Georgia Department of Behavioral Health and Developmental Disabilities
Division of Strategy, Technology, and Performance
Office of Incident Management and Compliance
Crisis Stabilization Unit (CSU) Review Tool

This tool outlines criteria evaluated during compliance reviews conducted by the Department of Behavioral Health and Developmental Disabilities (DBHDD) for CSU services as outlined in policy.
CSU: General Certification Requirements, 01-326

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ADULT CRISIS STABILIZATION UNIT (ADULT CSU)

Criteria Chapter	Number	Criteria
12.01	1	Each agency develops and implements a continuous quality improvement (CQI) policy which is reviewed and updated annually. The CQI policy must contain information specific to the operations of the CSU and BHCC.
12.01	2A	The policy specifically addresses the following areas of risk to individuals served, at a minimum: 1) High-risk situations and special cases (such as suicide, death, serious injury, violence, and abuse of any individual) initiate review within twenty-four (24) hours; 2) Medical emergencies; 3) Medication management; 4) Infection control; 5) Emergency safety interventions including any instances of seclusion or restraint are reviewed within twenty-four (24) hours; 6) Environmental safety and maintenance, including an environment scan which assesses risk for individuals served by or working in the CSU facility, and identified strategies and subsequent plans for mitigating those risks; 7) Clinical outcome measures; 8) Appropriate utilization of personnel to include competency, qualifications, numbers and type of staff, and staff to individual ratios; 9) Unexpected or unusual circumstances or trends that lead to health and safety issues or noncompliance with DBHDD standards; and 10) Use of internal mechanisms to document, investigate and take appropriate action for complaints and incidents which are not required to be reported to DBHDD.
12.01	3	The CQI policy identifies mechanisms that use performance measures and data collection that continually assess and improve the quality of the services being delivered.
12.01	4	The CQI policy includes the documentation of quarterly records reviews, which are kept on file for at least two (2) years. The CSU and BHCC have a standard records review form.
12.01	5	The CSU and BHCC have a CQI committee which submits a quarterly report to the nursing administrator, medical director, agency CEO, and governing body for their review and appropriate action, and such appropriate action is conducted timely.
12.01	6	Incidents and Safety Plans are entered into the incident database within the time frames outlined in DBHDD policy.
12.02	1A	A CSU must employ a full-time Nursing Administrator who is a Registered Nurse.
12.02	2A	For every 30 beds, there is one RN present at all times.
12.02	3	The ratio of nursing staff and unlicensed assistive personnel to individuals is not less than 1:8 (excluding the charge nurse).
12.02	5A	At all times there are at least three (3) staff (with at least one being a RN) present within the CSU.
12.02	6A	The ratio of nursing staff and unlicensed assistive personnel to individuals increases on the basis of the clinical care needs of the individual, including required levels of observation for high risk individuals.
12.02	7A	If a nurse is assigned a 1:1 support role, then he/she is not counted in the 1:8 ratio, an additional nurse is required during the 1:1 time period

12.02	8	The CSU has a registered nurse (RN) present within the CSU twenty-four hours a day, seven days a week who is the charge nurse for the CSU. If the charge nurse is an APRN, then he/she may not simultaneously serve as the provider during the same shift.
12.02	9	A physician, psychiatrist or physician extender is on call twenty-four hours a day. The physician need not be required to be on site twenty-four hours a day; however, the physician must respond to staff calls immediately (delay not to exceed one (1) hour). A physician or psychiatrist must make in-person rounds, for every admitted individual, once daily, seven days a week.
12.02	10	The functions performed by staff whose practice is regulated or licensed by the State of Georgia are within the scope allowed by State law and professional practice acts.
12.02	11	The CSU has procedures for verifying licenses, credentials, experience, and competence of staff, which procedures ensure that: (a) Licenses and credentials of all staff members are current as required by the licensing and accrediting agencies responsible for issuing the staff members' respective licenses and accreditations.; (b) All persons providing services comply with all applicable laws, rules and regulations regarding professional licenses, qualifications and requirements related to the scope of practice.
12.03	1	The provider must detail in its policies and procedures, by job classification, the following: (1) training required during orientation; (2) training that must be refreshed annually; (3) additional training required for professional level staff; and (4) additional training/recertification (if applicable) required for all other staff.
12.03	2A	Providers develop a detailed annual training plan that describes suicide prevention training. Components of this plan must minimally include: (1) Training for staff on any CSSRS measure they will be administering, including the CSSRS Screen Version Recent; the SAFE-T Protocol with CSSRS (Columbia Risk and Protective Factors) Lifetime/Recent Adult; the SAFE-T Protocol with CSSRS (Columbia Risk and Protective Factors) Lifetime/Recent Youth; and the Full Scale Since Last Contact for Healthcare and Communities. (2) Training in Assessing and Managing Suicide Risk (AMSR) or Safeside for clinical staff within three (3) months of hire. Documentation of training is maintained in the personnel file. At the discretion of the employer, existing proof of completed AMSR or Safeside training may be accepted upon hiring. (3) Training for non-clinical staff upon hire to build proficiency in an evidence-based basic gatekeeper training program to enhance awareness and vigilance around the signs of suicide (e.g., Question, Persuade and Refer (QPR), and Safetalk).
12.03	3	The CSU has documentation of an annual training plan that ensures that each and every staff member who delivers therapeutic content is trained annually in at least one (1) clinical/programmatic content topic related to the delivery of care.
12.09	17	The provider develops and follows policies and procedures (including the roles of the team members) for implementing prevention strategies or interventions for individuals experiencing higher level of clinical risk to include suicidality, psychosis, self-harming, and/or homicidality. Policies and procedures identifying the appropriate levels of observation for individuals determined to be clinically at a heightened risks.

12.04	4	The CSU/BHCC maintains safety equipment to include an Automatic External Defibrillator (AED) and all other necessary medical safety supplies.
12.04	5	Any CSU or BHCC that processes laboratory tests on-site must provide documented evidence of a current Clinical Laboratory Improvement Amendment Waiver for that specific location.
12.05	21	The CSU and BHCC policies and procedures provide for daily checks of and the maintenance of temperature logs for all medication room refrigerators. Temperatures for the refrigerator are set between 36°F to 41°F.

12.05	22	Requirements for safe storage of medication are as required by law includes: (1) Single and double locks; (2) Shift counting of the medications, (3) Individual dose sign-out recording; (4) Documented planned destruction.
12.05	23	The CSU and BHCC have a process to identify, track and correct deviations in medication prescribing, transcribing, dispensing, administration, documentation, or drug security of ordering or procurement of medication that results in a medication error or variance.
12.05	24	There is documented oversight by the medical director for the accounting of and dispensing of sample medications.
12.05	25	The CSU and BHCC may keep emergency drug kits in accordance with Georgia Rules and Regulations 480-24-.08.
12.05	26	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement.
12.05	27	The CSU and BHCC policies and procedures describe actions to follow when drug reactions and other emergencies related to the use of medications occur, and emergency medical care that may be initiated by a registered nurse to alleviate a life-threatening situation.
12.06	24A	The CSU must have documented operating agreements and referral mechanisms for psychiatric disorders, substance use disorders, and physical healthcare needs that are beyond the scope of the CSU and that require inpatient treatment. Operating agreements must delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility. These agreements must specifically address the criteria and procedures for transferring an individual to a designated treatment facility when the CSU is unable to stabilize the individual. Every such operating agreement is updated, at a minimum, every five (5) years as evidenced by date and signatures on the agreement document.
12.06	25A	Program offerings for the CSU are designed to meet the biopsychosocial stabilization needs of each individual, and the therapeutic content of the program (group therapy/training, individual therapy/training, education support, etc.) are annually approved by a medical and clinical leadership team. This annual review is documented by signature and date of review and by participating leadership.
12.07	8	At least 3 nutritious meals per day are served. No more than 14 hours may elapse between the end of the evening meal and the beginning of the morning meal.
12.07	9	Nutritional snacks are available for all individuals between meals.
12.08	15	The CSU or BHCC develops and implements policies regarding law enforcement involvement that protects the health and safety of staff and individuals served. Law enforcement should not be used as a means of behavioral health management or treatment. There must be a debriefing after any instance involving law enforcement.

12.1	2A	The CSU and BHCC documents monthly fire drills that are rotated so that each shift has at least one (1) drill quarterly. At least one (1) fire drill per quarter occurs during sleeping hours. Documentation of drills include details of the drills, including not limited to the type, location, staff involved, time of day and time taken to complete the drills. When the drills fail to meet the standard for fire and disaster safety. follow up recommendations are documented and implemented accordingly.
12.1	3A	The CSU and BHCC documents quarterly disaster drills for disasters such as flood, tornado, and hurricane. Documentation must include details of the drill, including not limited to the type, location, staff involved, time of day and time taken to complete the drills. When the drills fail to meet the standard for fire and disaster safety, follow up recommendations are documented and implemented accordingly.
12.1	4	The CSU and BHCC has directions for evacuation of the CSU utilizing posted evacuation routes. There is preparation of the individuals served by the CSU for evacuation.
12.1	5	There are monthly fire extinguisher inspection, and documentation of every inspection, and recharging as indicated.
12.1	6	There are annual inspections of other safety mechanisms such as sprinklers, smoke alarms, emergency lights, kitchen range/hood, etc., and documentation of all inspections by proper officials.
12.1	7	The CSU maintains a three-day supply of non-perishable emergency food and water at all times for the maximum bed capacity.
12.1	8	Off-site evaluation plans are confirmed with the evacuation facility annually to confirm it is available and appropriate for evacuation. Confirmation is maintained in writing from the evacuation facility.
12.11	1A	The infection control risk assessment and plan are reviewed annually for effectiveness and revised, if necessary by the appropriate clinical staff responsible for infection control. The practices are based upon a cited expert source (such as the U.S. Centers for Disease Control and Prevention) and updated annually to ensure the procedures reflect evolving standard practice.
12.11	2A	The policies developed, maintained, and implemented by CSUs and BHCCs include, at a minimum: a) Standard precautions are defined, and training is provided on the use of personal protective equipment when handling blood, body substances, excretions and secretions; and d) Prevention and treatment of needle-stick or "sharps" injuries. The policies describe prevention and management of common illnesses such as, but not limited to: Methicillin-Resistant Staphylococcus Aureus (MRSA), colds and influenza, gastrointestinal viruses, and Pediculosis (lice), scabies, and tinea pedis, etc. The policies describe specific procedures to manage infectious diseases, including but not limited to Tuberculosis, Hepatitis B, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), Coronavirus or other infectious diseases.

12.11	3	The CSU and BHCC has immediately available a quantity of clean bed linens and towels, etc., essential for the proper care of individuals at all times in sufficient numbers for full capacity.
12.11	4	The CSU and BHCC has collection, sorting, and cleaning procedures which are designated to prevent cross-contamination of the environment, individuals served, and personnel.
12.11	5	Hand washing facilities provided in the kitchen, bathroom, examination and medication areas include hot and cold running water, soap dispensers, disposable towels and/or hand blowers.
12.11	6	The CSU has consistently available drinking water for individuals' access using mechanisms which meet general expectation of infection control procedures.
12.11	7	Staff maintain the mechanical restraint devices in proper working order and keep them clean and sanitary, following the manufacturer's recommendations for cleaning.
12.12	1	A seclusion or restraint room must meet the following standards: The door to the room opens outward.
12.12	2	The floors and walls, up to a height of 3 feet, are finished to resist penetration of body fluids and are constructed of high impact sheet rock.
12.12	3	At least one identified room used for seclusion or restraint has a bed commercially designed for use with restraints that is bolted to the floor and without sharp edges. The surface of the bed is impermeable to resist penetration by body fluids.
12.12	4	A seclusion or restraint room must meet the following standards: The room is maintained at a comfortable temperature, properly vented, and free of respiratory irritants.
12.12	5	A seclusion or restraint room must meet the following standards: The room presents no ligature risks. The room is free from hazardous conditions.
12.12	6	The bed placement in the seclusion or restraint room provides adequate space for staff to apply restraints and does not allow individuals to access the lights, smoke detectors or other items that may be in the ceiling of the room.
12.12	7	Rooms used for seclusion or restraint provides staff full visual access to the individual and includes a vision panel installed in the door or a window that allows for full visual access to the individual. Glass needs to be tempered and free of risk of access to broken glass.
12.12	8	Where the interior of the seclusion or restraint room is padded, the padding is in good repair and is fully intact and secured to the wall in a manner that is safe for individuals (i.e. not stapled).
12.12	9	The CSU uses the restraint devices specific to the individual's height, weight and body mass.
12.12	10	Only beds suitable and appropriate for use with restraints are utilized in conjunction with mechanical restraints. The restraint devices are designed to be used on the restraint bed. When a restraint bed is in use, there are no bed linens.

12.12	11	For CSUs which apply for certification on or after March 29, 2015, the privacy of the person is protected by the seclusion or restraint room location either being not visible from the common areas, or if visible, the seclusion or restraint room is constructed to be offset from main thoroughfares and afford restricted visibility to the interior of the room.
12.13	1	The CSU has policies and procedures to routinely check and document the hot water temperature at various outlets throughout the CSU and to correct any variance from the standard temperature if needed.
12.13	2	The CSU maintains an environment that is clean, in good repair, safe, and free of items that could be used for self-harm.
12.13	3	The CSU is a locked facility.
12.13	4	Except as otherwise provided by law, weapons are prohibited. The facility posts notices regarding the prohibition of weapons at all entrances and has written protocols addressing the same.
12.13	5A	The CSU and BHCC have control of potentially harmful and contraband items as clearly defined in their policy and ensures proper management of such items. This control includes, but is not limited to: (a) Flammables, toxins, ropes, wire clothes hangers, sharp-pointed scissors, razors, luggage straps, belts, knives, shoestrings, pharmaceuticals, glass or other potentially injurious items. All items will be reviewed for return to the individual upon discharge; (b) Management of housekeeping supplies and chemicals, including procedures to avoid access by individuals during use or storage. Whenever practical, supplies and chemicals are non-toxic or non-caustic; (c) Safeguarding the use and disposal of facility's nursing and medical supplies including medications, needles and other "sharps" and breakable items.
12.13	7A	The interior of the CSU is non-smoking: If the Adult CSU offers smoking, the facility designates a sheltered, outside space as a smoking area.
12.13	8	Entrances and exits, sidewalks and escape routes are constantly maintained free of all impediments and hazards.
12.13	9	If the CSU is equipped with electronic locks on internal doors or egress doors, the CSU ensures that such locks have manual common key mechanical override that will operate in the event of a power failure or fire.
12.13	10	The CSU has a pre-admission waiting area, including restrooms, that meets all safety requirements applicable to designated individual areas.
12.13	11	The CSU has a secure area where individuals, including those being evaluated on an involuntary basis, can be held awaiting evaluation and/or observation prior to an admission determination being made.
12.13	12	The CSU has a screening area with the capacity to be locked where searches can be done in a private and safe manner, respecting individuals' rights and privacy.
12.13	13	The CSU has an exam room where examinations and lab procedures are conducted safely while respecting the individuals' confidentiality.
12.13	14	The general architecture of the CSU, along with tools and technology, provides for optimal line-of-sight observations from the nurses' station throughout the unit, mitigating hidden spots and blind corners.

12.13	15	Each furnishing, item of hardware, fixture, or protrusion of the CSU is: (a) Designed to release from its fixings to prevent a ligature if an abnormal load is applied, or the item is fixed in place; however, is free from points where a cord could be fastened to create a ligature point; (b) Made of materials which mitigate the risk of use as weapons or for self-harm (hanging, cutting, etc.); (c) Intact and functional; (d) Maintained in good condition; and (e) Tamper resistant.
12.13	16	Lighting fixtures are recessed and tamper resistant with Lexan or other strong translucent materials.
12.13	17	The ceiling and air distribution devices, light fixtures, and sprinkler heads, and other appurtenances are tamper-resistant. For CSUs who apply for certification after 3/29/15, sprinklers are flush mounted on ceilings less than 9 feet. Sprinklers have institutional heads that are recessed and drop down when activated.
12.13	18	Light switches and electrical outlets are secured with tamper-resistant type screws.
12.13	19	Security and safety devices are mounted, installed and secured in a matter that mitigates the risk of use as weapons or for self-harm, prevents interference, and prevents any attempt to render inoperable with its purpose as a security device.
12.13	20	Windows are protected with Lexan or other shatter-resistant material that will minimize breakage. Bedroom windows may be textured to provide privacy without the use of curtains or blinds.
12.13	21	The CSU is equipped and maintained so as to provide a sufficient amount of hot water for individuals' use. Heated water provided for individuals' use is maintained between 110°F and 120°F.
12.13	22	Beds and other heavy furniture capable of use to barricade a door are secured to the floor or wall.
12.13	23	The CSU maintains the environmental temperature between 65 degrees F and 82 degrees F.
12.13	25	The CSU has gender specific bathrooms with proper ventilation.
12.13	26	Exposed plumbing pipes are covered to prevent individuals' access.
12.13	27	The CSU has a minimum ratio of one (1) shower for each six (6) individuals receiving services and one (1) toilet and lavatory for each six (6) individuals receiving services; Individual shower stalls and dressing areas are provided.
12.13	28	Mirrors are not common glass and must be fully secured and flat mounted to the wall.
12.13	29	Overhead rods, fixtures, privacy stalls, supports or protrusions are selected and installed in a manner which mitigates the risk of use of weapons or for self-harm (hanging, cutting, etc.). If the physical plant space of the CSU is prohibitive of this, there are written policies and protocols to monitor and reduce this risk with supporting evidence of compliance to these policies and protocols. The toilet is secured and tamper resistant.

12.13	30	The CSU has an outdoor area that is (a) age appropriate; enclosed by a privacy fence no less than six (6) feet high, where individuals have access to fresh air and exercise. It provides privacy from public view and does not provide access to contact with the public; (b) This area is constructed to retain individuals inside the area and minimize elopements from the area; and (c) The fenced area is designed for safety without blind corners to be readily visible by one staff member standing in a central location, and designed to minimize elopement.
12.13	31	The CSU must have procedures and precautions in place to minimize ligature and safety risk for all recreational equipment.
12.13	32	The CSU has a bathroom facility that is in compliance with the Americans with Disabilities Act (ADA) for use by individuals with physical disabilities. It includes a toilet, lavatory, shower and flush-mounted safety grab bars.
12.13	33	The CSU has facilities accessible to and usable by physically disabled individuals.
12.13	34	The CSU has at least one (1) operable, non-pay telephone which is private and accessible at reasonable times for use by the individual.
12.13	35	Upon request, the CSU provides a means of locked storage for any individual's valuables or personal belongings.
12.13	36	The CSU provides laundry facilities on the premises for the individual's personal laundry.
12.13	37	The CSUs maintain a daily temperature log for the freezer(s) and refrigerator (s): (a) Temperature for the refrigerator is set between 34°F and 41°F. (b) Temperature for the freezer is set between 0°F and 10°F.
12.13	38	The CSU has a sufficient designated area to accommodate meal service. The eating area may double as a group or activity area.
12.13	39	Foods, drinks and condiments are dated when opened and discarded when expired.
12.13	40	To prepare food on-site, CSUs must have a satisfactory food service permit score. A copy of the current food service permit score must be on file at the CSU.
12.13	41	Off-site food preparation: (1) CSUs may utilize meal preparation services from an affiliated or contracted entity with a current food service permit (the "food service entity"); (2) CSUs enter into a formal written contract between the CSU and the contracted food service entity, containing assurances that the contracted food service entity meets all food service and dietary standards set forth in this policy; (3) CSUs that elect to have meals prepared off-site have a modified kitchen that includes a microwave, a refrigerator, an ice maker, and clean-up facilities.
12.03	4	An eligibility letter must be obtained before an applicant who will provide direct care services can start working for a DBHDD network provider.

12.03	5	Within the first 60 days from date of hire, all staff having direct contact with individuals receive the following training, at a minimum: (1) Person centered values, principles, and approaches; (2) Holistic approach to treatment of the individual; (3) Medical, physical, behavioral, and social needs and characteristics of the individuals served; (4) Human rights and responsibilities; (6) The utilization of: (a) communication skills; (b) Crisis intervention techniques to de-escalate challenging and unsafe behaviors, and (c) Nationally benchmarked techniques for safe utilization of emergency interventions of last resort; (7) Ethics, cultural preferences, and awareness; (8) Fire safety; (9) Emergency and disaster plans and procedures; (10) Techniques of Standard precautions, including: (a) Preventative measures to minimize risk of HIV; (b) Current information as published by the Centers for Disease Control (CDC); and (c) Approaches to individual education; (11) Current CPR/AED through the American Heart Association, Health & Safety Institute, or the American Red Cross; (12) First aid and safety training required for all staff as indicated â€¦ (13) Specific individual medications and their side effects; (14) Services, support, and treatment specific topics appropriate persons served, such as but not limited to: (a) Symptom management; (b)Principles of recovery relative to individuals with mental illness; (c) Principles of recovery relative to individuals with addictive disease; (d)Principles of recovery and resiliency relative to children and youth; and (e) Relapse prevention.
12.03	6	On an annual basis, staff must demonstrate their competencies in: (1) Techniques to identify staff and individual behaviors, events, and environmental factors that may trigger emergency safety situations; (2) The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and (3) The safe use of seclusion and the safe use of restraint, including the ability to recognize and respond to signs of physical distress in individuals who are in seclusion or restrained.
12.03	7A	Staff may not administer and score/rate the CSSRS until they have completed DBHDD approved training which is the Columbia Lighthouse training.
12.03	8A	Training occurs for non-clinical staff upon hire to build proficiency in an evidence-based basic gatekeeper training program to enhance awareness and vigilance around the signs of suicide (e.g., Question, Persuade and Refer (QPR), and Safetalk).
12.03	9A	Training in Assessing and Managing Suicide Risk (AMSR) or Safeside for clinical staff occurs within three (3) months of hire. Documentation of training is maintained in the personnel file. At the discretion of the employer, existing proof of completed AMSR or Safeside training may be accepted upon hiring.
12.03	10	All CSU staff who work with individuals must receive training on the seclusion or restraint policy in new employee orientation and annually thereafter
12.03	11	All CSU staff who work with the individuals served are certified in a nationally benchmarked technique for safe utilization of emergency interventions of last resort (if such techniques are permitted in the purview of the organization).

12.03	12	Only staff who have current training and competency in the use of seclusion and restraint are authorized to provide the monitoring and documentation for individuals in seclusion or restraint.
12.03	13	All physical searches (whether pat-down searches or personal/strip searches) are conducted by staff members who are trained in search procedures.
12.03	14	All staff are trained on standard precautions at the time of hire and annually thereafter.
12.04	1	Laboratory and other diagnostic procedures must be performed as ordered by a prescriber.
12.04	2	Individuals on medications likely to cause tardive dyskinesia are monitored at prescribed intervals using an Abnormal Involuntary Movement Scale (AIMS testing).
12.04	3	Therapeutic diets are provided when ordered by a physician.
12.05	1A	The CSU and BHCC ensures every order given by telephone is received by an RN or LPN and is recorded immediately as a telephone order with the ordering physician's name, date and time and is reviewed and signed by a physician within twenty-four (24) hours.
12.05	2	A valid physician's order must contain the individual's name, name of the medication, dose, route, frequency, special instructions (if needed) and the physician's signature.
12.05	3	A five (5) day supply of medications is prescribed and dispensed when individuals are discharged from the CSU. Less than a five (5) day supply may be given only when there is; documentation by the discharging physician of a safety issue and/or a verified outpatient physician appointment is scheduled within five (5) days of discharge and transportation for this appointment is assured.
12.05	4	The CSU and BHCC ensures access to pharmacy services for prescription medications within eight (8) hours of the physician's order.
12.05	5	STAT medication not maintained in the CSU and BHCC must be available for administration within one (1) hour of the order to give the medication.
12.05	8	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right: Right medication: includes verification of the medication order with the label on the prescription drug container and the MAR entry to verify that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member. The medication is inspected for expiration date. Insulin must be verified with another person prior to administering.
12.05	9	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right: Right time: includes the times the provider schedules medications, or the specific physician's instructions related to the drug.

12.05	10	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right: Right dose: includes verification of the physician's medication order of dosage amount of the medication; with the label on the prescription drug container and the Medication Administration Record entry to ensure that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member. The amount of the medication should make sense as to the volume of liquid or number of tablets to be taken.
12.05	11	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right: Right route: includes the method of administration.
12.05	12	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right: Right documentation includes proper methods of the recording on the MAR.
12.05	13	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right: Right to refuse medications: includes staff responsibilities to encourage compliance, document the refusal, and report the refusal to the administration, nurse administrator, and physician.
12.05	14	An MAR is in place for each calendar month that an individual takes or receives medication.
12.05	15	A listing of all medications taken or administered during that month including a full replication of information in the physician's order for each medication: (a) Name of the medication; (b) Dose as ordered; (C) Route as ordered; (d) Time of day as ordered; and (e) Special instructions accompanying the order, if any.
12.05	16	If the individual is to take or receive the medication more than one time during one calendar day, each time of day must have a corresponding line that permits as many entries as there are days in the month.
12.05	17	All lines presenting days and times preceding the beginning or ending of an order for medications are marked through with a single line.
12.05	18	When a physician discontinues (D/C) a medication order, that discontinuation is reflected by the entry of "D/C" at the date and time representing the discontinuation followed by a mark through of all lines representing days and times that were discontinued.
12.05	19	When "PRN" or "as needed" medication is used, the PRN medications shall be documented on the same MAR after the routine medications and clearly marked as "PRN" and the effectiveness is documented.
12.05	20	Each MAR shall include a legend that clarifies: (1) Identity of authorized staff initials using full signature and title; (2) Reasons that a medication may be not given, is held or otherwise not received by the individual.
12.05	28	Medications are used solely for the purpose of providing effective treatment and are not used as punishment, convenience of staff, or as chemical restraint.

12.06	1A	The CSU does not admit individuals presenting with issues listed under "Exclusion Criteria" according to DBHDD policy 01-350, CSU: Medical Evaluation Guidelines and Exclusion Criteria for Admission to CSUs.
12.06	3	A physician assesses each individual within twenty-four (24) hours of admission to the CSU, documents the findings of the assessment(s), and writes orders for care. Orders for care include the clinically appropriate level of observation for the individual.
12.06	6	The IRP is developed within 72 hours of admission on the basis of assessments conducted by the physician, RN, or professional social work or counseling staff.
12.06	7A	The IRP is developed in collaboration with the individual, and includes the following: (a) A problem statement or statement of needs; (b) Goals that are realistic, measurable, consistent with the individual's needs, linked to symptom reduction, and attainable by the individual during the individual's projected length of stay; (c) Objectives, stated in terms that allow measurement of progress, that build on the individual's needs and strengths; (d) Specific treatment offerings, methods of treatment, and staff responsible to deliver the treatments. There is evidence of involvement by the individual, as documented by his or her signature, or by documentation of the individual's inability or refusal to sign. There are signatures of all staff participating in the development of the plan.
12.06	8	For an individual with co-occurring substance abuse, mental health and I/DD diagnoses the plan must address issues specific to each diagnosis to include clinically appropriate treatment interventions; SA groups and aftercare linkage.
12.06	18A	The IRP is reviewed at a minimum of every 72 hours by the treatment team to assess the need for the individual's continued stay in the CSU. The plan is updated as appropriate when the individual's condition or needs change.
12.06	19	The CSU ensures documentation at least once per day by an RN as to the status of the individual.
12.06	21	The physician conducts an assessment of the individual at the time of discharge.
12.06	23A	Discharge summary information is provided to the individual at the time of discharge and includes: (a) criteria describing evidence of stabilization and discharge planning; (b) significant findings relevant to the individual's recovery; (c) specific instructions for ongoing care; (d) individualized recommendations for continued care to include recovery supports and community services (if indicated), and (e) contact information on acquiring access to community services.
12.07	1	The CSU and BHCC documents the legal and clinical basis for the individual's continued admission to the CSU and BHCC, whether voluntary or involuntary, consistent with all applicable state and federal laws, rules and regulations.
12.07	2	The CSU and BHCC documents the legal and clinical basis for the individual's continued admission to the CSU and BHCC, whether voluntary or involuntary, consistent with all applicable state and federal laws, rules and regulations.
12.07	3	The CSU and BHCC maintains a record of voluntary or involuntary status change, including the date and time of such change.

12.07	4	The CSU and BHCC ensures the documentation of the assessment of the individual's capacity to understand and exercise the rights and powers of voluntary admission.
12.07	5A	The CSU and BHCC uses specific DBHDD legal forms to document any of the above mentioned actions. These forms are Form 1013, 2013, 1014, 1009 & 1012, and 1011.
12.07	6	Staff conducts a pat-down search of each individual, his or her clothing, and all personal effects before admission to the unit.
12.07	7	Personal searches of individuals (e.g., strip searches) are to be performed only for cause and if ordered by the physician. The rationale for a personal search must be clearly documented in the order. Sequential steps of the search, including documentation of staff involved by name and title, are recorded in the progress notes section of the clinical record. Neither the CSU nor the physician may require mandatory removal of clothing for all individuals, or allow standing orders for personal searches of all individuals.
12.08	1	The following practices are prohibited: (a) The use of chemical restraint for any individual. (b) The combined use of seclusion and prone mechanical and/or manual restraint. (c) Standing orders for seclusion or any form of restraint. (d) PRN orders for seclusion or any form of restraint. (e) Prone manual or mechanical restraints. (f) Transporting an individual face down while being carried or moved. (g) Use of seclusion or restraint as a part of a Behavior Support Plan (BSP) or an Individual Recovery Plan (IRP). (h) The use of handcuffs for an individual not under the jurisdiction of the criminal justice system. (i) The use of medication as a chemical restraint.
12.08	2	An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior as well as the individual's chronological and developmental age, size, gender, physical, medical, psychiatric condition, and personal history (including any history of physical or sexual abuse).
12.08	3	Initiation and Authorization of Seclusion or Restraint: (a) If the physician or other LIP who is responsible for the care of the individual and is authorized to order seclusion or restraint is available, only he or she can order the utilization of seclusion or any form of restraint. (b) If the physician or other LIP who is responsible for the care of the individual is unavailable, his or her designee or other LIP who is authorized to order seclusion or restraint may order the utilization of seclusion or restraint. (c) The physician or other LIP conducts an assessment prior to the initiation and authorization of seclusion or restraint and documents the assessment using Nursing Evaluation and Physician/LIP Order Form for Seclusion or Restraint in Crisis Stabilization Services.
12.08	4	The following pertains in Emergency Safety Situations (as defined in Definitions section above) when it is not possible to obtain orders in advance from a physician or other LIP: When a seclusion or restraint is initiated without an order by a physician or Licensed Independent Practitioner, the order will be obtained within thirty (30) minutes.

12.08	5A	The physician or LIP who is primarily responsible for the individual's ongoing care, or in his or her absence, the physician or LIP's designee or other LIP, sees the individual face to face or via video-equipped telemedicine and evaluates the need for seclusion or restraint within one (1) hour of initiation of seclusion or restraint. This requirement applies regardless of whether the seclusion or restraint has already been discontinued. If more than one episode of seclusion or restraint occurs, the physician or other LIP must complete the evaluation within one hour of each order.
12.08	6	As part of [the seclusion or restraint episode] evaluation, the physician or LIP: (i) Considers information that was obtained during the assessment regarding risk for the individual associated with use of seclusion or any form of restraint; (ii) Reviews the individual's current physical and psychological status, as well as all information relative to their status prior to the implementation of seclusion or restraint; (iii).Assesses the appropriateness of the seclusion or restraint used, and determines whether seclusion or restraint needs to be continued, if not already discontinued; (iv). Assesses any complications resulting from the seclusion or restraint; (v). Provides guidance to staff and the individual to identify de-escalation strategies and coping skills to help the individual regain control so that the intervention can be discontinued. (vi). Revises the individual's plan of care, treatment and services as needed; (vii) If necessary, provides a new written order; (viii) Completes documentation of the evaluation on Nursing Evaluation and Physician/LIP Order Form for Seclusion or Restraint in Crisis Stabilization Services (Attachment B).
12.08	7	For individuals aged 21 and over, with the approval of the Medical Director, orders for 2-point ambulatory wrist-to-waist restraints may be ordered for up to 4 hours and reassessed for a second order if needed for a total of 8 hours in extreme cases, where an individual's level of aggression is so severe and unpredictable, ambulatory restraint when out of room, is the only option to avoid having the individual in prolonged seclusion or non-ambulatory restraints. The individual must be re-assessed every 2-hours to determine if the order is still needed.
12.08	8	The Charge Nurse or other designated staff provide one-to-one observation of the individual throughout the period of seclusion or restraint. Video monitoring is not allowed as a substitute for personal monitoring of an individual who is in seclusion or restraint. The staff member personally monitors the individual and documents this monitoring of the individual on the Seclusion or Restraint Monitoring Form for Crisis Stabilization Services.

12.08	9	Documentation occurs at least every fifteen (15) minutes regarding the following (as appropriate for the type of intervention): (a) Checking individual's physical and psychological status and comfort by speaking with or to the person. (b) Check and attend to the individual's hygiene and toileting needs. (c) Checking the individual for signs of injury associated with the implementation of seclusion or restraint. (d)If restrained, checking vital signs at least every 30 minutes, with ongoing monitoring of other physical or behavioral indications for signs of physical distress. (e) If restrained, checking circulation every 15 minutes, including looking for signs of swelling or abrasions.(f) If restrained, checking range of motion of extremities; (g) Attention to individual's nutrition and hydration; (h) Monitoring the individual's readiness to discontinue the intervention; (i) In addition, the Registered Nurse conducts an evaluation of the individual at least every 1 hour during the time the person is in seclusion or restraint. This evaluation is documented by the nurse on the Seclusion or Restraint Monitoring Form for Crisis Stabilization Services.
12.08	10	As soon as the emergency safety situation has ceased and the individual's safety and the safety of others can be ensured, the individual is released from seclusion or restraint even if this is prior to the arrival of the physician or other LIP. Orders never exceed two (2) hours for individuals ages 9 and older; one (1) hour for children under age 9.
12.08	11	Debriefing with the individual occurs as soon as possible after the episode of seclusion or restraint. The individual (and if appropriate, their family) participate with staff members involved in the episode (who are available) in a debriefing about the episode. If the individual is not physically or mentally able to participate in the debriefing within 24 hours, a member of the staff documents the reasons on Debriefing with Individual Following Use of Seclusion or Restraint in Crisis Stabilization Services and reschedules the debriefing as soon as possible. Information obtained from the debriefing is used to modify the individual's plan of care and used in performance improvement activities.
12.08	12	Debriefing for staff involved in the episode of seclusion or restraint occurs as soon as possible following an episode of seclusion or restraint; a debriefing is held for staff to discuss all issues around the seclusion or restraint episode. The debriefing includes components outlined in policy.
12.08	13	Review of all episodes of seclusion or restraint and the subsequent debriefing must be completed by the Medical Director within 8 hours of an episode.
12.09	1A	An initial screening for risk of suicide or harm to others is conducted for each individual presenting for evaluation. All individuals who present at crisis or outpatient services are screened for the need for further assessment, using the CSSRS Screen Version (Lifetime or Recent). Screening occurs on the same day as the initial presentation. If this requirement is not met due to the individual's refusal or ability, documentation in the record reflects this.
12.09	2A	A "yes" answer on questions 1, 2, or 6 either recent or lifetime, means a suicide assessment or reassessment is completed.

12.09	5A	The provider places a prominent alert in the electronic or paper clinical record to ensure that all staff associated with the individual's care are aware of a current moderate or high suicide risk level. All individuals with a history of suicide attempts at any time in their lifetime have a chart alert with "suicide attempt history" in addition to their current risk level.
12.09	6A	For individuals being discharged from inpatient or crisis stabilization services with a current moderate or high risk of suicide or suicidal risk behaviors having necessitated admission, the Crisis Stabilization Units (CSUs) or state contracted bed provider communicates by phone and in clinical documentation that corresponding risk for suicide exists when an individual is transitioning to another level of care or another provider.
12.09	7A	A registered professional nurse or other licensed or certified clinician may initiate a higher level of observation prior to obtaining an APRN/Physician Extender order, but in all instances must obtain an order within one (1) hour of initiating the intervention. Such levels of care are communicated to the appropriate staff working in the milieu. The individual's record is updated following the modification of the level of observation.
12.09	10	A Full Scale Since Last Contact for Healthcare or new SAFE-T is completed if an individual presents with clinical indicators of potential risk factors, including but not limited to, a recurrence or anticipation of a precipitating event associated with a previous attempt; if there are signs of change in mental status or behavior; at times of increased stress; if risk factors are triggered; or immediately after self-harm behavior.
12.09	11	For individuals who screen needing further clinical assessment, a Masters or Doctorate level associate license or fully licensed clinician completes a Suicide Risk Assessment (SAFE-T), reassessment (Full Scale Since Last Contact for Healthcare and Communities), or other documented clinical assessment.
12.09	12	Modifications or removal of interventions for individuals experiencing higher level of clinical risk to include suicidality, psychosis, self-harming, and/or homicidality require clinical justification determined by an assessment and are specified by the attending physician and documented in the clinical record.
12.09	13	Each record must contain a level of risk and how it was formulated, including documentation of how discrepancies between assessment tools and other clinical documentation were reconciled.
12.09	14	Every individual must have a complete Stanley Brown Safety Plan. Providers collaborate with individuals to develop an individualized Stanley Brown Safety Plan. The Safety Plan is reviewed or developed within twenty-four (24) hours prior to discharge.

12.09	15	For individuals discharging from a crisis admission who were treated for suicidal behaviors, CSU crisis staff monitor for suicide risk within seventy-two (72) hours of discharge, and then weekly (documenting any action taken) until the individual is linked to ongoing care as evidenced by: 1) The date of the individual's first follow-up appointment post-discharge with their ongoing service provider, or 2) The individual declines further monitoring (which must be documented in the clinical record). Providers give resources including the provider after-hour crisis line or 988 and contact information for providers in the individual's area, or 3) The provider attempts to contact the individual three times with no answer or response.
12.09	16	Individuals who are at moderate or high risk for suicide must have the treatment of suicidal behaviors addressed in the treatment plan.

CHILD AND ADOLESCENT CRISIS STABILIZATION UNIT (C&A CSU)

Criteria Chapter	Number	Criteria
12.01	1	Each agency develops and implements a continuous quality improvement (CQI) policy which is reviewed and updated annually. The CQI policy must contain information specific to the operations of the CSU and BHCC.
12.01	3	The CQI policy identifies mechanisms that use performance measures and data collection that continually assess and improve the quality of the services being delivered.
12.01	4	The CQI policy includes the documentation of quarterly records reviews, which are kept on file for at least two (2) years. The CSU and BHCC have a standard records review form.
12.01	5	The CSU and BHCC have a CQI committee which submits a quarterly report to the nursing administrator, medical director, agency CEO, and governing body for their review and appropriate action, and such appropriate action is conducted timely.
12.01	6	Incidents and Safety Plans are entered into the incident database within the time frames outlined in DBHDD policy.
12.02	1B	The CSU has a full-time position classified as a nursing administrator. The nursing administrator in the C&A CSU has training or experience with treating children and youth.
12.02	2B	For every sixteen (16) CSU beds in a C&A CSU, there is one (1) RN present at all times.
12.02	4	There are not more than four (4) individuals for every one (1) staff (including the charge nurse).
12.02	5B	At all times there are at least three (3) staff present within the C&A CSU including the charge nurse, who is at least an RN.
12.02	6B	The ratio of nursing staff to individuals increases on the basis of the clinical care needs of the individual, including required levels of observation for high risk individuals.
12.02	7B	If a nursing staff is assigned a 1:1 support role, then he/she is not counted in the 1:4 ratios above.
12.02	8	The CSU has a registered nurse (RN) present within the CSU twenty-four hours a day, seven days a week who is the charge nurse for the CSU. If the charge nurse is an APRN, then he/she may not simultaneously serve as the provider during the same shift.
12.02	9	A physician, psychiatrist or physician extender is on call twenty-four hours a day. The physician need not be required to be on site twenty-four hours a day; however, the physician must respond to staff calls immediately (delay not to exceed one (1) hour). A physician or psychiatrist must make in-person rounds, for every admitted individual, once daily, seven days a week.
12.02	10	The functions performed by staff whose practice is regulated or licensed by the State of Georgia are within the scope allowed by State law and professional practice acts.

12.02	11	The CSU has procedures for verifying licenses, credentials, experience, and competence of staff, which procedures ensure that: (a)Licenses and credentials of all staff members are current as required by the licensing and accrediting agencies responsible for issuing the staff members' respective licenses and accreditations.; (b) All persons providing services comply with all applicable laws, rules and regulations regarding professional licenses, qualifications and requirements related to the scope of practice.
12.02	12A	The CSU must have an independently licensed/credentialed practitioner (or a supervised S/T) on staff and available to provide individual, group, and family therapy.
12.03	1	The provider must detail in its policies and procedures, by job classification, the following: (1) training required during orientation; (2) training that must be refreshed annually; (3) additional training required for professional level staff; and (4) additional training/recertification (if applicable) required for all other staff.
12.03	3	The CSU has documentation of an annual training plan that ensures that each and every staff member who delivers therapeutic content is trained annually in at least one (1) clinical/programmatic content topic related to the delivery of care.
12.03	2A	Providers develop a detailed annual training plan that describes suicide prevention training. Components of this plan must minimally include: (1) Training for staff on any CSSRS measure they will be administering, including the CSSRS Screen Version Recent; the SAFE-T Protocol with CSSRS (Columbia Risk and Protective Factors) Lifetime/Recent Adult; the SAFE-T Protocol with CSSRS (Columbia Risk and Protective Factors) Lifetime/Recent Youth; and the Full Scale Since Last Contact for Healthcare and Communities. (2) Training in Assessing and Managing Suicide Risk (AMSR) or Safeside for clinical staff within three (3) months of hire. Documentation of training is maintained in the personnel file. At the discretion of the employer, existing proof of completed AMSR or Safeside training may be accepted upon hiring. (3) Training for non-clinical staff upon hire to build proficiency in an evidence-based basic gatekeeper training program to enhance awareness and vigilance around the signs of suicide (e.g., Question, Persuade and Refer (QPR), and Safetalk).
12.09	17	The provider develops and follows policies and procedures (including the roles of the team members) for implementing prevention strategies or interventions for individuals experiencing higher level of clinical risk to include suicidality, psychosis, self-harming, and/or homicidality. Policies and procedures identifying the appropriate levels of observation for individuals determined to be clinically at a heightened risks.
12.01	2A	The policy specifically addresses the following areas of risk to individuals served, at a minimum: 1) High-risk situations and special cases (such as suicide, death, serious injury, violence, and abuse of any individual) initiate review within twenty-four (24) hours; 2) Medical emergencies; 3) Medication management; 4) Infection control; 5) Emergency safety interventions including any instances of seclusion or restraint are reviewed within twenty-four (24) hours; 6) Environmental safety and maintenance, including an environment scan which assesses risk for individuals served by or working in the CSU facility, and identified strategies and subsequent plans for mitigating those risks; 7) Clinical outcome measures; 8) Appropriate utilization of personnel to include competency, qualifications, numbers and type of staff, and staff to individual ratios; 9) Unexpected or unusual circumstances or trends that lead to health and safety issues or noncompliance with DBHDD standards; and 10) Use of internal mechanisms to document, investigate and take appropriate action for complaints and incidents which are not required to be reported to DBHDD.

12.04	4	The CSU/BHCC maintains safety equipment to include an Automatic External Defibrillator (AED) and all other necessary medical safety supplies.
12.04	5	Any CSU or BHCC that processes laboratory tests on-site must provide documented evidence of a current Clinical Laboratory Improvement Amendment Waiver for that specific location.
12.05	21	The CSU and BHCC policies and procedures provide for daily checks of and the maintenance of temperature logs for all medication room refrigerators. Temperatures for the refrigerator are set between 36°F to 41°F.
12.05	22	Requirements for safe storage of medication are as required by law includes: (1) Single and double locks; (2) Shift counting of the medications, (3) Individual dose sign-out recording; (4) Documented planned destruction.
12.05	23	The CSU and BHCC have a process to identify, track and correct deviations in medication prescribing, transcribing, dispensing, administration, documentation, or drug security of ordering or procurement of medication that results in a medication error or variance.
12.05	24	There is documented oversight by the medical director for the accounting of and dispensing of sample medications.
12.05	25	The CSU and BHCC may keep emergency drug kits in accordance with Georgia Rules and Regulations 480-24-.08.
12.05	26	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement.
12.05	27	The CSU and BHCC policies and procedures describe actions to follow when drug reactions and other emergencies related to the use of medications occur, and emergency medical care that may be initiated by a registered nurse to alleviate a life-threatening situation.
12.06	24A	The CSU must have documented operating agreements and referral mechanisms for psychiatric disorders, substance use disorders, and physical healthcare needs that are beyond the scope of the CSU and that require inpatient treatment. Operating agreements must delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility. These agreements must specifically address the criteria and procedures for transferring an individual to a designated treatment facility when the CSU is unable to stabilize the individual. Every such operating agreement is updated, at a minimum, every five (5) years as evidenced by date and signatures on the agreement document.
12.06	25A	Program offerings for the CSU are designed to meet the biopsychosocial stabilization needs of each individual, and the therapeutic content of the program (group therapy/training, individual therapy/training, education support, etc.) are annually approved by a medical and clinical leadership team. This annual review is documented by signature and date of review and by participating leadership.
12.07	8	At least 3 nutritious meals per day are served. No more than 14 hours may elapse between the end of the evening meal and the beginning of the morning meal.

12.07	9	Nutritional snacks are available for all individuals between meals.
12.08	15	The CSU or BHCC develops and implements policies regarding law enforcement involvement that protects the health and safety of staff and individuals served. Law enforcement should not be used as a means of behavioral health management or treatment. There must be a debriefing after any instance involving law enforcement.
12.1	2A	The CSU and BHCC documents monthly fire drills that are rotated so that each shift has at least one (1) drill quarterly. At least one (1) fire drill per quarter occurs during sleeping hours. Documentation of drills include details of the drills, including not limited to the type, location, staff involved, time of day and time taken to complete the drills. When the drills fail to meet the standard for fire and disaster safety. follow up recommendations are documented and implemented accordingly.
12.1	3A	The CSU and BHCC documents quarterly disaster drills for disasters such as flood, tornado, and hurricane. Documentation must include details of the drill, including not limited to the type, location, staff involved, time of day and time taken to complete the drills. When the drills fail to meet the standard for fire and disaster safety, follow up recommendations are documented and implemented accordingly.
12.1	4	The CSU and BHCC has directions for evacuation of the CSU utilizing posted evacuation routes. There is preparation of the individuals served by the CSU for evacuation.
12.1	5	There are monthly fire extinguisher inspection, and documentation of every inspection, and recharging as indicated.
12.1	6	There are annual inspections of other safety mechanisms such as sprinklers, smoke alarms, emergency lights, kitchen range/hood, etc., and documentation of all inspections by proper officials.
12.1	7	The CSU maintains a three-day supply of non-perishable emergency food and water at all times for the maximum bed capacity.
12.1	8	Off-site evaluation plans are confirmed with the evacuation facility annually to confirm it is available and appropriate for evacuation. Confirmation is maintained in writing from the evacuation facility.
12.11	1A	The infection control risk assessment and plan are reviewed annually for effectiveness and revised, if necessary by the appropriate clinical staff responsible for infection control. The practices are based upon a cited expert source (such as the U.S. Centers for Disease Control and Prevention) and updated annually to ensure the procedures reflect evolving standard practice.
12.11	2A	The policies developed, maintained, and implemented by CSUs and BHCCs include, at a minimum: a) Standard precautions are defined, and training is provided on the use of personal protective equipment when handling blood, body substances, excretions and secretions; and d) Prevention and treatment of needle-stick or "sharps" injuries. The policies describe prevention and management of common illnesses such as, but not limited to: Methicillin-Resistant Staphylococcus Aureus (MRSA), colds and influenza, gastrointestinal viruses, and Pediculosis (lice), scabies, and tinea pedis, etc. The policies describe specific procedures to manage infectious diseases, including but not limited to Tuberculosis, Hepatitis B, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), Coronavirus or other infectious diseases.
12.11	3	The CSU and BHCC has immediately available a quantity of clean bed linens and towels, etc., essential for the proper care of individuals at all times in sufficient

		numbers for full capacity.
12.11	4	The CSU and BHCC has collection, sorting, and cleaning procedures which are designated to prevent cross-contamination of the environment, individuals served, and personnel.
12.11	5	Hand washing facilities provided in the kitchen, bathroom, examination and medication areas include hot and cold running water, soap dispensers, disposable towels and/or hand blowers.
12.11	6	The CSU has consistently available drinking water for individuals' access using mechanisms which meet general expectation of infection control procedures.
12.11	7	Staff maintain the mechanical restraint devices in proper working order and keep them clean and sanitary, following the manufacturer's recommendations for cleaning.
12.12	1	A seclusion or restraint room must meet the following standards: The door to the room opens outward.
12.12	2	The floors and walls, up to a height of 3 feet, are finished to resist penetration of body fluids and are constructed of high impact sheet rock.
12.12	3	At least one identified room used for seclusion or restraint has a bed commercially designed for use with restraints that is bolted to the floor and without sharp edges. The surface of the bed is impermeable to resist penetration by body fluids.
12.12	4	A seclusion or restraint room must meet the following standards: The room is maintained at a comfortable temperature, properly vented, and free of respiratory irritants.
12.12	5	A seclusion or restraint room must meet the following standards: The room presents no ligature risks. The room is free from hazardous conditions.
12.12	6	The bed placement in the seclusion or restraint room provides adequate space for staff to apply restraints and does not allow individuals to access the lights, smoke detectors or other items that may be in the ceiling of the room.
12.12	7	Rooms used for seclusion or restraint provides staff full visual access to the individual and includes a vision panel installed in the door or a window that allows for full visual access to the individual. Glass needs to be tempered and free of risk of access to broken glass.
12.12	8	Where the interior of the seclusion or restraint room is padded, the padding is in good repair and is fully intact and secured to the wall in a manner that is safe for individuals (i.e. not stapled).
12.12	9	The CSU uses the restraint devices specific to the individual's height, weight and body mass.
12.12	10	Only beds suitable and appropriate for use with restraints are utilized in conjunction with mechanical restraints. The restraint devices are designed to be used on the restraint bed. When a restraint bed is in use, there are no bed linens.
12.12	11	For CSUs which apply for certification on or after March 29, 2015, the privacy of the person is protected by the seclusion or restraint room location either being not visible from the common areas, or if visible, the seclusion or restraint room is constructed to be offset from main thoroughfares and afford restricted visibility to the interior of the room.
12.13	1	The CSU has policies and procedures to routinely check and document the hot water temperature at various outlets throughout the CSU and to correct any variance from the standard temperature if needed.

12.13	2	The CSU maintains an environment that is clean, in good repair, safe, and free of items that could be used for self-harm.
12.13	3	The CSU is a locked facility.
12.13	4	Except as otherwise provided by law, weapons are prohibited. The facility posts notices regarding the prohibition of weapons at all entrances and has written protocols addressing the same.
12.13	5A	The CSU and BHCC have control of potentially harmful and contraband items as clearly defined in their policy and ensures proper management of such items. This control includes, but is not limited to: (a) Flammables, toxins, ropes, wire clothes hangers, sharp-pointed scissors, razors, luggage straps, belts, knives, shoestrings, pharmaceuticals, glass or other potentially injurious items. All items will be reviewed for return to the individual upon discharge; (b) Management of housekeeping supplies and chemicals, including procedures to avoid access by individuals during use or storage. Whenever practical, supplies and chemicals are non-toxic or non-caustic; (c) Safeguarding the use and disposal of facility's nursing and medical supplies including medications, needles and other "sharps" and breakable items.
12.13	7B	The interior of the CSU is non-smoking. The grounds of the Child and Adolescent (C&A) CSU are also non-smoking
12.13	8	Entrances and exits, sidewalks and escape routes are constantly maintained free of all impediments and hazards.
12.13	9	If the CSU is equipped with electronic locks on internal doors or egress doors, the CSU ensures that such locks have manual common key mechanical override that will operate in the event of a power failure or fire.
12.13	10	The CSU has a pre-admission waiting area, including restrooms, that meets all safety requirements applicable to designated individual areas.
12.13	11	The CSU has a secure area where individuals, including those being evaluated on an involuntary basis, can be held awaiting evaluation and/or observation prior to an admission determination being made.
12.13	12	The CSU has a screening area with the capacity to be locked where searches can be done in a private and safe manner, respecting individuals' rights and privacy.
12.13	13	The CSU has an exam room where examinations and lab procedures are conducted safely while respecting the individuals' confidentiality.
12.13	14	The general architecture of the CSU, along with tools and technology, provides for optimal line-of-sight observations from the nurses' station throughout the unit, mitigating hidden spots and blind corners.
12.13	15	Each furnishing, item of hardware, fixture, or protrusion of the CSU is: (a) Designed to release from its fixings to prevent a ligature if an abnormal load is applied, or the item is fixed in place; however, is free from points where a cord could be fastened to create a ligature point; (b) Made of materials which mitigate the risk of use as weapons or for self-harm (hanging, cutting, etc.); (c) Intact and functional; (d) Maintained in good condition; and (e) Tamper resistant.
12.13	16	Lighting fixtures are recessed and tamper resistant with Lexan or other strong translucent materials.
12.13	17	The ceiling and air distribution devices, light fixtures, and sprinkler heads, and other appurtenances are tamper-resistant. For CSUs who apply for certification after 3/29/15, sprinklers are flush mounted on ceilings less than 9 feet. Sprinklers

		have institutional heads that are recessed and drop down when activated.
12.13	18	Light switches and electrical outlets are secured with tamper-resistant type screws.
12.13	19	Security and safety devices are mounted, installed and secured in a matter that mitigates the risk of use as weapons or for self-harm, prevents interference, and prevents any attempt to render inoperable with its purpose as a security device.
12.13	20	Windows are protected with Lexan or other shatter-resistant material that will minimize breakage. Bedroom windows may be textured to provide privacy without the use of curtains or blinds.
12.13	21	The CSU is equipped and maintained so as to provide a sufficient amount of hot water for individuals' use. Heated water provided for individuals' use is maintained between 110°F and 120°F.
12.13	22	Beds and other heavy furniture capable of use to barricade a door are secured to the floor or wall.
12.13	23	The CSU maintains the environmental temperature between 65 degrees F and 82 degrees F.
12.13	24	The C&A CSU has sleeping areas that are gender specific.
12.13	25	The CSU has gender specific bathrooms with proper ventilation.
12.13	26	Exposed plumbing pipes are covered to prevent individuals' access.
12.13	27	The CSU has a minimum ratio of one (1) shower for each six (6) individuals receiving services and one (1) toilet and lavatory for each six (6) individuals receiving services; Individual shower stalls and dressing areas are provided.
12.13	28	Mirrors are not common glass and must be fully secured and flat mounted to the wall.
12.13	29	Overhead rods, fixtures, privacy stalls, supports or protrusions are selected and installed in a manner which mitigates the risk of use of weapons or for self-harm (hanging, cutting, etc.). If the physical plant space of the CSU is prohibitive of this, there are written policies and protocols to monitor and reduce this risk with supporting evidence of compliance to these policies and protocols. The toilet is secured and tamper resistant.
12.13	30	The CSU has an outdoor area that is (a) age appropriate; enclosed by a privacy fence no less than six (6) feet high, where individuals have access to fresh air and exercise. It provides privacy from public view and does not provide access to contact with the public; (b) This area is constructed to retain individuals inside the area and minimize elopements from the area; and (c) The fenced area is designed for safety without blind corners to be readily visible by one staff member standing in a central location, and designed to minimize elopement.
12.13	31	The CSU must have procedures and precautions in place to minimize ligature and safety risk for all recreational equipment.
12.13	32	The CSU has a bathroom facility that is in compliance with the Americans with Disabilities Act (ADA) for use by individuals with physical disabilities. It includes a toilet, lavatory, shower and flush-mounted safety grab bars.
12.13	33	The CSU has facilities accessible to and usable by physically disabled individuals.

12.13	34	The CSU has at least one (1) operable, non-pay telephone which is private and accessible at reasonable times for use by the individual.
12.13	35	Upon request, the CSU provides a means of locked storage for any individual's valuables or personal belongings.
12.13	36	The CSU provides laundry facilities on the premises for the individual's personal laundry.
12.13	37	The CSUs maintain a daily temperature log for the freezer(s) and refrigerator (s): (a) Temperature for the refrigerator is set between 34°F and 41°F. (b) Temperature for the freezer is set between 0°F and 10°F.
12.13	38	The CSU has a sufficient designated area to accommodate meal service. The eating area may double as a group or activity area.
12.13	39	Foods, drinks and condiments are dated when opened and discarded when expired.
12.13	40	To prepare food on-site, CSUs must have a satisfactory food service permit score. A copy of the current food service permit score must be on file at the CSU.
12.13	41	Off-site food preparation: (1) CSUs may utilize meal preparation services from an affiliated or contracted entity with a current food service permit (the "food service entity"); (2) CSUs enter into a formal written contract between the CSU and the contracted food service entity, containing assurances that the contracted food service entity meets all food service and dietary standards set forth in this policy; (3) CSUs that elect to have meals prepared off-site have a modified kitchen that includes a microwave, a refrigerator, an ice maker, and clean-up facilities.
12.03	4	An eligibility letter must be obtained before an applicant who will provide direct care services can start working for a DBHDD network provider.
12.03	5	Within the first 60 days from date of hire, all staff having direct contact with individuals receive the following training, at a minimum: (1) Person centered values, principles, and approaches; (2) Holistic approach to treatment of the individual; (3) Medical, physical, behavioral, and social needs and characteristics of the individuals served; (4) Human rights and responsibilities; (6) The utilization of: (a) communication skills; (b) Crisis intervention techniques to de-escalate challenging and unsafe behaviors, and (c) Nationally benchmarked techniques for safe utilization of emergency interventions of last resort; (7) Ethics, cultural preferences, and awareness; (8) Fire safety; (9) Emergency and disaster plans and procedures; (10) Techniques of Standard precautions, including: (a) Preventative measures to minimize risk of HIV; (b) Current information as published by the Centers for Disease Control (CDC); and (c) Approaches to individual education; (11) Current CPR/AED through the American Heart Association, Health & Safety Institute, or the American Red Cross; (12) First aid and safety training required for all staff as indicated â€¦ (13) Specific individual medications and their side effects; (14) Services, support, and treatment specific topics appropriate persons served, such as but not limited to: (a) Symptom management; (b)Principles of recovery relative to individuals with mental illness; (c) Principles of recovery relative to individuals with addictive disease; (d)Principles of recovery and resiliency relative to children and youth; and (e) Relapse prevention.

12.03	6	On an annual basis, staff must demonstrate their competencies in: (1) Techniques to identify staff and individual behaviors, events, and environmental factors that may trigger emergency safety situations; (2) The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and (3) The safe use of seclusion and the safe use of restraint, including the ability to recognize and respond to signs of physical distress in individuals who are in seclusion or restrained.
12.03	7A	Staff may not administer and score/rate the CSSRS until they have completed DBHDD approved training which is the Columbia Lighthouse training.
12.03	8A	Training occurs for non-clinical staff upon hire to build proficiency in an evidence-based basic gatekeeper training program to enhance awareness and vigilance around the signs of suicide (e.g., Question, Persuade and Refer (QPR), and Safetalk).
12.03	9A	Training in Assessing and Managing Suicide Risk (AMSR) or Safeside for clinical staff occurs within three (3) months of hire. Documentation of training is maintained in the personnel file. At the discretion of the employer, existing proof of completed AMSR or Safeside training may be accepted upon hiring.
12.03	10	All CSU staff who work with individuals must receive training on the seclusion or restraint policy in new employee orientation and annually thereafter
12.03	11	All CSU staff who work with the individuals served are certified in a nationally benchmarked technique for safe utilization of emergency interventions of last resort (if such techniques are permitted in the purview of the organization).
12.03	12	Only staff who have current training and competency in the use of seclusion and restraint are authorized to provide the monitoring and documentation for individuals in seclusion or restraint.
12.03	13	All physical searches (whether pat-down searches or personal/strip searches) are conducted by staff members who are trained in search procedures.
12.03	14	All staff are trained on standard precautions at the time of hire and annually thereafter.
12.04	1	Laboratory and other diagnostic procedures must be performed as ordered by a prescriber.
12.04	2	Individuals on medications likely to cause tardive dyskinesia are monitored at prescribed intervals using an Abnormal Involuntary Movement Scale (AIMS testing).
12.04	3	Therapeutic diets are provided when ordered by a physician.
12.05	2	A valid physician's order must contain the individual's name, name of the medication, dose, route, frequency, special instructions (if needed) and the physician's signature.
12.05	3	A five (5) day supply of medications is prescribed and dispensed when individuals are discharged from the CSU. Less than a five (5) day supply may be given only when there is; documentation by the discharging physician of a safety issue and/or a verified outpatient physician appointment is scheduled within five (5) days of discharge and transportation for this appointment is assured.
12.05	4	The CSU and BHCC ensures access to pharmacy services for prescription medications within eight (8) hours of the physician's order.

12.05	5	STAT medication not maintained in the CSU and BHCC must be available for administration within one (1) hour of the order to give the medication.
12.05	8	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right: Right medication: includes verification of the medication order with the label on the prescription drug container and the MAR entry to verify that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member. The medication is inspected for expiration date. Insulin must be verified with another person prior to administering.
12.05	9	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right: Right time: includes the times the provider schedules medications, or the specific physician's instructions related to the drug.
12.05	10	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right: Right dose: includes verification of the physician's medication order of dosage amount of the medication; with the label on the prescription drug container and the Medication Administration Record entry to ensure that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member. The amount of the medication should make sense as to the volume of liquid or number of tablets to be taken.
12.05	11	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right: Right route: includes the method of administration.
12.05	12	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right: Right documentation includes proper methods of the recording on the MAR.
12.05	13	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right: Right to refuse medications: includes staff responsibilities to encourage compliance, document the refusal, and report the refusal to the administration, nurse administrator, and physician.
12.05	14	An MAR is in place for each calendar month that an individual takes or receives medication.
12.05	15	A listing of all medications taken or administered during that month including a full replication of information in the physician's order for each medication: (a) Name of the medication; (b) Dose as ordered; (C) Route as ordered; (d) Time of day as ordered; and (e) Special instructions accompanying the order, if any.
12.05	16	If the individual is to take or receive the medication more than one time during one calendar day, each time of day must have a corresponding line that permits as many entries as there are days in the month.
12.05	17	All lines presenting days and times preceding the beginning or ending of an order for medications are marked through with a single line.
12.05	18	When a physician discontinues (D/C) a medication order, that discontinuation is reflected by the entry of "D/C" at the date and time representing the discontinuation followed by a mark through of all lines representing days and times that were discontinued.
12.05	19	When "PRN" or "as needed" medication is used, the PRN medications shall be documented on the same MAR after the routine medications and clearly marked as

		"PRN" and the effectiveness is documented.
12.05	20	Each MAR shall include a legend that clarifies: (1) Identity of authorized staff initials using full signature and title; (2) Reasons that a medication may be not given, is held or otherwise not received by the individual.
12.05	1A	The CSU and BHCC ensures every order given by telephone is received by an RN or LPN and is recorded immediately as a telephone order with the ordering physician's name, date and time and is reviewed and signed by a physician within twenty-four (24) hours.
12.05	28	Medications are used solely for the purpose of providing effective treatment and are not used as punishment, convenience of staff, or as chemical restraint.
12.06	1A	The CSU does not admit individuals presenting with issues listed under "Exclusion Criteria" according to DBHDD policy 01-350, CSU: Medical Evaluation Guidelines and Exclusion Criteria for Admission to CSUs.
12.06	3	A physician assesses each individual within twenty-four (24) hours of admission to the CSU, documents the findings of the assessment(s), and writes orders for care. Orders for care include the clinically appropriate level of observation for the individual.
12.06	5	The Child and Adolescent CSU ensures that a Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Physician, Physician Assistant, Clinical Nurse Specialist, Nurse Practitioner, or Psychologist assess the individual within 48 hours of admission.
12.06	6	The IRP is developed within 72 hours of admission on the basis of assessments conducted by the physician, RN, or professional social work or counseling staff.
12.06	7B	The IRP is developed in collaboration with the individual, and includes the following: (a) A problem statement or statement of needs; (b) Goals that are realistic, measurable, consistent with the individual's needs, linked to symptom reduction, and attainable by the individual during the individual's projected length of stay; (c) Objectives, stated in terms that allow measurement of progress, that build on the individual's needs and strengths; (d) Specific treatment offerings, methods of treatment, and staff responsible to deliver the treatments. There is evidence of involvement by the individual, as documented by his or her signature, or by documentation of the individual's inability or refusal to sign. There are signatures of all staff participating in the development of the plan. In addition, the Child and Adolescent CSU ensures that evidence of involvement by the individual's legal guardian is documented by his or her signature or refusal to sign.
12.06	8	For an individual with co-occurring substance abuse, mental health and I/DD diagnoses the plan must address issues specific to each diagnosis to include clinically appropriate treatment interventions; SA groups and aftercare linkage.
12.06	18A	The IRP is reviewed at a minimum of every 72 hours by the treatment team to assess the need for the individual's continued stay in the CSU. The plan is updated as appropriate when the individual's condition or needs change.
12.06	19	The CSU ensures documentation at least once per day by an RN as to the status of the individual.
12.06	21	The physician conducts an assessment of the individual at the time of discharge.

12.06	23A	Discharge summary information is provided to the individual at the time of discharge and includes: (a) criteria describing evidence of stabilization and discharge planning; (b) significant findings relevant to the individual's recovery; (c) specific instructions for ongoing care; (d) individualized recommendations for continued care to include recovery supports and community services (if indicated), and (e) contact information on acquiring access to community services.
12.07	1	The CSU and BHCC documents the legal and clinical basis for the individual's admission to the CSU and BHCC, whether voluntary or involuntary, consistent with all applicable state and federal laws, rules and regulations.
12.07	2	The CSU and BHCC documents the legal and clinical basis for the individual's continued admission to the CSU and BHCC, whether voluntary or involuntary, consistent with all applicable state and federal laws, rules and regulations.
12.07	3	The CSU and BHCC maintains a record of voluntary or involuntary status change, including the date and time of such change.
12.07	4	The CSU and BHCC ensures the documentation of the assessment of the individual's capacity to understand and exercise the rights and powers of voluntary admission.
12.07	5A	The CSU and BHCC uses specific DBHDD legal forms to document any of the above mentioned actions. These forms are Form 1013, 2013, 1014, 1009 & 1012, and 1011.
12.07	7	Personal searches of individuals (e.g., strip searches) are to be performed only for cause and if ordered by the physician. The rationale for a personal search must be clearly documented in the order. Sequential steps of the search, including documentation of staff involved by name and title, are recorded in the progress notes section of the clinical record. Neither the CSU nor the physician may require mandatory removal of clothing for all individuals, or allow standing orders for personal searches of all individuals.
12.08	1	The following practices are prohibited: (a) The use of chemical restraint for any individual. (b) The combined use of seclusion and prone mechanical and/or manual restraint. (c) Standing orders for seclusion or any form of restraint. (d) PRN orders for seclusion or any form of restraint. (e) Prone manual or mechanical restraints. (f) Transporting an individual face down while being carried or moved. (g) Use of seclusion or restraint as a part of a Behavior Support Plan (BSP) or an Individual Recovery Plan (IRP). (h) The use of handcuffs for an individual not under the jurisdiction of the criminal justice system. (i) The use of medication as a chemical restraint.
12.08	2	An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior as well as the individual's chronological and developmental age, size, gender, physical, medical, psychiatric condition, and personal history (including any history of physical or sexual abuse).
12.08	3	Initiation and Authorization of Seclusion or Restraint: (a) If the physician or other LIP who is responsible for the care of the individual and is authorized to order seclusion or restraint is available, only he or she can order the utilization of seclusion or any form of restraint. (b) If the physician or other LIP who is responsible for the care of the individual is unavailable, his or her designee or other LIP who is authorized to order seclusion or restraint may order the utilization of seclusion or restraint. (c) The physician or other LIP conducts an assessment prior to the initiation and authorization of seclusion or restraint and documents the

		assessment using Nursing Evaluation and Physician/LIP Order Form for Seclusion or Restraint in Crisis Stabilization Services.
12.08	4	The following pertains in Emergency Safety Situations (as defined in Definitions section above) when it is not possible to obtain orders in advance from a physician or other LIP: When a seclusion or restraint is initiated without an order by a physician or Licensed Independent Practitioner, the order will be obtained within thirty (30) minutes.
12.08	5B	The physician or LIP who is primarily responsible for the individual's ongoing care, or in his or her absence, the physician or LIP's designee or other LIP, sees the individual face to face or via video-equipped telemedicine and evaluates the need for seclusion or restraint within one (1) hour of initiation of seclusion or restraint. Children under nine (9) will be seen, face to face or via video-equipped telemedicine, prior to expiration of the hour. This requirement applies regardless of whether the seclusion or restraint has already been discontinued. If more than one episode of seclusion or restraint occurs, the physician or other LIP must complete the evaluation within one hour of each order.
12.08	6	As part of [the seclusion or restraint episode] evaluation, the physician or LIP: (i) Considers information that was obtained during the assessment regarding risk for the individual associated with use of seclusion or any form of restraint; (ii) Reviews the individual's current physical and psychological status, as well as all information relative to their status prior to the implementation of seclusion or restraint; (iii).Assesses the appropriateness of the seclusion or restraint used, and determines whether seclusion or restraint needs to be continued, if not already discontinued; (iv). Assesses any complications resulting from the seclusion or restraint; (v). Provides guidance to staff and the individual to identify de-escalation strategies and coping skills to help the individual regain control so that the intervention can be discontinued. (vi). Revises the individual's plan of care, treatment and services as needed; (vii) If necessary, provides a new written order; (viii) Completes documentation of the evaluation on Nursing Evaluation and Physician/LIP Order Form for Seclusion or Restraint in Crisis Stabilization Services (Attachment B).
12.08	8	The Charge Nurse or other designated staff provide one-to-one observation of the individual throughout the period of seclusion or restraint. Video monitoring is not allowed as a substitute for personal monitoring of an individual who is in seclusion or restraint. The staff member personally monitors the individual and documents this monitoring of the individual on the Seclusion or Restraint Monitoring Form for Crisis Stabilization Services.
12.08	9	Documentation occurs at least every fifteen (15) minutes regarding the following (as appropriate for the type of intervention): (a) Checking individual's physical and psychological status and comfort by speaking with or to the person. (b) Check and attend to the individual's hygiene and toileting needs. (c) Checking the individual for signs of injury associated with the implementation of seclusion or restraint. (d)If restrained, checking vital signs at least every 30 minutes, with ongoing monitoring of other physical or behavioral indications for signs of physical distress. (e) If restrained, checking circulation every 15 minutes, including looking for signs of swelling or abrasions.(f) If restrained, checking range of motion of extremities; (g) Attention to individual's nutrition and hydration; (h) Monitoring the individual's readiness to discontinue the intervention; (i) In addition, the Registered Nurse conducts an evaluation of the individual at least every 1 hour during the time the person is in seclusion or restraint. This evaluation is documented by the nurse on

		the Seclusion or Restraint Monitoring Form for Crisis Stabilization Services.
12.08	10	As soon as the emergency safety situation has ceased and the individual's safety and the safety of others can be ensured, the individual is released from seclusion or restraint even if this is prior to the arrival of the physician or other LIP. Orders never exceed two (2) hours for individuals ages 9 and older; one (1) hour for children under age 9.
12.08	11	Debriefing with the individual occurs as soon as possible after the episode of seclusion or restraint. The individual (and if appropriate, their family) participate with staff members involved in the episode (who are available) in a debriefing about the episode. If the individual is not physically or mentally able to participate in the debriefing within 24 hours, a member of the staff documents the reasons on Debriefing with Individual Following Use of Seclusion or Restraint in Crisis Stabilization Services and reschedules the debriefing as soon as possible. Information obtained from the debriefing is used to modify the individual's plan of care and used in performance improvement activities.
12.08	12	Debriefing for staff involved in the episode of seclusion or restraint occurs as soon as possible following an episode of seclusion or restraint; a debriefing is held for staff to discuss all issues around the seclusion or restraint episode. The debriefing includes components outlined in policy.
12.08	13	Review of all episodes of seclusion or restraint and the subsequent debriefing must be completed by the Medical Director within 8 hours of an episode.
12.08	14	If the individual is a minor, staff promptly notifies the individual's parent(s) or legal guardian that an incident of seclusion or restraint has occurred. Notice to the parents(s) or legal guardian must occur as soon as possible after the initiation of each emergency safety intervention. The CSU must document in the individual's record that the parent(s), legal guardian, and/or other authorized person have been so notified.
12.09	1A	An initial screening for risk of suicide or harm to others is conducted for each individual presenting for evaluation. All individuals who present at crisis or outpatient services are screened for the need for further assessment, using the CSSRS Screen Version (Lifetime or Recent). Screening occurs on the same day as the initial presentation. If this requirement is not met due to the individual's refusal or ability, documentation in the record reflects this.
12.09	2A	A "yes" answer on questions 1, 2, or 6 either recent or lifetime, means a suicide assessment or reassessment is completed.
12.09	5A	The provider places a prominent alert in the electronic or paper clinical record to ensure that all staff associated with the individual's care are aware of a current moderate or high suicide risk level. All individuals with a history of suicide attempts at any time in their lifetime have a chart alert with "suicide attempt history" in addition to their current risk level.
12.09	6A	For individuals being discharged from inpatient or crisis stabilization services with a current moderate or high risk of suicide or suicidal risk behaviors having necessitated admission, the Crisis Stabilization Units (CSUs) or state contracted bed provider communicates by phone and in clinical documentation that corresponding risk for suicide exists when an individual is transitioning to another level of care or another provider.
12.09	7A	A registered professional nurse or other licensed or certified clinician may initiate a higher level of observation prior to obtaining an APRN/Physician Extender order, but in all instances must obtain an order within one (1) hour of initiating the

		intervention. Such levels of care are communicated to the appropriate staff working in the milieu. The individual's record is updated following the modification of the level of observation.
12.09	10	A Full Scale Since Last Contact for Healthcare or new SAFE-T is completed if an individual presents with clinical indicators of potential risk factors, including but not limited to, a recurrence or anticipation of a precipitating event associated with a previous attempt; if there are signs of change in mental status or behavior; at times of increased stress; if risk factors are triggered; or immediately after self-harm behavior.
12.09	11	For individuals who screen needing further clinical assessment, a Masters or Doctorate level associate license or fully licensed clinician completes a Suicide Risk Assessment (SAFE-T), reassessment (Full Scale Since Last Contact for Healthcare and Communities), or other documented clinical assessment.
12.09	12	Modifications or removal of interventions for individuals experiencing higher level of clinical risk to include suicidality, psychosis, self-harming, and/or homicidality require clinical justification determined by an assessment and are specified by the attending physician and documented in the clinical record.
12.09	13	Each record must contain a level of risk and how it was formulated, including documentation of how discrepancies between assessment tools and other clinical documentation were reconciled.
12.09	14	Every individual must have a complete Stanley Brown Safety Plan. Providers collaborate with individuals to develop an individualized Stanley Brown Safety Plan. The Safety Plan is reviewed or developed within twenty-four (24) hours prior to discharge.
12.09	15	For individuals discharging from a crisis admission who were treated for suicidal behaviors, CSU crisis staff monitor for suicide risk within seventy-two (72) hours of discharge, and then weekly (documenting any action taken) until the individual is linked to ongoing care as evidenced by: 1) The date of the individual's first follow-up appointment post-discharge with their ongoing service provider, or 2) The individual declines further monitoring (which must be documented in the clinical record). Providers give resources including the provider after-hour crisis line or 988 and contact information for providers in the individual's area, or 3) The provider attempts to contact the individual three times with no answer or response.
12.09	16	Individuals who are at moderate or high risk for suicide must have the treatment of suicidal behaviors addressed in the treatment plan.

Autism Crisis Stabilization Unit (ASD CSU)

Criteria Chapter	Number	Criteria
12.01	1	Each agency develops and implements a continuous quality improvement (CQI) policy which is reviewed and updated annually. The CQI policy must contain information specific to the operations of the CSU and BHCC.
12.01	2A	The policy specifically addresses the following areas of risk to individuals served, at a minimum: 1) High-risk situations and special cases (such as suicide, death, serious injury, violence, and abuse of any individual) initiate review within twenty-four (24) hours; 2) Medical emergencies; 3) Medication management; 4) Infection control; 5) Emergency safety interventions including any instances of seclusion or restraint are reviewed within twenty-four (24) hours; 6) Environmental safety and maintenance, including an environment scan which assesses risk for individuals served by or working in the CSU facility, and identified strategies and subsequent plans for mitigating those risks; 7) Clinical outcome measures; 8) Appropriate utilization of personnel to include competency, qualifications, numbers and type of staff, and staff to individual ratios; 9) Unexpected or unusual circumstances or trends that lead to health and safety issues or noncompliance with DBHDD standards; and 10) Use of internal mechanisms to document, investigate and take appropriate action for complaints and incidents which are not required to be reported to DBHDD.
12.01	3	The CQI policy identifies mechanisms that use performance measures and data collection that continually assess and improve the quality of the services being delivered.
12.01	4	The CQI policy includes the documentation of quarterly records reviews, which are kept on file for at least two (2) years. The CSU and BHCC have a standard records review form.
12.01	5	The CSU and BHCC have a CQI committee which submits a quarterly report to the nursing administrator, medical director, agency CEO, and governing body for their review and appropriate action, and such appropriate action is conducted timely.
12.01	6	Incidents and Safety Plans are entered into the incident database within the time frames outlined in DBHDD policy.
12.02	1C	ASD CSU must employ a full-time (FT) Nursing Administrator who is a Registered Nurse.
12.02	2C	For every eight (8) CSU beds in a C&A ASD CSU, there is one (1) nurse present at all times. The first nurse must be an RN. The second nurse may be either an RN or a Licensed Practicing Nurse (LPN).
12.02	4	There are not more than four (4) individuals for every one (1) staff (including the charge nurse).
12.02	5C	At all times there are at least three (3) staff present within the ASD CSU including the charge nurse, who is at least an RN.
12.02	6B	The ratio of nursing staff to individuals increases on the basis of the clinical care needs of the individual, including required levels of observation for high risk individuals.

12.02	7B	If a nursing staff is assigned a 1:1 support role, then he/she is not counted in the 1:4 ratios above.
12.02	8	The CSU has a registered nurse (RN) present within the CSU twenty-four hours a day, seven days a week who is the charge nurse for the CSU. If the charge nurse is an APRN, then he/she may not simultaneously serve as the provider during the same shift.
12.02	9	A physician, psychiatrist or physician extender is on call twenty-four hours a day. The physician need not be required to be on site twenty-four hours a day; however, the physician must respond to staff calls immediately (delay not to exceed one (1) hour). A physician or psychiatrist must make in-person rounds, for every admitted individual, once daily, seven days a week.
12.02	10	The functions performed by staff whose practice is regulated or licensed by the State of Georgia are within the scope allowed by State law and professional practice acts.
12.02	11	The CSU has procedures for verifying licenses, credentials, experience, and competence of staff, which procedures ensure that: (a)Licenses and credentials of all staff members are current as required by the licensing and accrediting agencies responsible for issuing the staff members' respective licenses and accreditations.; (b) All persons providing services comply with all applicable laws, rules and regulations regarding professional licenses, qualifications and requirements related to the scope of practice.
12.02	12B	The CSU must have an independently licensed/credentialed practitioner (or a Supervisee/Trainee) on staff and available to provide individual, group, and family therapy.
12.02	13	ASD CSU services must be provided by a physician or a physician extender under the supervision of a physician, practicing within the scope of State law. All services provided within the CSU must be delivered under the direction of a physician. A physician must conduct an assessment of new admissions, address issues of care, and write orders as required.
12.02	14	ASD CSU must employ a full-time-equivalent (FTE) Board Certified Behavior Analyst (BCBA), who serves as the lead for all Applied Behavior Analysis (ABA) aspects of treatment.
12.02	15	A BCBA and/or BCaBA (under the supervision of the lead BCBA) supervises behavior intervention programs.
12.02	16	In a C&A ASD CSU, a Board-Certified Behavior Analyst (BCBA) and/or BCaBA must provide oversight to direct care staff during awake hours (first and second shift, 7 days a week). Functions performed by the BCBA and/or BCaBA must be performed within the scope of their practice and aligned with their professional standards. The BCaBA must receive supervision from lead BCBA on staff.
12.02	17	Functions performed by an RBT, QASP-S, QASP, or ABAT must be performed within the scope of their practice, and aligned with their professional standards. RBTs must be supervised by either the BCBA or Board Certified Assistant Behavior Analyst (BCaBA) on staff. QASP-Ss, QASPs, and ABATs must be supervised by the BCBA on staff.
12.03	1	The provider must detail in its policies and procedures, by job classification, the following: (1) training required during orientation; (2) training that must be refreshed annually; (3) additional training required for professional level staff; and (4) additional training/recertification (if applicable) required for all other staff.

12.03	2A	Providers develop a detailed annual training plan that describes suicide prevention training. Components of this plan must minimally include: (1) Training for staff on any CSSRS measure they will be administering, including the CSSRS Screen Version Recent; the SAFE-T Protocol with CSSRS (Columbia Risk and Protective Factors) Lifetime/Recent Adult; the SAFE-T Protocol with CSSRS (Columbia Risk and Protective Factors) Lifetime/Recent Youth; and the Full Scale Since Last Contact for Healthcare and Communities. (2) Training in Assessing and Managing Suicide Risk (AMSR) or Safeside for clinical staff within three (3) months of hire. Documentation of training is maintained in the personnel file. At the discretion of the employer, existing proof of completed AMSR or Safeside training may be accepted upon hiring. (3) Training for non-clinical staff upon hire to build proficiency in an evidence-based basic gatekeeper training program to enhance awareness and vigilance around the signs of suicide (e.g., Question, Persuade and Refer (QPR), and Safetalk).
12.03	3	The CSU has documentation of an annual training plan that ensures that each and every staff member who delivers therapeutic content is trained annually in at least one (1) clinical/programmatic content topic related to the delivery of care.
12.09	17	The provider develops and follows policies and procedures (including the roles of the team members) for implementing prevention strategies or interventions for individuals experiencing higher level of clinical risk to include suicidality, psychosis, self-harming, and/or homicidality. Policies and procedures identifying the appropriate levels of observation for individuals determined to be clinically at a heightened risks.
12.04	4	The CSU/BHCC maintains safety equipment to include an Automatic External Defibrillator (AED) and all other necessary medical safety supplies.
12.04	5	Any CSU or BHCC that processes laboratory tests on-site must provide documented evidence of a current Clinical Laboratory Improvement Amendment Waiver for that specific location.
12.05	21	The CSU and BHCC policies and procedures provide for daily checks of and the maintenance of temperature logs for all medication room refrigerators. Temperatures for the refrigerator are set between 36°F to 41°F.
12.05	22	Requirements for safe storage of medication are as required by law includes: (1) Single and double locks; (2) Shift counting of the medications, (3) Individual dose sign-out recording; (4) Documented planned destruction.
12.05	23	The CSU and BHCC have a process to identify, track and correct deviations in medication prescribing, transcribing, dispensing, administration, documentation, or drug security of ordering or procurement of medication that results in a medication error or variance.
12.05	24	There is documented oversight by the medical director for the accounting of and dispensing of sample medications.
12.05	25	The CSU and BHCC may keep emergency drug kits in accordance with Georgia Rules and Regulations 480-24-.08.
12.05	26	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement.
12.05	27	The CSU and BHCC policies and procedures describe actions to follow when drug reactions and other emergencies related to the use of medications occur, and emergency medical care that may be initiated by a registered nurse to alleviate a life-threatening situation.

12.06	24C	The CSU must have documented operating agreements and referral mechanisms for Autism Spectrum Disorder, psychiatric disorders, substance use disorders, and physical healthcare needs that are beyond the scope of the CSU and that require inpatient treatment. Operating agreements must delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility. These agreements must specifically address the criteria and procedures for transferring the youth to a designated treatment facility when the CSU is unable to stabilize the youth. Every such operating agreement is updated, at a minimum, every five (5) years as evidenced by date and signatures on the agreement document.
12.06	25B	Program offerings for the C&A ASD CSU are designed to meet the biopsychosocial and behavioral stabilization needs of each individual, and the therapeutic content of the program (behavior intervention, group therapy/training, individual therapy/training, educational support, etc.) are annually approved by a licensed/certified clinician. This content is captured in a master file which has the licensed clinician's approval, signature and date of review.
12.06	29	A daily activity schedule (per shift) must be posted in the ASD CSU, and available to external reviewers. A significant portion of the ASD CSUs daily schedule must consist of structured activities and treatment targeted toward reduction of maladaptive behaviors, acquisition of adaptive behaviors, and mitigation of any co-occurring behavioral health symptoms related to the emanating crisis. These activities should be consistent with each youth's needs as identified in their Positive Behavior Support Plan and Individualized Resiliency Plan.
12.06	30	The daily schedule should reflect that no more than 30% of all youth's waking hours (except educational schooling, mealtimes and ADL times) should be spent in milieu activities.
12.07	8	At least 3 nutritious meals per day are served. No more than 14 hours may elapse between the end of the evening meal and the beginning of the morning meal.
12.07	9	Nutritional snacks are available for all individuals between meals.
12.08	15	The CSU or BHCC develops and implements policies regarding law enforcement involvement that protects the health and safety of staff and individuals served. Law enforcement should not be used as a means of behavioral health management or treatment. There must be a debriefing after any instance involving law enforcement.
12.1	2A	The CSU and BHCC documents monthly fire drills that are rotated so that each shift has at least one (1) drill quarterly. At least one (1) fire drill per quarter occurs during sleeping hours. Documentation of drills include details of the drills, including not limited to the type, location, staff involved, time of day and time taken to complete the drills. When the drills fail to meet the standard for fire and disaster safety. follow up recommendations are documented and implemented accordingly.
12.1	3A	The CSU and BHCC documents quarterly disaster drills for disasters such as flood, tornado, and hurricane. Documentation must include details of the drill, including not limited to the type, location, staff involved, time of day and time taken to complete the drills. When the drills fail to meet the standard for fire and disaster safety, follow up recommendations are documented and implemented accordingly.
12.1	4	The CSU and BHCC has directions for evacuation of the CSU utilizing posted evacuation routes. There is preparation of the individuals served by the CSU for evacuation.

12.1	5	There are monthly fire extinguisher inspection, and documentation of every inspection, and recharging as indicated.
12.1	6	There are annual inspections of other safety mechanisms such as sprinklers, smoke alarms, emergency lights, kitchen range/hood, etc., and documentation of all inspections by proper officials.
12.1	7	The CSU maintains a three-day supply of non-perishable emergency food and water at all times for the maximum bed capacity.
12.1	8	Off-site evaluation plans are confirmed with the evacuation facility annually to confirm it is available and appropriate for evacuation. Confirmation is maintained in writing from the evacuation facility.
12.11	1A	The infection control risk assessment and plan are reviewed annually for effectiveness and revised, if necessary, by the appropriate clinical staff responsible for infection control. The practices are based upon a cited expert source (such as the U.S. Centers for Disease Control and Prevention) and updated annually to ensure the procedures reflect evolving standard practice.
12.11	2A	The policies developed, maintained, and implemented by CSUs and BHCCs include, at a minimum: a) Standard precautions are defined, and training is provided on the use of personal protective equipment when handling blood, body substances, excretions and secretions; and d) Prevention and treatment of needle-stick or "sharps" injuries. The policies describe prevention and management of common illnesses such as, but not limited to: Methicillin-Resistant Staphylococcus Aureus (MRSA), colds and influenza, gastrointestinal viruses, and Pediculosis (lice), scabies, and tinea pedis, etc. The policies describe specific procedures to manage infectious diseases, including but not limited to Tuberculosis, Hepatitis B, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), Coronavirus or other infectious diseases.
12.11	3	The CSU and BHCC has immediately available a quantity of clean bed linens and towels, etc., essential for the proper care of individuals at all times in sufficient numbers for full capacity.
12.11	4	The CSU and BHCC has collection, sorting, and cleaning procedures which are designated to prevent cross-contamination of the environment, individuals served, and personnel.
12.11	5	Hand washing facilities provided in the kitchen, bathroom, examination and medication areas include hot and cold running water, soap dispensers, disposable towels and/or hand blowers.
12.11	6	The CSU has consistently available drinking water for individuals' access using mechanisms which meet general expectation of infection control procedures.
12.11	7	Staff maintain the mechanical restraint devices in proper working order and keep them clean and sanitary, following the manufacturer's recommendations for cleaning.
12.12	1	A seclusion or restraint room must meet the following standards: The door to the room opens outward.
12.12	2	The floors and walls, up to a height of 3 feet, are finished to resist penetration of body fluids and are constructed of high impact sheet rock.
12.12	3	At least one identified room used for seclusion or restraint has a bed commercially designed for use with restraints that is bolted to the floor and without sharp edges. The surface of the bed is impermeable to resist penetration by body fluids.

12.12	4	A seclusion or restraint room must meet the following standards: The room is maintained at a comfortable temperature, properly vented, and free of respiratory irritants.
12.12	5	A seclusion or restraint room must meet the following standards: The room presents no ligature risks. The room is free from hazardous conditions.
12.12	6	The bed placement in the seclusion or restraint room provides adequate space for staff to apply restraints and does not allow individuals to access the lights, smoke detectors or other items that may be in the ceiling of the room.
12.12	7	Rooms used for seclusion or restraint provides staff full visual access to the individual and includes a vision panel installed in the door or a window that allows for full visual access to the individual. Glass needs to be tempered and free of risk of access to broken glass.
12.12	8	Where the interior of the seclusion or restraint room is padded, the padding is in good repair and is fully intact and secured to the wall in a manner that is safe for individuals (i.e. not stapled).
12.12	9	The CSU uses the restraint devices specific to the individual's height, weight and body mass.
12.12	10	Only beds suitable and appropriate for use with restraints are utilized in conjunction with mechanical restraints. The restraint devices are designed to be used on the restraint bed. When a restraint bed is in use, there are no bed linens.
12.12	11	For CSUs which apply for certification on or after March 29, 2015, the privacy of the person is protected by the seclusion or restraint room location either being not visible from the common areas, or if visible, the seclusion or restraint room is constructed to be offset from main thoroughfares and afford restricted visibility to the interior of the room.
12.13	1	The CSU has policies and procedures to routinely check and document the hot water temperature at various outlets throughout the CSU and to correct any variance from the standard temperature if needed.
12.13	2	The CSU maintains an environment that is clean, in good repair, safe, and free of items that could be used for self-harm.
12.13	3	The CSU is a locked facility.
12.13	4	Except as otherwise provided by law, weapons are prohibited. The facility posts notices regarding the prohibition of weapons at all entrances and has written protocols addressing the same.
12.13	5B	The CSU and BHCC have control of potentially harmful and contraband items as clearly defined in their policy and ensures proper management of such items. This control includes but is not limited to: (a) Flammables, toxins, ropes, wire clothes hangers, sharp-pointed scissors, razors, luggage straps, belts, knives, shoestrings, pharmaceuticals, glass or other potentially injurious items. All items will be reviewed for return to the individual upon discharge; (b) Management of housekeeping supplies and chemicals, including procedures to avoid access by individuals during use or storage. Whenever practical, supplies and chemicals are non-toxic or non-caustic; (c) Safeguarding the use and disposal of facility's nursing and medical supplies including medications, needles and other "sharps" and breakable items. In consideration of the varied sensory and support needs of those youth served in the ASD CSU, special exceptions will apply to therapeutic items on an individual basis that are typically excluded from a CSU environment, provided the following are implemented: (a) Ongoing assessment to reflect clinical necessity and appropriateness of use, (b) Risk Mitigation procedures to include but not

		limited to: when, where, and how the item(s) will be used, with documentation in the IRP/IBSP and evidence of staff training, (c) Documented inspection of each item after use (checking for any wear and tear, and safety hazards), (d) Documented protocols and processes for initial sanitization and ongoing sanitization of all items and, (e) Storage of each item under lock and key when not in use, and (f) Items considered a ligature risk (e.g., strings, belts, ropes) remain excluded from use in the C&A ASD CSU.
12.13	6	The CSU has policies and procedures to address identification, detection, handling, and storage of individuals' belongings that are determined to be contraband and potentially harmful. In consideration of the varied sensory and support needs of those youth served in the C&A ASD CSU, special exceptions will apply to therapeutic items on an individual basis that are typically excluded from a CSU environment, provided the following are implemented: (i). Ongoing assessment to reflect clinical necessity and appropriateness of use; (ii) Risk Mitigation procedures to include but not limited to: when, where, and how the item(s) will be used, with documentation in the IRP/IBSP and evidence of staff training; (iii) Documented inspection of each item after use (checking for any wear and tear, and safety hazards); (iv) Documented protocols and processes for initial sanitization and ongoing sanitization of all items and; (v) Storage of each item under lock and key when not in use; (vi) Items considered a ligature risk (e.g., strings, belts, ropes) remain excluded from use in the C&A ASD CSU.
12.13	7B	The interior of the CSU is non-smoking. The grounds of the Child and Adolescent (C&A) CSU are also non-smoking
12.13	8	Entrances and exits, sidewalks and escape routes are constantly maintained free of all impediments and hazards.
12.13	9	If the CSU is equipped with electronic locks on internal doors or egress doors, the CSU ensures that such locks have manual common key mechanical override that will operate in the event of a power failure or fire.
12.13	10	The CSU has a pre-admission waiting area, including restrooms, that meets all safety requirements applicable to designated individual areas.
12.13	11	The CSU has a secure area where individuals, including those being evaluated on an involuntary basis, can be held awaiting evaluation and/or observation prior to an admission determination being made.
12.13	12	The CSU has a screening area with the capacity to be locked where searches can be done in a private and safe manner, respecting individuals' rights and privacy.
12.13	13	The CSU has an exam room where examinations and lab procedures are conducted safely while respecting the individuals' confidentiality.
12.13	14	The general architecture of the CSU, along with tools and technology, provides for optimal line-of-sight observations from the nurses' station throughout the unit, mitigating hidden spots and blind corners.
12.13	15	Each furnishing, item of hardware, fixture, or protrusion of the CSU is: (a) Designed to release from its fixings to prevent a ligature if an abnormal load is applied, or the item is fixed in place; however, is free from points where a cord could be fastened to create a ligature point; (b) Made of materials which mitigate the risk of use as weapons or for self-harm (hanging, cutting, etc.); (c) Intact and functional; (d) Maintained in good condition; and (e) Tamper resistant.
12.13	16	Lighting fixtures are recessed and tamper resistant with Lexan or other strong translucent materials.

12.13	17	The ceiling and air distribution devices, light fixtures, and sprinkler heads, and other appurtenances are tamper-resistant. For CSUs who apply for certification after 3/29/15, sprinklers are flush mounted on ceilings less than 9 feet. Sprinklers have institutional heads that are recessed and drop down when activated.
12.13	18	Light switches and electrical outlets are secured with tamper-resistant type screws.
12.13	19	Security and safety devices are mounted, installed and secured in a matter that mitigates the risk of use as weapons or for self-harm, prevents interference, and prevents any attempt to render inoperable with its purpose as a security device.
12.13	20	Windows are protected with Lexan or other shatter-resistant material that will minimize breakage. Bedroom windows may be textured to provide privacy without the use of curtains or blinds.
12.13	21	The CSU is equipped and maintained so as to provide a sufficient amount of hot water for individuals' use. Heated water provided for individuals' use is maintained between 110°F and 120°F.
12.13	22	Beds and other heavy furniture capable of use to barricade a door are secured to the floor or wall.
12.13	23	The CSU maintains the environmental temperature between 65 degrees F and 82 degrees F.
12.13	24	The C&A CSU has sleeping areas that are gender specific.
12.13	25	The CSU has gender specific bathrooms with proper ventilation.
12.13	26	Exposed plumbing pipes are covered to prevent individuals' access.
12.13	27	The CSU has a minimum ratio of one (1) shower for each six (6) individuals receiving services and one (1) toilet and lavatory for each six (6) individuals receiving services; Individual shower stalls and dressing areas are provided.
12.13	28	Mirrors are not common glass and must be fully secured and flat mounted to the wall.
12.13	29	Overhead rods, fixtures, privacy stalls, supports or protrusions are selected and installed in a manner which mitigates the risk of use of weapons or for self-harm (hanging, cutting, etc.). If the physical plant space of the CSU is prohibitive of this, there are written policies and protocols to monitor and reduce this risk with supporting evidence of compliance to these policies and protocols. The toilet is secured and tamper resistant.
12.13	30	The CSU has an outdoor area that is (a) age appropriate; enclosed by a privacy fence no less than six (6) feet high, where individuals have access to fresh air and exercise. It provides privacy from public view and does not provide access to contact with the public; (b) This area is constructed to retain individuals inside the area and minimize elopements from the area; and (c) The fenced area is designed for safety without blind corners to be readily visible by one staff member standing in a central location, and designed to minimize elopement.
12.13	31	The CSU must have procedures and precautions in place to minimize ligature and safety risk for all recreational equipment.
12.13	32	The CSU has a bathroom facility that is in compliance with the Americans with Disabilities Act (ADA) for use by individuals with physical disabilities. It includes a toilet, lavatory, shower and flush-mounted safety grab bars.

12.13	33	The CSU has facilities accessible to and usable by physically disabled individuals.
12.13	34	The CSU has at least one (1) operable, non-pay telephone which is private and accessible at reasonable times for use by the individual.
12.13	35	Upon request, the CSU provides a means of locked storage for any individual's valuables or personal belongings.
12.13	36	The CSU provides laundry facilities on the premises for the individual's personal laundry.
12.13	37	The CSUs maintain a daily temperature log for the freezer(s) and refrigerator (s): (a) Temperature for the refrigerator is set between 34°F and 41°F. (b) Temperature for the freezer is set between 0°F and 10°F.
12.13	38	The CSU has a sufficient designated area to accommodate meal service. The eating area may double as a group or activity area.
12.13	39	Foods, drinks and condiments are dated when opened and discarded when expired.
12.13	40	To prepare food on-site, CSUs must have a satisfactory food service permit score. A copy of the current food service permit score must be on file at the CSU.
12.13	41	Off-site food preparation: (1) CSUs may utilize meal preparation services from an affiliated or contracted entity with a current food service permit (the "food service entity"); (2) CSUs enter into a formal written contract between the CSU and the contracted food service entity, containing assurances that the contracted food service entity meets all food service and dietary standards set forth in this policy; (3) CSUs that elect to have meals prepared off-site have a modified kitchen that includes a microwave, a refrigerator, an ice maker, and clean-up facilities.
12.03	4	An eligibility letter must be obtained before an applicant who will provide direct care services can start working for a DBHDD network provider.
12.03	5	Within the first 60 days from date of hire, all staff having direct contact with individuals receive the following training, at a minimum: (1) Person centered values, principles, and approaches; (2) Holistic approach to treatment of the individual; (3) Medical, physical, behavioral, and social needs and characteristics of the individuals served; (4) Human rights and responsibilities; (6) The utilization of: (a) communication skills; (b) Crisis intervention techniques to de-escalate challenging and unsafe behaviors, and (c) Nationally benchmarked techniques for safe utilization of emergency interventions of last resort; (7) Ethics, cultural preferences, and awareness; (8) Fire safety; (9) Emergency and disaster plans and procedures; (10) Techniques of Standard precautions, including: (a) Preventative measures to minimize risk of HIV; (b) Current information as published by the Centers for Disease Control (CDC); and (c) Approaches to individual education; (11) Current CPR/AED through the American Heart Association, Health & Safety Institute, or the American Red Cross; (12) First aid and safety training required for all staff as indicated; (13) Specific individual medications and their side effects; (14) Services, support, and treatment specific topics appropriate persons served, such as but not limited to: (a) Symptom management; (b) Principles of recovery relative to individuals with mental illness; (c) Principles of recovery relative to individuals with addictive disease; (d)Principles of recovery and resiliency relative to children and youth; and (e) Relapse prevention.
12.03	6	On an annual basis, staff must demonstrate their competencies in: (1) Techniques to identify staff and individual behaviors, events, and environmental factors that may trigger emergency safety situations; (2) The use of nonphysical intervention

		skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and (3) The safe use of seclusion and the safe use of restraint, including the ability to recognize and respond to signs of physical distress in individuals who are in seclusion or restrained.
12.03	7A	Staff may not administer and score/rate the CSSRS until they have completed DBHDD approved training which is the Columbia Lighthouse training.
12.03	8A	Training occurs for non-clinical staff upon hire to build proficiency in an evidence-based basic gatekeeper training program to enhance awareness and vigilance around the signs of suicide (e.g., Question, Persuade and Refer (QPR), and Safetalk).
12.03	9A	Training in Assessing and Managing Suicide Risk (AMSR) or Safeside for clinical staff occurs within three (3) months of hire. Documentation of training is maintained in the personnel file. At the discretion of the employer, existing proof of completed AMSR or Safeside training may be accepted upon hiring.
12.03	10	All CSU staff who work with individuals must receive training on the seclusion or restraint policy in new employee orientation and annually thereafter
12.03	11	All CSU staff who work with the individuals served are certified in a nationally benchmarked technique for safe utilization of emergency interventions of last resort (if such techniques are permitted in the purview of the organization).
12.03	12	Only staff who have current training and competency in the use of seclusion and restraint are authorized to provide the monitoring and documentation for individuals in seclusion or restraint.
12.03	13	All physical searches (whether pat-down searches or personal/strip searches) are conducted by staff members who are trained in search procedures.
12.03	14	All staff are trained on standard precautions at the time of hire and annually thereafter.
12.04	1	Laboratory and other diagnostic procedures must be performed as ordered by a prescriber.
12.04	2	Individuals on medications likely to cause tardive dyskinesia are monitored at prescribed intervals using an Abnormal Involuntary Movement Scale (AIMS testing).
12.04	3	Therapeutic diets are provided when ordered by a physician.
12.05	1A	The CSU and BHCC ensures every order given by telephone is received by an RN or LPN and is recorded immediately as a telephone order with the ordering physician's name, date and time and is reviewed and signed by a physician within twenty-four (24) hours.
12.05	2	A valid physician's order must contain the individual's name, name of the medication, dose, route, frequency, special instructions (if needed) and the physician's signature.
12.05	3	A five (5) day supply of medications is prescribed and dispensed when individuals are discharged from the CSU. Less than a five (5) day supply may be given only when there is; documentation by the discharging physician of a safety issue and/or a verified outpatient physician appointment is scheduled within five (5) days of discharge and transportation for this appointment is assured.
12.05	4	The CSU and BHCC ensures access to pharmacy services for prescription medications within eight (8) hours of the physician's order.

12.05	5	STAT medication not maintained in the CSU and BHCC must be available for administration within one (1) hour of the order to give the medication.
12.05	8	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right: Right medication: includes verification of the medication order with the label on the prescription drug container and the MAR entry to verify that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member. The medication is inspected for expiration date. Insulin must be verified with another person prior to administering.
12.05	9	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right: Right time: includes the times the provider schedules medications, or the specific physician's instructions related to the drug.
12.05	10	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right: Right dose: includes verification of the physician's medication order of dosage amount of the medication; with the label on the prescription drug container and the Medication Administration Record entry to ensure that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member. The amount of the medication should make sense as to the volume of liquid or number of tablets to be taken.
12.05	11	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right: Right route: includes the method of administration.
12.05	12	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right: Right documentation includes proper methods of the recording on the MAR.
12.05	13	The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right: Right to refuse medications: includes staff responsibilities to encourage compliance, document the refusal, and report the refusal to the administration, nurse administrator, and physician.
12.05	14	An MAR is in place for each calendar month that an individual takes or receives medication.
12.05	15	A listing of all medications taken or administered during that month including a full replication of information in the physician's order for each medication: (a) Name of the medication; (b) Dose as ordered; (C) Route as ordered; (d) Time of day as ordered; and (e) Special instructions accompanying the order, if any.
12.05	16	If the individual is to take or receive the medication more than one time during one calendar day, each time of day must have a corresponding line that permits as many entries as there are days in the month.
12.05	17	All lines presenting days and times preceding the beginning or ending of an order for medications are marked through with a single line.
12.05	18	When a physician discontinues (D/C) a medication order, that discontinuation is reflected by the entry of "D/C" at the date and time representing the discontinuation followed by a mark through of all lines representing days and times that were discontinued.
12.05	19	When "PRN" or "as needed" medication is used, the PRN medications shall be documented on the same MAR after the routine medications and clearly marked as

		"PRN" and the effectiveness is documented.
12.05	20	Each MAR shall include a legend that clarifies: (1) Identity of authorized staff initials using full signature and title; (2) Reasons that a medication may be not given, is held or otherwise not received by the individual.
12.05	28	Medications are used solely for the purpose of providing effective treatment and are not used as punishment, convenience of staff, or as chemical restraint.
12.06	1B	The CSU does not admit individuals presenting with issues listed under "Exclusion Criteria" according to DBHDD policy 01-350, CSU: Medical Evaluation Guidelines and Exclusion Criteria for Admission to CSUs. Individuals being considered for admission to the C&A ASD CSU are exempt from the standard CSU requirement that they be able to complete their ADLs independently.
12.06	2	If there is a parental/caregiver affirmation that an actual diagnosis of ASD exists, documentation of this diagnosis must be confirmed and acquired by the CSU provider within one (1) week of admission; or if an actual diagnosis of ASD cannot be confirmed, the CSU provider must arrange for a full diagnostic workup resulting in a confirmed and documented diagnosis of ASD within two (2) weeks of admission. In either case, if a diagnosis of ASD is not confirmed via documentation within the specified timeframe, the provider must immediately begin arranging for transfer of the youth to services that are more appropriate for his or her needs.
12.06	3	A physician assesses each individual within twenty-four (24) hours of admission to the CSU, documents the findings of the assessment(s), and writes orders for care. Orders for care include the clinically appropriate level of observation for the individual.
12.06	5	The Child and Adolescent CSU ensures that a Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Physician, Physician Assistant, Clinical Nurse Specialist, Nurse Practitioner, or Psychologist assess the individual within 48 hours of admission.
12.06	6	The IRP is developed within 72 hours of admission on the basis of assessments conducted by the physician, RN, or professional social work or counseling staff.
12.06	7C	For the C&A ASD CSU, at a minimum, the Individualized Recovery/Resiliency Plan is developed in collaboration with the individual, and includes the following: (1) A problem statement or statement of needs; (2) Goals that are realistic, measurable, consistent with the individual's needs, linked to symptom reduction, and attainable by the individual during the individual's projected length of stay; (3) Objectives, stated in terms that allow measurement of progress, that build on the individual's needs and strengths; (4) Specific treatment offerings, methods of treatment, and staff responsible to deliver the treatments; (5) Interventions and preferred approaches that are responsive to findings of past trauma and abuse; (6) Evidence of involvement by the individual, as documented by his or her signature, or by documentation of the individual's inability or refusal to sign; (7) Signatures of all staff participating in the development of the plan; and (8 In addition, the Child and Adolescent CSU ensures that evidence of involvement by the individual's legal guardian is documented by his or her signature or refusal to sign. (9) A Positive Behavior Support Plan that includes the following components: (a). Operational definition of each behavior and the goal needs; (b). Operationally defined and measurable goals and objectives; (c). Description of data collection procedures and methods, including the staff responsible for data collection. (d). Specific behavior management procedures for reduction of maladaptive behaviors and acquisition of adaptive behaviors, methods of treatment, and staff responsible to deliver the

		treatments.
12.06	9	For youth who already have an active Positive Behavior Support Plan that was developed by another service provider, the ASD CSU should use interventions from that existing Plan to inform the development of the interventions to be implemented during the crisis stabilization process.
12.06	10	A Functional Behavior Assessment administered by the CSU's Board Certified Behavior Analyst (BCBA) and/or Board Certified Assistant Behavior Analyst (BCaBA) is used to determine the level and type of behavior interventions to be used with the individual in the ASD CSU to address ASD-related needs. A BCBA must begin a functional behavior assessment on each youth within 36 hours of admission to develop the individualized Crisis Intervention Plan and Positive Behavior Support Plan. If clinically indicated, an Adaptive behavior assessment can be completed during the initial assessment by the appropriate credentialed provider. The ASD CSU must use an established adaptive behavior assessment such as the Adaptive Behavior Assessment System, 3rd Ed. (ABAS-3), Vineland Adaptive Behavior Scales, 2nd Ed, Assessment of Functional Living Skills (AFLS), etc. A BCaBA's completion of a Functional Behavior Assessment must be reviewed and approved by the BCBA on staff.
12.06	11	Within three (3) days of admission, a provisional PBSP must be developed (which is primarily focused on the crisis-related behavior) and implemented.
12.06	12	The PBSP must include the following elements: (i). Background and Statement of Problem; (ii). Relevant Medical History/Medical Necessity; (iii). Functional Behavioral Assessment; (iv). Operational definitions of each challenging behavior and goal needs; (v). Measurable goals and objectives; (vi). Identified replacement behaviors and/or necessary skill acquisition; (vii). Description of data collection procedures and methods including staff responsible for data collection; (viii). Specific behavior strategies and methods of interventions for reduction of maladaptive behaviors, methods of treatment, and staff responsible to deliver the treatments; (ix). Any environmental modifications needed (if applicable); (x). Data recording, data analyses, and fidelity/program monitoring; (xi). Generalization, Maintenance, and fading strategies; (xii). Staff Training/Caregiver Training; (xiii). Risks and Benefits; (xiv). Consent; (xv). Data Collection Forms/Checklist; (xvi). Staff Training Record/Roster."
12.06	13	Within five (5) days of admission, a finalized PBSP must be fully implemented.
12.06	14	Within 36 hours of admission, an individual's crisis plan must be developed (or updated if one already exists) and implemented for each youth served.
12.06	15	All children/youth have an individualized Crisis Intervention Plan that includes the following elements: (1). Operational Definition of behaviors; (2). Description of situations in which the challenging behavior typically occurs; (3). Common warning signs and/or precursor behaviors that indicate a crisis is imminent; (4). Identification of staffing needed to carry out crisis curriculum procedures; (5). Identification of equipment necessary; (6). Contact information for additional staff that may be available for assistance; (7). Specific crisis curriculum techniques to use for each challenging behavior; (8). Protocols to access community-based crisis services to include the Georgia Crisis Response System, access emergency room care or law enforcement, if the acute crisis presents a substantial risk of imminent harm to self and others must be included in the crisis intervention plan provided upon discharge; (9) Procedures for debriefing and documentation. A functionally

		appropriate debriefing should occur.
12.06	16	The ASD CSU must maintain documentation of: (1) quantitative data, graphs and narrative analysis of behavior change programs, replacement behaviors, skill acquisition, and medication changes related to behavior intervention and the emanating crisis behaviors; (2) Fidelity monitoring regarding implementation of the Positive Behavior Support Plan and interventions; (3) Behavior support plan and intervention competency training of staff and caregivers.
12.06	17	The CSU must have detailed documentation of the interventions that were identified in the Positive Behavior Support Plan, and that these were both attempted and exhausted before initiating crisis interventions.
12.06	18B	The IRP and PBSP are reviewed at a minimum every three (3) business days by the treatment team to assess the need for the individual's continued stay in the CSU. These plans are updated as appropriate when the individual's condition or needs change.
12.06	19	The CSU ensures documentation at least once per day by an RN as to the status of the individual.
12.06	20	The Caregiver Training shall, at a minimum, result in the following: (1). Comprehensive knowledge on the child's complete diagnosis; (2) Competence in the behavior plan developed on the unit; (3). Knowledge on how to respond to challenging behaviors; (4) Knowledge on how to prevent challenging behaviors; (5) Knowledge on how to advocate for the child's needs; and (6) Knowledge on how to respond and implement the crisis safety plan.
12.06	21	The physician conducts an assessment of the individual at the time of discharge.
12.06	22	The ASD CSU will dedicate a staff member whose primary role is to plan the appropriate discharge of the youth from the ASD CSU. This staff will work with the ASD Case Expeditors and other identified and/or established service providers to, at a minimum, complete the following: (a). Upon admission, provider must begin developing an individualized discharge/transition plan, to include coordination and continuity of post-discharge services and supports. The CSU's case manager must assist each youth and caregiver/family with identifying and accessing needed services/supports post-discharge and must update/coordinate with any existing supporting providers and key stakeholders. (b).Research the available community resources and outpatient providers that meet the youth's and caregiver's/guardian's needs, including financial resources and preferences for location; (c). Discuss the transition options with the guardian/caregiver and youth engaging in the process, as appropriate; (d). Develop a transition plan, clearly outlining the recommended, continued treatment plan and responsibilities of the guardian/caregiver; (e). Perform all tasks related to placing the youth with the outpatient providers; (f). At least one (1) follow-up call within seven (7) days of discharge to ensure needed community support connections have been made, and that the discharge plan is being implemented.
12.06	23B	Discharge summary information is provided to the individual at the time of discharge and includes: (1) Criteria describing evidence of stabilization and discharge planning; (2) Significant findings relevant to the individual's recovery (strengths, needs, preferences). For individuals in the C&A ASD CSU, behavior data to support the determination that the individual met behavioral goals identified in the Positive Behavior Support Plan, or the need for a different level of care; (3) Specific instructions for ongoing care; (4) Individualized recommendations for

		continued care to include recovery supports, behavior supports, and community services (if indicated); and (5) Contact information on acquiring access to community services.
12.06	27	Children or youth return to their natural environment as quickly as possible; therefore, the total length of stay in a C&A ASD CSU for any one episode of care does not exceed thirty (30) calendar days.
12.06	28	An individualized daily schedule must be included in each child/youth's clinical record.
12.07	1	The CSU and BHCC documents the legal and clinical basis for the individual's admission to the CSU and BHCC, whether voluntary or involuntary, consistent with all applicable state and federal laws, rules and regulations.
12.07	2	The CSU and BHCC documents the legal and clinical basis for the individual's continued admission to the CSU and BHCC, whether voluntary or involuntary, consistent with all applicable state and federal laws, rules and regulations.
12.07	3	The CSU and BHCC maintains a record of voluntary or involuntary status change, including the date and time of such change.
12.07	4	The CSU and BHCC ensures the documentation of the assessment of the individual's capacity to understand and exercise the rights and powers of voluntary admission.
12.07	5A	The CSU and BHCC uses specific DBHDD legal forms to document any of the above mentioned actions. These forms are Form 1013, 2013, 1014, 1009 & 1012, and 1011.
12.07	6	Staff conducts a pat-down search of each individual, his or her clothing, and all personal effects before admission to the unit.
12.07	7	Personal searches of individuals (e.g., strip searches) are to be performed only for cause and if ordered by the physician. The rationale for a personal search must be clearly documented in the order. Sequential steps of the search, including documentation of staff involved by name and title, are recorded in the progress notes section of the clinical record. Neither the CSU nor the physician may require mandatory removal of clothing for all individuals, or allow standing orders for personal searches of all individuals.
12.08	1	The following practices are prohibited: (a) The use of chemical restraint for any individual. (b) The combined use of seclusion and prone mechanical and/or manual restraint. (c) Standing orders for seclusion or any form of restraint. (d) PRN orders for seclusion or any form of restraint. (e) Prone manual or mechanical restraints. (f) Transporting an individual face down while being carried or moved. (g) Use of seclusion or restraint as a part of a Behavior Support Plan (BSP) or an Individual Recovery Plan (IRP). (h) The use of handcuffs for an individual not under the jurisdiction of the criminal justice system. (i) The use of medication as a chemical restraint.
12.08	2	An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior as well as the individual's chronological and developmental age, size, gender, physical, medical, psychiatric condition, and personal history (including any history of physical or sexual abuse).
12.08	3	Initiation and Authorization of Seclusion or Restraint: (a) If the physician or other LIP who is responsible for the care of the individual and is authorized to order seclusion or restraint is available, only he or she can order the utilization of seclusion or any form of restraint. (b) If the physician or other LIP who is

		responsible for the care of the individual is unavailable, his or her designee or other LIP who is authorized to order seclusion or restraint may order the utilization of seclusion or restraint. (c) The physician or other LIP conducts an assessment prior to the initiation and authorization of seclusion or restraint and documents the assessment using Nursing Evaluation and Physician/LIP Order Form for Seclusion or Restraint in Crisis Stabilization Services.
12.08	4	The following pertains in Emergency Safety Situations (as defined in Definitions section above) when it is not possible to obtain orders in advance from a physician or other LIP: When a seclusion or restraint is initiated without an order by a physician or Licensed Independent Practitioner, the order will be obtained within thirty (30) minutes.
12.08	5B	The physician or LIP who is primarily responsible for the individual's ongoing care, or in his or her absence, the physician or LIP's designee or other LIP, sees the individual face to face or via video-equipped telemedicine and evaluates the need for seclusion or restraint within one (1) hour of initiation of seclusion or restraint. Children under nine (9) will be seen, face to face or via video-equipped telemedicine, prior to expiration of the hour. This requirement applies regardless of whether the seclusion or restraint has already been discontinued. If more than one episode of seclusion or restraint occurs, the physician or other LIP must complete the evaluation within one hour of each order.
12.08	6	As part of [the seclusion or restraint episode] evaluation, the physician or LIP: (i) Considers information that was obtained during the assessment regarding risk for the individual associated with use of seclusion or any form of restraint; (ii) Reviews the individual's current physical and psychological status, as well as all information relative to their status prior to the implementation of seclusion or restraint; (iii).Assesses the appropriateness of the seclusion or restraint used, and determines whether seclusion or restraint needs to be continued, if not already discontinued; (iv). Assesses any complications resulting from the seclusion or restraint; (v). Provides guidance to staff and the individual to identify de-escalation strategies and coping skills to help the individual regain control so that the intervention can be discontinued. (vi). Revises the individual's plan of care, treatment and services as needed; (vii) If necessary, provides a new written order; (viii) Completes documentation of the evaluation on Nursing Evaluation and Physician/LIP Order Form for Seclusion or Restraint in Crisis Stabilization Services (Attachment B).
12.08	8	The Charge Nurse or other designated staff provide one-to-one observation of the individual throughout the period of seclusion or restraint. Video monitoring is not allowed as a substitute for personal monitoring of an individual who is in seclusion or restraint. The staff member personally monitors the individual and documents this monitoring of the individual on the Seclusion or Restraint Monitoring Form for Crisis Stabilization Services.
12.08	9	Documentation occurs at least every fifteen (15) minutes regarding the following (as appropriate for the type of intervention): (a) Checking individual's physical and psychological status and comfort by speaking with or to the person. (b) Check and attend to the individual's hygiene and toileting needs. (c) Checking the individual for signs of injury associated with the implementation of seclusion or restraint. (d)If restrained, checking vital signs at least every 30 minutes, with ongoing monitoring of other physical or behavioral indications for signs of physical distress. (e) If restrained, checking circulation every 15 minutes, including looking for signs of swelling or abrasions.(f) If restrained, checking range of motion of extremities; (g)

		Attention to individual's nutrition and hydration; (h) Monitoring the individual's readiness to discontinue the intervention; (i) In addition, the Registered Nurse conducts an evaluation of the individual at least every 1 hour during the time the person is in seclusion or restraint. This evaluation is documented by the nurse on the Seclusion or Restraint Monitoring Form for Crisis Stabilization Services.
12.08	10	As soon as the emergency safety situation has ceased and the individual's safety and the safety of others can be ensured, the individual is released from seclusion or restraint even if this is prior to the arrival of the physician or other LIP. Orders never exceed two (2) hours for individuals ages 9 and older; one (1) hour for children under age 9.
12.08	11	Debriefing with the individual occurs as soon as possible after the episode of seclusion or restraint. The individual (and if appropriate, their family) participate with staff members involved in the episode (who are available) in a debriefing about the episode. If the individual is not physically or mentally able to participate in the debriefing within 24 hours, a member of the staff documents the reasons on Debriefing with Individual Following Use of Seclusion or Restraint in Crisis Stabilization Services and reschedules the debriefing as soon as possible. Information obtained from the debriefing is used to modify the individual's plan of care and used in performance improvement activities.
12.08	12	Debriefing for staff involved in the episode of seclusion or restraint occurs as soon as possible following an episode of seclusion or restraint; a debriefing is held for staff to discuss all issues around the seclusion or restraint episode. The debriefing includes components outlined in policy.
12.08	13	Review of all episodes of seclusion or restraint and the subsequent debriefing must be completed by the Medical Director within 8 hours of an episode.
12.08	14	If the individual is a minor, staff promptly notifies the individual's parent(s) or legal guardian that an incident of seclusion or restraint has occurred. Notice to the parents(s) or legal guardian must occur as soon as possible after the initiation of each emergency safety intervention. The CSU must document in the individual's record that the parent(s), legal guardian, and/or other authorized person have been so notified.
12.09	1A	An initial screening for risk of suicide or harm to others is conducted for each individual presenting for evaluation. All individuals who present at crisis or outpatient services are screened for the need for further assessment, using the CSSRS Screen Version (Lifetime or Recent). Screening occurs on the same day as the initial presentation. If this requirement is not met due to the individual's refusal or ability, documentation in the record reflects this.
12.09	2A	A "yes" answer on questions 1, 2, or 6 either recent or lifetime, means a suicide assessment or reassessment is completed.
12.09	5A	The provider places a prominent alert in the electronic or paper clinical record to ensure that all staff associated with the individual's care are aware of a current moderate or high suicide risk level. All individuals with a history of suicide attempts at any time in their lifetime have a chart alert with "suicide attempt history" in addition to their current risk level.
12.09	6A	For individuals being discharged from inpatient or crisis stabilization services with a current moderate or high risk of suicide or suicidal risk behaviors having necessitated admission, the Crisis Stabilization Units (CSUs) or state contracted bed provider communicates by phone and in clinical documentation that corresponding risk for suicide exists when an individual is transitioning to another level of care or another provider.

12.09	7A	A registered professional nurse or other licensed or certified clinician may initiate a higher level of observation prior to obtaining an APRN/Physician Extender order, but in all instances must obtain an order within one (1) hour of initiating the intervention. Such levels of care are communicated to the appropriate staff working in the milieu. The individual's record is updated following the modification of the level of observation.
12.09	10	A Full Scale Since Last Contact for Healthcare or new SAFE-T is completed if an individual presents with clinical indicators of potential risk factors, including but not limited to, a recurrence or anticipation of a precipitating event associated with a previous attempt; if there are signs of change in mental status or behavior; at times of increased stress; if risk factors are triggered; or immediately after self-harm behavior.
12.09	11	For individuals who screen needing further clinical assessment, a Masters or Doctorate level associate license or fully licensed clinician completes a Suicide Risk Assessment (SAFE-T), reassessment (Full Scale Since Last Contact for Healthcare and Communities), or other documented clinical assessment.
12.09	12	Modifications or removal of interventions for individuals experiencing higher level of clinical risk to include suicidality, psychosis, self-harming, and/or homicidality require clinical justification determined by an assessment and are specified by the attending physician and documented in the clinical record.
12.09	13	Each record must contain a level of risk and how it was formulated, including documentation of how discrepancies between assessment tools and other clinical documentation were reconciled.
12.09	14	Every individual must have a complete Stanley Brown Safety Plan. Providers collaborate with individuals to develop an individualized Stanley Brown Safety Plan. The Safety Plan is reviewed or developed within twenty-four (24) hours prior to discharge.
12.09	15	For individuals discharging from a crisis admission who were treated for suicidal behaviors, CSU crisis staff monitor for suicide risk within seventy-two (72) hours of discharge, and then weekly (documenting any action taken) until the individual is linked to ongoing care as evidenced by: 1) The date of the individual's first follow-up appointment post-discharge with their ongoing service provider, or 2) The individual declines further monitoring (which must be documented in the clinical record). Providers give resources including the provider after-hour crisis line or 988 and contact information for providers in the individual's area, or 3) The provider attempts to contact the individual three times with no answer or response.
12.09	16	Individuals who are at moderate or high risk for suicide must have the treatment of suicidal behaviors addressed in the treatment plan.