crisis Stabilization Unit Site Visit Observations

Crisis Service Center

- A peer support specialist continued to support individuals during the registration process.
- The resource center was stocked with updated recovery and assistance pamphlets.
- Individuals are encouraged to complete a satisfaction survey via agency computer at discharge.

Temporary Observation Unit:

- The census at the time of the tour was one.
- Three of the six recliners were recently replaced and another three are on order, an improvement since the last review in 7/2024.

Crisis Stabilization Unit

- The current census at the time of the tour was 24.
- The bedrooms were gender-separated and double/triple occupancy rooms.
- The CSU has increased security enhancements and added more security cameras since the review in July 2024. They now have a total of 35 cameras.
- The emergency food and water supplies were neatly organized with visible expiration dates.
- The kitchen/cafeteria food score was 100% as of 5/29/2025.
- The medication refrigerator was 40 degrees Fahrenheit.

Ongoing Issues Noted from Previous CSUQR (7/2024):

- There continued to be mold in both the male and female bathroom shower stalls.
- Tiles were either missing or broken in the male bathroom.
- Damage to the walls was evident in both the male and female bathrooms.

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.

- A discharge summary was created and signed by a staff member on 4/18/25 but the individual did not discharge until 4/21/25.
- In some records the individual's preferred gender pronoun was not consistently documented within the IRPs and discharge summaries when referencing the individual.

Individual Interviews

Individual Interviews Conducted: 3

Three individuals were interviewed during this review. All reported:

- being offered options for support and services.
- they felt supported in moving toward their desired goals.
- staff followed up on any expressed whole health related needs and requested assistance.

When asked, *"What are some things this agency does exceptionally well?"* The individuals shared,

- *"This is the first place I really feel safe. I feel very comfortable. I can joke around with the staff. They are really friendly."*
- *"Staff are very nice. I know I will get help when I come here."*
- *"The people who work here really have a heart for people who come here."*

Quality Improvement Requirements

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 requirements below.

Requirements: Current and Prior Review

Individual Record Review - Transition/Discharge Planning

- Discharge summaries must be entered into the ASO's ProviderConnect/batch system within 48 hours of discharge.
- A Need of Supportive Housing (NSH) survey should be completed, and a referral made, for necessary residential supports for all individuals identified as homeless.
- CSU staff must collaborate care with the aftercare provider.

Compliance w/Service Guidelines - Crisis Stabilization Services

- The adult Crisis Stabilization Unit must meet all staffing requirements.
- All staff credentialing criteria/requirements must be met.

Requirements: Current Review

Individual Record Review - CSU Planning

- Each individual's NCP/IRP must be discussed a minimum of once every 72 hours with the treatment team.
- Suicidality must be addressed on the NCP/IRP for Individuals assessed as having any suicide risk.

Individual Record Review - Transition/Discharge Planning

- The medical record must reflect follow-up and connection to continuing care within 5 - 7 days post discharge.
- Records must be flagged for high risk of suicide for individuals assessed to have recent suicidal ideation.

Individual Record Review - Crisis Service Center

- Documentation of attempts to de-escalate any crisis must be contained within the medical record.
- Individuals seen in the Crisis Service Center, but not admitted to the CSU, must include documentation of a discharge plan that includes linkage to appropriate aftercare/follow-up services.

Compliance w/Service Guidelines - Crisis Stabilization Services

- The Crisis Service Center must meet all staffing requirements.

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/