COBB COUNTY COMMUNITY SERVICES BOARD
DOUGLAS COUNTY COMMUNITY SERVICES BOARD

Policy # 8153	**Behavioral Health Crisis Center Individualized Care – Acute Unit**
Origination Date: July 2, 2015	
Revision Date: July 29, 2015, December 28, 2015, December 19, 2016 **Reviewed Date:**	
Approved: Bryan G. Stephens **Bryan G. Stephens, Interim Executive Director**	

POLICY:

It is the policy of the Cobb County Community Services Board and the Douglas County Community Services Board's Behavioral Health Crisis Center (BHCC) that multidisciplinary assessments that support the stabilization and recovery of individuals are developed by licensed clinicians and are incorporated into the Individualized Recovery Plan for Adults.

PROCEDURE:

A. The staff will follow the Admission Protocol, Acute Unit # 8149 for Assessment and Referral to services. This includes Safety Search, #8144.
B. The MD/APRN:
    1. Conducts the initial assessment of the individual within 24 hours
    2. Documents the rationale for medications prescribed to each individual
    3. Assesses the individual's response to care and services provided
    4. Assesses the individual for risk of suicide
    5. Conducts an assessment of the individual at the time of discharge
C. The Individualized Recovery Plan for an adult is developed and written within seventy-two (72) hours of admission on the basis of assessments conducted by the physician, registered nurse, and professional social work or counseling staff. The Individualized Recovery Plan is reviewed at a minimum every seventy-two (72) hours by the treatment team to assess the need for the individual's continued stay in the Acute Unit.
    1. A major goal of each Individualized Recovery Plan is the individual's stabilization and recovery.
    2. For an individual with both substance abuse and mental health diagnoses, the plan addresses issues relevant to both diagnoses.
    3. Discharge Planning begins with admission
D. At a minimum, the Individual Recovery Plan is developed in collaboration with the individual, and includes the following:
    1. A problem statement or statement of needs;
    2. Goals that is realistic, measurable, consistent with the individuals, 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 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 developing of the plan.

E. All Individuals following, with the individuals' permission (developed with RN or Social Worker)
   1. Copy of Discharge Plan
   2. Medications for 5 days
   3. Safety Plan
   4. Contact Numbers for the Suicide Hotline and GCAL (part of Safety Plan)
   5. Follow up appointment with appropriate services
      a) Outpatient Appointment
      b) Links to community services as needed

F. Clients leaving Transition Beds will also Follow the Discharge protocol in item E, above.

G. This policy is referenced in Policy #8031