

LPH/U RIGHTS POLICY REVIEW

LPH/U _____

Date of Review _____ Name/Title of Reviewer _____

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Y e s	N o	(A)	COMPLAINT PROCESS AND APPEAL PROCESS {MHC 722, 752, 755, 776-782, 788}	COMMENTS	REQUIRED ACTION
		A1	Is there a policy? What is the date of the policy?		
		A2	The licensed hospital Rights Advisor assured that recipients, parents of minors, guardians and others had ready access to complaint forms. [MHC 776 (1), (5)]		
		A3	Each rights complaint was recorded upon receipt by the rights office. [MHC 776 (3)]		
		A4	Acknowledgment of the recording in A3 above was sent along with a copy of the complaint to complainant within 5 business days. [MHC 776 (3)]		
		A5	The rights office notified the complainant within 5 business days after it received the complaint if it determined that no investigation of the complaint was warranted. [MHC 776 (4)]		
		A6	The rights office assisted the recipient or other individual with the complaint process as necessary. [MHC 776 (5)]		
		A7	The rights office advised the recipient or other individual that there are advocacy organizations available to assist in preparation of a written rights complaint and offered to make the referral. [MHC 776 (5)]		
		A8	In the absence of assistance from an advocacy organization, the office assisted in preparing a written complaint which contained a statement of the allegation, the right allegedly violated, and the outcome desired by complainant. [MHC 776 (2)(a-c); (5)]		
		A9	The rights office informed the recipient or other individual of the option of mediation and under what circumstances and when it may be exercised. [MHC 776 (5)]; [788]		
		A10	The rights office initiated investigation of apparent or suspected rights violations in a timely and efficient manner. [MHC 778 (1)]		
		A11	Subject to delays involving pending action by external agencies (CPS, law enforcement, etc.), the office completed investigations no later than 90 calendar days following receipt. [MHC 778 (1)]		
		A12	Investigation was immediately initiated in cases involving alleged abuse, neglect, serious injury, or death of a recipient when a rights violation was apparent or suspected. [MHC 778 (1)]		
		A13	Investigation activities for each rights complaint were accurately recorded by the office. [MHC 778 (2)]		
		A14	The rights office used a preponderance of the evidence as its standard of proof in determining whether a right was violated. [MHC 778 (3)]		
		A15	The rights office issued a written status report every 30 calendar days during the course of the investigation to the complainant, respondent and the responsible mental health agency (RMHA). [MHC 778 (4)]		
		A16	The 30 day status report contained: a) Statement of the allegations. c) Citations to relevant provisions to the Mental Health Code, rules, policies, and guidelines. b) Statement of the issues involved. d) Investigative progress to date. e) Expected date for completion. [MHC 778 (4)]		
		A17	Upon completion of the investigation, the office submitted a written investigative report to the hospital director. (Issuance of the written investigative report may be delayed pending completion of investigations that involve external agencies). (MHC 778 [5])		
		A18	The written investigative report included all of the following: a) Statement of the allegations. c) Citations to relevant provisions of the Mental Health Code, rules, policies, and guidelines. b) Statement of the issues involved. d) Investigative findings. e) Conclusions f) Recommendations, if any. [MHC 778 (5)]		

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Y e s	N o	(A)	COMPLAINT PROCESS AND APPEAL PROCESS {MHC 722, 752, 755, 776-782, 788}	COMMENTS	REQUIRED ACTION
		A19	On substantiated rights violations, the hospital director took appropriate remedial action that met all the following requirements: a) Corrects or provides remedy for the rights violation. b) Is implemented in a timely manner. c) Attempts to prevent a recurrence of the rights violation. [MHC 780 (1)]		
		A20	The remedial action taken on substantiated violations was documented and made part of the record maintained by the rights office. [MHC 780 (2)]		
		A21	The hospital director submitted a written summary report to the complainant, recipient, if different than the complainant, guardian or parent of minor recipient within 10 business days after the hospital director received a copy of the investigative report from the rights office. (MHC 782 [1])		
		A22	The written summary report above contained all of the following: a) Statement of the allegations. c) Citations to relevant provisions of the Mental Health Code, rules, policies, and guidelines. b) Statement of the issues involved. d) Summary of investigation findings of the rights office. e) Conclusions of the rights office. f) Recommendations made by the rights office. g) Action taken, or plan of action proposed, by the hospital director. h) A statement describing the complainant's right to appeal and the grounds for appeal. [MHC 782 (1)]		
		A23	Information in the summary report was provided within the constraints of the confidentiality/privileged communications sections (748, 750) of the Mental Health Code. [MHC 782 (2)]		
		A24	Information in the summary report did not violate the rights of any employee (ex. Bullard-Plawewski Employee Right to Know Act, Act No. 397 of the Public Acts of 1978, MCL 423.501 et. seq) [MHC 782 (2)]		
		A25	The licensed hospital ensured that appropriate disciplinary action was taken against those who have engaged in abuse or neglect. (MHC 722 [2])		
		A26	When licensed hospital personnel failed to report suspected violations of rights, appropriate administrative action was taken. (MHC 752(1))		
		A27	The rights office complied with pertinent hospital policies to assure that investigations were conducted in a manner that did not violate employee rights. [MHC 755 (3)(b)]		
		A28	Rights complaints filed by recipients or anyone on their behalf were sent or given to the designated rights officer/advisor in a timely manner. [MHC 776 (1); 778 (1)]		
		A29	The governing body of the licensed hospital designated the appeals committee of the responsible CMHSP to hear an appeal of a decision on a recipient rights matter brought by or on behalf of a recipient of that CMHSP (MHC 744[3])		
		A30	The governing body of the licensed hospital did one of the following with respect to an appeal of a rights matter brought by or on behalf of an individual who is not a recipient of a CMHSP: (MHC 774[4]) a) Appointed an appeals committee consisting of individuals, none of whom is employed by DCH or a CMHSP, 2 of whom shall be primary consumers and 2 of whom shall be community members; b) By agreement with DCH, designated the appeals committee appointed by DCH to hear appeals of rights complaints brought against the hospital/unit		
		A31	Standard A31 applies only if LPH has their own appeals committee. A member of the appeals committee who has a personal or professional relationship with an individual involved in an appeal abstains from participating in that appeal as a member of the committee. [MHC 774 (6)]		

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Y e s	N o	(A)	COMPLAINT PROCESS AND APPEAL PROCESS {MHC 722, 752, 755, 776-782, 788}	COMMENTS	REQUIRED ACTION
		A32	The complainant, recipient (if different than complainant), guardian or parent of minor, in the summary report from the hospital director/designee, was informed of both of the following: (MHC 782 [1])(MHC 784 [2]) a) An appeal may be filed no later than 45 days after receipt of the summary report. b) The grounds for appeal are: - The investigative findings of the rights office are not consistent with the facts, law, rules, policies or guidelines. - The action taken or plan of action proposed by the hospital/unit does not provide an adequate remedy. - An investigation was not initiated or completed on a timely basis.		
		A33	The rights office advised the complainant that there are advocacy organizations available to assist in preparing the written appeal and offered to make the referral. [MHC 784 (3)]		
		A34	In the absence of assistance from an advocacy organization, the rights office assisted the complainant in meeting the procedural requirements of a written appeal. [MHC 784(3)]		
		A35	The rights office informed the complainant of the option of mediation. [MHC 784 (3)]		
		A36	Standards A36-A44 apply only if LPH has their own appeals committee. Within 5 business days after receipt of a written appeal, members of the Appeals Committee reviewed the appeal to determine whether it met criteria (see above). [MHC 784(4)]		
		A37	If the appeal was not accepted, appellant was notified in writing within the 5 business day period. [MHC 784 (4)]		
		A38	If the appeal was accepted, appellant was notified in writing within the 5 business day period. [MHC 784 (4)]		
		A39	If the appeal was accepted, a copy of the appeal was provided to the hospital/respondent within the 5 business day period. (MHC 784 [4])		
		A40	Within 30 days after the written appeal was received, the Appeals Committee met and reviewed the facts as stated in all complaint investigation documents. [MHC 784 (5)]		
		A41	The Appeals Committee did one of the following in deciding upon an appeal: a) Upheld the findings of the rights office and the action taken or plan of action proposed respondent. b) Returned the investigation to the rights office with request that it be reopened or reinvestigated. c) Upheld the investigative findings of the rights office but recommended that respondent take additional or different action to remedy the violation. d) Recommended that the Board of the CMHSP request an external investigation by the DCH Office of Recipient Rights. [MHC 784(5)(a-d)]		
		A42	The Appeals Committee documented its decision in writing. [MHC 784 (6)]		
		A43	Within 10 days after reaching its decision, the Appeals Committee provided copies of the decision to the respondent, appellant, recipient if different than appellant, recipient's guardian if one has been appointed, the CMHSP, and the rights office. [MHC 784 (6)]		
		A44	Copies of Appeals Committee decision included a statement of appellant's right to appeal to the DCH, the time frame for appeal (45 days from receipt of decision) and ground for appeal (investigative findings of the rights office are inconsistent with facts, rules, policies or guidelines.) [MHC 784 (6);(786)]		

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Y e s	N o	(B)	CONSENT {AR 7003, MHC 752}	COMMENTS	REQUIRED ACTION
		B1	Is there a policy? What is the date of the policy?		
		B2	Is consent defined? [Including Competency- Knowledge- Comprehension- Voluntariness] [MHC 1100A(17), AR 7003(1)(b-d)]		
		B3	Does it provide that the individual consenting shall be aware of the procedures, risks, other consequences and relevant information? [AR 7003(1)(b)]		
		B4	Is there provision for making recipient/guardian aware that consent can be withdrawn at any time without prejudice to the recipient/guardian? [AR 7003(1)(d)]		
		B5	Is there a procedure for evaluating comprehension? [AR 7003(2)]		
		B6	Does policy reference that an evaluation of the ability to give consent shall precede any guardianship proceedings? [AR 7003(2)]		

Y e s	N o	(C)	STERILIZATION/ABORTION/CONTRACEPTION (FAMILY PLANNING {AR 7029, MHC 752}	COMMENTS	REQUIRED ACTION
		C1	Is there a policy? What is the date of the policy?		
		C2	Does it include notice by the individual in charge of the recipient's written plan of service to recipients, their guardians, and parents of minor recipients of the availability of family planning and health information? [AR 7029(1)]		
		C3	Does it provide for referral assistance to providers of family planning and health information services upon request of the recipient, guardian or parent of a minor recipient? [AR 7029(1)]		
		C4	Does the policy provide that the notice include a statement that mental health services are not contingent upon receiving family planning services? [AR 7029]		

Y e s	N o	(D)	FINGERPRINTING, PHOTOGRAPHS, AUDIOTAPE, OR USE OF 1- WAY GLASS (MHC 724, 752; AR 7003)	COMMENTS	REQUIRED ACTION
		D1	Is there a policy? What is the date of the policy?		
		D2	Does policy indicate circumstances for which audiotapes or photos may be taken and 1-way glass used? [MHC 724(7)(a-c)]		
		D3	Is there a procedure for use of fingerprints, photos, or audio- tapes for purpose of recipient identification? [MHC 724(4)]		
		D4	Does it provide for prior written consent? [MHC 724(2)] [AR 7003(1)(c)]		
		D5	Does it provide for withdrawing consent? [AR 7003 (1)(d)]		
		D6	Does it provide a means to object when photos are for personal information or social purposes? [MHC 724(6)]		
		D7	Does it prescribe methods of safekeeping? [MHC 724(4)]		
		D8	Does it provide review of current need for audio taping, photographing/fingerprinting or use of 1-way glass? [MHC 724(5)]		
		D9	Does the policy indicate that video surveillance may only be conducted for the purposes of safety, security and quality improvement; in common areas (hallways, nursing station, social activity areas) [MHC 724(9)]	New	
		D10	Does it require identification of the locations where the surveillance images will be recorded and saved? [MHC 724(9)(a)]	New	
		D11	Does it indicate how recipients and visitors will be advised of the video surveillance? [MHC 724(9)(b)]	New	

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		D12	Does it include Security provisions that include: The security provisions shall include all of the following: (i) Who may authorize viewing of recorded surveillance video. (ii) Circumstances under which recorded surveillance video may be viewed. (iii) Who may view recorded surveillance video with proper authorization. (iv) Safeguards to prevent and detect unauthorized viewing of recorded surveillance video. (v) Circumstances under which recorded surveillance video may be duplicated and what steps will be taken to prevent unauthorized distribution of the duplicate. [MHC 724(9)(c)]	New	
		D13	Documentation, and maintenance of that documentation, regarding each instance of authorized access, viewing duplication, or distribution of a surveillance video. [MHC 724(9)(d)]	New	
		D14	A process to retrieve a distributed video when the purpose for which it was distributed no longer exists. [MHC 724(9)(e)]	New	
		D15	Archiving footage of surveillance recordings for up to 30 days where an incident requires investigation by various entities, including law enforcement, Office of Recipient Rights, state licensing entity, and Centers for Medicaid and Medicare Services. [MHC 724(9)(f)]	New	
		D16	Prohibition on maintaining a recorded video surveillance image as part of a recipient's clinical record. [MHC 724(9)(g)]	New	

Y e s	N o	(E)	ABUSE/NEGLECT {MHC 722, 723, 752, 778; AR 7035}	COMMENTS	REQUIRED ACTION
		E1	Is there a policy? What is the date of the policy?		
		E2	Does policy define abuse? [MHC 100 (2)]		
		E3	Does policy establish detailed categories of abuse by type and severity? [AR 7001 (a-c)]		
		E4	Does policy define neglect? [MHC 100(18)]		
		E5	Does policy establish detailed categories of neglect by type and severity? [AR 7001 (g-i)]		
		E6	Does policy establish procedure for reporting abuse or neglect to: a) Administration [MHC 752(1)] b) The Rights Office [AR 7035] c) DHS Protective Services [P.A. 519, 1982; P.A. 238, 1978]		
		E7	Does policy establish procedures for reporting criminal abuse including Vulnerable Adult Abuse and Child Abuse to local law enforcement? [MHC 723]		
		E8	Does policy provide mechanism for investigation of abuse/neglect allegations by Rights Officer/Advisor? [MHC 778 (1)]		
		E9	If allegation is found to be substantiated, is there a mechanism for: a) Remedial action [MHC 722(2)] b) Firm and appropriate disciplinary action [MHC 722(2)]		
		E10	Does policy clearly define who is required to report abuse? [MHC 723(1); P.A. 238, 1978; P.A. 519, 1982; and MHC 722(2)]		
		E11	Is it clear as to how policy will be implemented?		
		E12	Does policy define who shall prepare written reports to law enforcement agencies regarding criminal abuse? [MHC 723(2)]		

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Y e s	N o	(F)	CONFIDENTIALITY/DISCLOSURE	COMMENTS	REQUIRED ACTION
			<p>{MHC 748, 752; AR 7051}</p> <p><i>* Advice should be sought from legal/corporate counsel as to the interpretation and implementation of HIPAA standards as they apply to agency policy and procedures relative to disclosure of confidential information. This policy was reviewed <u>only</u> for compliance with state law and was <u>not</u> reviewed for compliance with HIPAA.</i></p>		
		F1	Is there a policy? What is the date of the policy?		
		F2	Is there a provision that all information in the record and that obtained in the course of providing services is confidential? [MHC 748(1)]		
		F3	Is there provision for a summary of section 748 of the mental health code to be made part of each recipient file? [AR 7051(1)]		
		F4	<p>Is a record kept of disclosures including: [AR 7051 (2)(a-e)]</p> <p>a) Information released [(2)(a)]</p> <p>b) To whom it is released [(2)(b)]</p> <p>c) Purpose stated by person requesting the information [(2)(c)]</p> <p>d) Statement indicating how disclosed information is germane to the state purpose [(2)(c)]</p> <p>e) The part of law under which disclosure is made [(2)(d)]</p> <p>f) Statement that the persons receiving the disclosed information could only further disclose consistent with the authorized purpose for which it was released [(2)(e)]</p>		
		F5	<p>When requested, confidential information shall be disclosed only under one or more of the following circumstances: [MHC 748(5)(a-g)]</p> <p>a) Order or subpoena of a court of record or legislature for non-privileged information.</p> <p>b) To a prosecutor as necessary for the prosecutor to participate in a proceeding governed by the MHC.</p> <p>c) To the recipient's attorney with consent of the recipient, the recipient's guardian with authority to consent, or the parent with legal and physical custody of a minor recipient.</p> <p>d) To the Auditor General.</p> <p>e) When necessary to comply with another provision of law.</p> <p>f) To DCH when necessary in order for the department to discharge a responsibility placed upon it by law.</p> <p>g) To a surviving spouse, or if none, closest relative of the recipient in order to apply for and receive benefits, but only if spouse or closest relative has been designated the personal representative or has a court order.</p> <p>[45CFR 164.502(g)(4)]</p>		
		F5a	Within 14 days after receipt of written request from DHS/CPS pertinent records and information are released. [MHC 748a]		
		F6	<p>Except as otherwise provided in Sec 748 (4) [see F7] confidential information <u>may</u> be disclosed to providers of mental health services to the recipient or to any individual or agency if consent has been obtained from: [MHC 748(6)]</p> <p>a) Recipient</p> <p>b) Recipient's guardian with authority to consent</p> <p>c) Parent with legal custody of a minor recipient</p> <p>d) Court approved personal representative or executor of the estate of a deceased recipient.</p>		
		F7	For case records made subsequent to March 28, 1996, information made confidential by Sec. 748 of the Mental Health Code shall be disclosed to a competent adult recipient upon the recipient's request. Release is done as expeditiously as possible but in no event later than the earlier of 30 days of the request or prior to release from treatment. [MHC 748 (4)]		

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			<p>{MHC 748, 752; AR 7051}</p> <p><i>* Advice should be sought from legal/corporate counsel as to the interpretation and implementation of HIPAA standards as they apply to agency policy and procedures relative to disclosure of confidential information. This policy was reviewed <u>only</u> for compliance with state law and was <u>not</u> reviewed for compliance with HIPAA.</i></p>		
		F8	Unless Sec. 748(4) of the act applies to the request for information, is there provision that if a request for information has been delayed, the director of the provider shall review the request and make a determination within 3 business days if record is on-site or 10 business days if record is off - site whether the disclosure would be detrimental to the recipients or others? [AR 7051(3)]		
		F9	Is there provision that this determination can be appealed to the recipient rights office having jurisdiction. [AR 7051(3)]		
		F10	Except for MHC 748 (4) preceding, if a holder of the record, for a documented reason, declines to disclose, there shall be a determination whether part of the information can be released without detriment. [AR 7051(3)]		
		F11	Information shall be provided to private physicians psychologists appointed by the court or retained to testify in civil, criminal, or administrative proceedings as follows: [AR 7051(5)(a-b)] They shall be notified before their review when the records contain privileged communication which cannot be disclosed in court, unless disclosure is permitted because of an express waiver of privilege or by law which permits or requires disclosure.		
		F12	A prosecutor may be given non-privileged information or privileged information which may be disclosed if it contains information relating to names of witnesses to acts which support the criteria for involuntary admission, information relevant to alternatives to admission to a hospital or facility, and other information designated in policies of governing body. [AR 7051 (6)(a-c)]		
		F13	The holder of a record may disclose information that enables a recipient to apply for or receive benefits without the consent of the recipient or legally authorized representative only if the benefits shall accrue to the provider or shall be subject to collection for liability for mental health service. [MHC 748(7)(a); [AR 7051(7)]		
		F14a	If required by federal law, the licensed hospital grants a representative of Michigan Protection and Advocacy Services access to the records of all of the following [MHC 748 (8)]: a) A recipient, the recipient, or other empowered representative has consented to the access.		
		F14b-1	b) A recipient, including a recipient who has died or whose whereabouts are unknown, if all of the following apply: b.1. Because of mental of physical condition, the recipient is unable to consent to the access.		
		F14b-2	The recipient does not have a guardian or other legal representative, or the recipient's guardian is the state.		
		F14b-3	Michigan Protection and Advocacy Services has received a complaint on behalf of the recipient or has probable cause to believe based on monitoring or other evidence that the recipient has been subject to abuse or neglect.		
		F14c-1	A recipient who has a guardian or other legal representative if all of the following apply: c.1. A complaint has been received by the protection and advocacy system or there is probable cause to believe the health or safety of the recipient is in serious and immediate jeopardy.		
		F14c-2	c.2. Upon receipt of the name and address of the recipient's legal representative, Michigan Protection and Advocacy Services has contacted the representative and offered assistance in resolving the situation.		
		F14c-3	c.3. The representative has failed or refused to act on behalf of the recipient.		

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		F15	The records, data, and knowledge collected for or by individuals or committees assigned a peer review function including the review function under section 143a (1) of the Mental Health Code are confidential, are used only for the purpose of peer review, are not public records, and are not subject to court subpoena. [MHC 748 (9)]		
		F16	The licensed hospital, when authorized to release information for clinical purposes by the individual or the individual's guardian or a parent of a minor, releases a copy of the entire medical and clinical record to the provider of mental health services. [MHC 748 (10)]		
		F17	A recipient, guardian, or parent of a minor recipient, after having gained access to treatment records, may challenge the accuracy, completeness, timeliness, or relevance of factual information in the recipient's record; the recipient or other empowered representative was allowed to insert into the record a statement correcting or amending the information at issue; the statement became part of the record. (MHC 749) (does it address how, who, what form?)		

Y e s	N o	(G)	TREATMENT BY SPIRITUAL MEANS {AR 7135, MHC 752}	COMMENTS	REQUIRED ACTION
		G1	Is there a policy? What is the date of the policy?		
		G2	Does the policy define "treatment by spiritual means" (as a spiritual discipline or school of thought that a recipient wishes to rely on to aid physical or mental recovery)? [AR 7001(r)]		
		G3	Does it allow for treatment by spiritual means on request by recipient, guardian, or parent of a minor recipient?		
		G4	Is there a procedure to insure recourse to court when there is refusal of medication or other treatment for a minor? [AR 7135(6)(a)]		
		G5	Is there a procedure that requesting persons must be informed of denial and given the reasons? [AR 7135(6)(b)]		
		G6	Is there an administrative review or appeal process when treatment by spiritual means is denied? [AR 7135(7)]		
		G7	Does it provide for the same provision for contact with agencies providing treatment by spiritual means as is provided for contact with private mental health professionals? [AR 7135(2)]		
		G8	Does it include right to refuse medications if: <ul style="list-style-type: none"> a) Spiritual treatment predates current allegation of mental illness or disability. [AR 7135(4)] b) No court order empowering guardian or facility to make those decisions. [AR 7135(4)(a)] c) Recipient is not imminently dangerous to self or others. [AR 7135(4)(b)] 		
		G9	Does the policy include the legal restrictions for: <ul style="list-style-type: none"> a) Mechanical, chemical or organic compounds that are physically harmful. [AR 7135(5)(a)] b) Activity prohibited by law. [AR 7135(5)(b)] c) Activity physically harmful to self or others. [AR 7135(5)(c)] d) Activity inconsistent with court ordered custody or placement by person other than recipient. [AR 7135(5)(d)] 		

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Y e s	N o	(H)	QUALIFICATIONS AND TRAINING FOR RECIPIENT RIGHTS STAFF {MHC 752, 755}	COMMENTS	REQUIRED ACTION
		H1	Is there a policy? What is the date of the policy?		
		H2	Does it require staff of the Office of Recipient Rights to receive annual training in recipient rights protection? [MHC 755 (2)(e)]		
		H3	Does it state that the director of the Office of Recipient Rights must have the education, training, and experience to fulfill the responsibilities of the office? [MHC 755 (4)]		
		H4	Does it indicate what education, training, and experience is required either in policy or position description? [MHC 755(4)]		
		H5	Does it require that the rights officer, advisor and alternate attend DCH-ORR Basic Skills I and II and Developing Effective Training (DET) within 3 months of hire? [LPH/CMHSP Contract referencing the DCH/CMH Master Contract, FY 02-04, 6.3.2]		

Y e s	N o	(I)	CHANGE IN TYPE OF TREATMENT {MHC 712, 752; AR 7199 (2)(j)}	COMMENTS	REQUIRED ACTION
		I1	Is there a policy? What is the date of the policy?		
		I2	Does policy require that the written POS have a specific date or dates when the overall plan and any of its sub-components will be formally reviewed for possible modification or revision? [AR 7199(2)(j)]		
		I3	Is there a procedure to assure that the plan is kept current and modified when indicated? (MHC 712 (1), MHC 752)		
		I4	Does policy require that the recipient be informed orally and in writing of his or her clinical status and progress at reasonable intervals established in the IPOS in a manner appropriate to his or her clinical condition? (MHC 714)		
		I5	If the recipient is not satisfied with his/her individual plan of services, the recipient or his/her guardian or parent of a minor recipient may make a request for review to the designated individual in charge or implementing the plan. (MHC 712 [2])		
		I6	The above review is completed with 30 days and is carried out in a manner approved by the licensed hospital. [MHC 712 (2)]		

Y e s	N o	(J)	MEDICATION PROCEDURES {AR 7158, MHC 752}	COMMENTS	REQUIRED ACTION
		J1	Is there a policy? What is the date of the policy?		
		J2	Does policy require a doctor's order for medication? [AR 7158 (1)]		
		J3	Does it specify that medication shall not be used as punishment or for staff's convenience? [AR 7158 (3)]		
		J4	Does it require periodic medication reviews as specified in plan of service and based on recipient's clinical status [AR 7158 (4)]		
		J5	Does policy specify that medications must be administered by or under supervision of personnel who are qualified and trained staff? [AR 7158 (5)]		
		J6	Does procedure require documentation of the administration of all medication in recipient's clinical record? [AR 7158 (6)]		
		J7	Does policy require reporting and documentation in the recipient's clinical record of medication errors and adverse reactions? [AR 7158(7)]		
		J8	Does it specify that only medications authorized by a physician are to be given at discharge or leave and that enough medication is made available to ensure the recipient has an adequate supply until he or she can become established with another provider. [AR 7158 (9)]		

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Y e s	N o	(K)	USE OF PSYCHOTROPIC DRUGS {MHC 718, 719, 752; AR 7158}	COMMENTS	REQUIRED ACTION
		K1	Is there a policy? What is the date of the policy?		
		K2	Does it provide that: Psychotropic chemotherapy shall not be administered unless: [AR 7158 (8)(a)-(e)] a) Individual gives informed consent b) Administration necessary to prevent physical injury to person or another. c) Court order.		
		K3	Does policy restrict initial administration of psychotropic chemotherapy to less than 48 hours without consent? [AR 7158 (8)(d)]		
		K4	Does policy define psychotropic chemotherapy? [AR 7001 (m)]		
		K5	A provider may administer chemotherapy to prevent physical harm or injury after signed documentation of the physician is placed in the resident's clinical record and when the actions of a resident or other objective criteria clearly demonstrate to a physician that the resident poses a risk of harm to himself, herself or others [AR 7158(8)(c)]		
		K6	Does it specify minimal duration and safe termination? [AR 7158 (8)(d)]		
		K7	Does procedure require documentation of the administration of all medication in recipient's clinical record? [AR 7158 (6)]		
		K8	Does policy state that before initiating a course of psychotropic drug treatment for a recipient, the prescriber or a licensed health professional acting under the delegated authority of the prescriber shall do both of the following: (a) Explain the specific risks and most common adverse side effects associated with that drug, and (b) Provide the individual with a written summary of those common adverse side effects. (MHC 719 as amended by SB 1048)		

Y e s	N o	(L)	RESTRAINT {MHC 700, 740, 752; AR 7243; 42 CFR 482; 42 CFR 483}	COMMENTS	REQUIRED ACTION
		L1	Is there a policy? What is the date of the policy?		
		L2	Is restraint defined, as applicable to the setting? [MHC 700 (i); 42 CFR 482; 42 CFR 483]		

PLEASE NOTE: There are significant changes to the restraint requirements. This includes allowing LPH policies to establish standards in some areas. Please review LPH policies carefully to ensure compliance with both state and federal regulations. This includes any LPH policy that establishes a standard allowed by the regulations. Currently the Michigan Mental Health Code only permits a physician to authorize or order restraints in a LPH/U. No other category of licensed Independent Practitioner may authorize or order restraint. Note that a physician may not delegate his/her authority to authorize or order restraint to another category of Licensed Independent Practitioner or licensed health professional. These standards apply only to LPH/Us that are certified Medicaid/Medicare providers.

For LPH/U's, does the policy minimally provide that:

		L3	(a) All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. (b) The type or technique of restraint used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.		
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Y e s	N o	(L)	<p align="center">RESTRAINT {MHC 700, 740, 752; AR 7243; 42 CFR 482; 42 CFR 483}</p>	COMMENTS	REQUIRED ACTION
			(c) The use of restraint must be-- (i) In accordance with a written modification to the patient's plan of care; and (ii) Implemented in accordance with safe and appropriate restraint techniques as determined by hospital policy in accordance with State law. (iii) If a patient is restrained repeatedly, the patient's individual plan of services shall be reviewed and modified to facilitate the reduction of the use of restraints [MHC 330.1740 (9)]		
			(d) A recipient may be temporarily restrained without an order or authorization in an emergency. Immediately after the imposition of the temporary restraint, a physician shall be contacted. If, after being contacted, the physician does not order or authorize the restraint, the restraint shall be removed. [MHC 330.1740(3)]		
			(e) Orders for the use of restraint must never be written as a standing order or on an as needed basis (PRN).		
			(f) The attending physician must be consulted as soon as possible if the attending physician did not order the restraint.		
			(g) Orders (i) A patient may be restrained pursuant to an order by a physician made after personal examination of the patient. An order for restraint shall continue only for that period of time specified in the order or for up to the following limits, whichever is less: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1 hour for children under 9 years of age; and (ii) Before writing a new order for the use of restraint for the management of violent or self-destructive behavior, a physician must see and assess the patient. (iii) The required examination by a physician shall be conducted not more than 30 minutes before the expiration of the expiring order for restraint. [AR 330.7243 (6b)]		
			(h) Restraint must be discontinued at the earliest possible time, regardless of the length of time identified in the order.		
			(i) A restrained patient shall: [MHC 330.1740 (6), AR 330.7243] (i) Continue to receive food (ii) Be given hourly access to toilet facilities (iii) Be bathed as often as needed, but at least every 24 hours (iv) Be clothed or otherwise covered (v) Be given the opportunity to sit or lie down		
			(j) Restraints shall be removed every 2 hours for not less than 15 minutes, unless medically contraindicated [MHC 330.1740 (7)]		
			(k) A provider shall ensure that an assessment of the circulation status of restrained limbs is conducted and documented at 15 minute intervals or more often if medically indicated. [AR 330.7243 (9)]		
			(l) The condition of the patient who is restrained must be monitored by a physician or trained staff that have completed the training criteria specified in paragraph (s) of this section at an interval determined by hospital policy.		
			(m) Physician training requirements must be specified in hospital policy. At a minimum, physicians must have a working knowledge of hospital policy regarding the use of restraint.		

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Y e s	N o	(L)	<p align="center">RESTRAINT {MHC 700, 740, 752; AR 7243; 42 CFR 482; 42 CFR 483}</p>	COMMENTS	REQUIRED ACTION
			<p>(n) When restraint is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention--</p> <ul style="list-style-type: none"> (i) By a-- <ul style="list-style-type: none"> (A) Physician (ii) To evaluate-- <ul style="list-style-type: none"> (A) The patient's immediate situation; (B) The patient's reaction to the intervention; (C) The patient's medical and behavioral condition; and (D) The need to continue or terminate the restraint or seclusion. 		
			<p>(o) If the face-to-face evaluation specified in paragraph (n) of this section is conducted by a physician other than the attending physician, the physician must consult the attending physician who is responsible for the care of the patient as soon as possible after the completion of the 1-hour face-to-face evaluation.</p>		
			<p>(p) All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored--</p> <ul style="list-style-type: none"> (i) Face-to-face by an assigned, trained staff member; or (ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient. 		
			<p>(q) When restraint is used, there must be documentation in the patient's medical record of the following:</p> <ul style="list-style-type: none"> (i) The 1-hour face-to-face medical and behavioral evaluation if restraint is used to manage violent or self-destructive behavior; (ii) A description of the patient's behavior and the intervention used; (iii) Alternatives or other less restrictive interventions attempted (as applicable); (iv) The patient's condition or symptom(s) that warranted the use of the restraint; and (v) The patient's response to the intervention(s) used, including the rationale for continued use of the intervention. (vi) A provider shall ensure that documentation of staff monitoring and observation is entered into the medical record of the patient. [AR330.7243 (3)] 		
			<p>(r) A separate permanent record of each instance of restraint shall be kept and shall comply with applicable standards.[AR330.7243(1)]</p>		
			<p>(s) Standard: Restraint: Staff training requirements.</p> <p>The patient has the right to safe implementation of restraint by trained staff.</p> <p>(1) Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, monitoring, assessment, and providing care for a patient in restraint --</p> <ul style="list-style-type: none"> (i) Before performing any of the actions specified in this paragraph; (ii) As part of orientation; and (iii) Subsequently on a periodic basis consistent with hospital policy. 		
			<p>(2) Training content. The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:</p> <ul style="list-style-type: none"> (i) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint. (ii) The use of nonphysical intervention skills. (iii) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition. (iv) The safe application and use of all types of used in the hospital, psychological distress (for example, positional asphyxia); (v) Clinical identification of specific behavioral changes that indicate that restraint is no longer necessary. 		

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Y e s	N o	(L)	RESTRAINT {MHC 700, 740, 752; AR 7243; 42 CFR 482; 42 CFR 483}	COMMENTS	REQUIRED ACTION
			(vi) Monitoring the physical and psychological well-being of the patient who is restrained, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation. (vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.		
			(3) Trainer requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors. (4) Training documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.		
			(t) Standard: Death reporting requirements: Hospitals must report deaths associated with the use of restraint. (1) The hospital must report the following information to CMS: (i) Each death that occurs while a patient is in restraint. (ii) Each death that occurs within 24 hours after the patient has been removed from restraint. (iii) Each death known to the hospital that occurs within 1 week after restraint where it is reasonable to assume that use of restraint contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation. (2) Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death. (3) Staff must document in the patient's medical record the date and time the death was reported to CMS. [All citations from 42CFR482.13 unless otherwise indicated]		

Y e s	N o	(M)	DIGNITY AND RESPECT {MHC 704, 708, 711, 752}	COMMENTS	REQUIRED ACTION
		M1	Is there a policy? What is the date of the policy?		
		M2	The licensed hospital protects and promotes the dignity and respect to which a recipient of services is entitled. [MHC 704 (3), 708 (4)]		
		M3	Family members are treated with dignity and respect. [MHC 711]		
		M4	Family members are given an opportunity to provide information to the treating professionals. [MHC 711]		
		M5	Family members are provided an opportunity to request and receive general educational information about the nature of disorders, medications, and their side effects, available support services, advocacy and support groups, financial assistance and coping strategies. [MHC 711]		

Y e s	N o	(N)	LEAST RESTRICTIVE SETTING {MHC 708, 752}	COMMENTS	REQUIRED ACTION
		N1	Is there a policy? What is the date of the policy?		

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		N2	The licensed hospital offers mental health services in the least restrictive setting that is appropriate and available. [MHC 708 (3)]		
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Y e s	N o	(O)	SERVICES SUITED TO CONDITION {MHC 409, 705, 712, 752; AR 7199}	COMMENTS	REQUIRED ACTION
		O1	Is there a policy? What is the date of the policy?		
		O2	The licensed hospital ensures that a person-centered planning process is used to develop a written IPS in partnership with the recipient [MHC 712 (1)]		
		O3	The IPOS includes assessments of the recipient's need for food, shelter, clothing, health care, employment opportunities where appropriate, educational opportunities where appropriate, legal services and recreation. [AR 7199(h)]		
		O4	The IPOS identified any limitations of the recipient's rights and includes documentation describing how the limitation is justified and time-limited. Documentation shall be included that describes attempts that have been made to avoid limitations, as well as what actions will be taken as part of the plan to ameliorate or eliminate the need for the limitations in the future. [AR 7199 (g)(ii)]		
		O5	Limitations of the recipient's rights, any intrusive treatment techniques or any use of psychoactive drugs where the target behavior is due to an active substantiated Axis 1 psychiatric diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders need not be reviewed and approved by a specially constituted body described in this subdivision. [AR 7199(g)(i)]		
		O6	Justification for exclusion of individuals chosen by the recipient to participate in the IPOS process shall be documented in the case record [MHC 712 (3)]		
		O7	The licensed hospital ensures that a recipient is given a choice of physician or mental health professional within the limits of available staff [MHC 713]		

Y e s	N o	(P)	RIGHT TO ENTERTAINMENT MATERIALS, INFORMATION & NEWS {AR 7139, MHC 752}	COMMENTS	REQUIRED ACTION
		P1	Is there a policy? What is the date of the policy?		
		P2	Does policy specify that resident shall not be prevented from obtaining reading/viewing/listening material at his/her own expense for reasons of, or similar to, censorship? [AR 7139(1)]		
		P3	A provider may limit access to entertainment materials, information, or news only if such a limitation is specifically approved in the resident's individualized plan of service. A provider shall document each instance when a limitation is imposed in the resident's record. [AR 7139(2)(3)]		
		P4	Does it require limitations/restrictions to be removed when no longer clinically justified? [AR 7139(4)]		
		P5	Does it specify that minors may not have access over objection of parent/guardian or if against state law? [AR 7139(5)]		
		P6	Does it: [AR 7139 (6)(a-e)] a) Specify general program restrictions on access to material? b) Provide for determining resident's interest for provision of daily newspaper? c) Permit staff person to persuade a parent or guardian of a minor to withdraw objection to material desired by the minor? d) Provide appeal mechanism? e) Specify restrictions for entire living unit?		

Y e s	N o	(Q)	COMPREHENSIVE EXAMINATIONS {AR 7181, MHC 752}	COMMENTS	REQUIRED ACTION
		Q1	Is there a policy? What is the date of the policy? [MHC 752 (1)(p)(ii)]		

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Y e s	N o	(R)	PERSONAL PROPERTY AND FUNDS {MHC 728, 730, 732, 752; AR 7009}	COMMENTS	REQUIRED ACTION
		R1	Is there a policy on personal property and funds? What is the date of the policy?		
		R2	Are excluded items listed (including weapons, sharp objects, explosives, drugs and alcohol)? [MHC 728 (3)]		
		R3	Does policy require any exclusions of personal property be in writing and posted in each residential unit? [MHC 728 (3)]		
		R4	Is there a procedure for search for contraband items? [AR 7009 (7)]		
		R5	Does the search procedure include justification and documentation in the record? [AR 7009 (7)]		
		R6	Does policy require limitations of property to be justified and documented in the record of the resident? [MHC 728(5)]		
		R7	Does policy require a receipt to be given to the resident and an individual he/she designates for property taken for into possession by the residential facility? [MHC 728(7)]		
		R8	A resident is permitted to inspect personal property at reasonable times? [MHC 728 (2)]		
		R9	The individual in charge of the plan of service may limit property in order to prevent the resident from physically harming himself, herself or others, theft, loss, or destruction of the property, unless a waiver is signed by the resident. [MHC 728 (4) (a)]		

Y e s	N o	(S)	FREEDOM OF MOVEMENT {MHC 712, 744, 752}	COMMENTS	REQUIRED ACTION
		S1	Is there a policy? What is the date of the policy?		
		S2	Does it provide for placement in least restrictive setting? [MHC 708 (3)]		
		S3	Does the policy provide that the freedom of movement of a recipient shall not be restricted more than is necessary to provide mental health services to him or her, to prevent injury to him or her or to others, or to prevent substantial property damage, except that security precautions appropriate to the condition and circumstances of an individual admitted by order of a criminal court or transferred as a sentence-serving convict from a penal institution may be taken? [MHC 744 (1)]		
		S4	Any limitations must be: a) Justified in record [MHC 744 (2)] b) Time limited [MHC 744 (2)]		
		S5	Any restriction on freedom of movement of a recipient is removed when the circumstance that justified its adoption ceases to exist. [MHC 744 (3)]		

Y e s	N o	(T)	RESIDENT LABOR {MHC 736, 752; AR 7229}	COMMENTS	REQUIRED ACTION
		T1	Is there a policy? What is the date of the policy?		
		T2	Does policy require that the resident voluntarily agree to perform the work? [MHC 736(1)]		

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Y e s	N o	(T)	RESIDENT LABOR {MHC 736, 752; AR 7229}	COMMENTS	REQUIRED ACTION
		T3	Is there a procedure to assure that a resident may perform labor that contributes to the operation and maintenance of the facility for which the facility would otherwise employ someone only if the resident voluntarily agrees to perform the labor, engaging in the labor would not be inconsistent with the IPOS for the resident, the amount of time or effort necessary to perform the labor would not be excessive and that in no event shall discharge or privileges be conditioned upon the performance of labor? [MHC 736 (1)]		
		T4	Does policy provide for compensation when performing labor which benefits another person/agency? [MHC 736(3)]		
		T5	Does it specify that labor of personal housekeeping nature is not paid? [MHC 736 (5)]		
		T6	Does it specify that one-half of any compensation paid to a resident for labor performed shall be exempt from collection for payment of mental health services provided. [MHC 736 (6)]		

Y e s	N o	(U)	COMMUNICATION/MAIL/TELEPHONE/VISITS {MHC 715, 726, 752}	COMMENTS	REQUIRED ACTION
		U1	Is there a policy? What is the date of the policy?		
		U2	Does the policy state that telephones shall be reasonably accessible and that funds for telephone usage are available in reasonable amounts? [MHC 726 (2)]		
		U3	Does policy on mail specify that correspondence can be conveniently and confidentially received and mailed and writing materials and postage are provided in reasonable amounts?[MHC 726 (2)]		
		U4	Does policy assure that space will be made for visits? [MHC 726 (2)]		
		U5	Is there a procedure for instances of opening or destruction of mail by staff? [MHC 726 [2], MHC 752)		
		U6	Does the policy require a postal box or daily pickup and deposit of mail? [MHC 726 (2)]		
		U7	Does policy state that reasonable time and place for the use of telephones and for visits may be established and if established, shall be in writing and posted in each living unit of a residential program? [MHC 726 (3)]		
		U8	Does the policy state that the right to communicate by mail or telephone or to receive visitors shall not be further limited except as authorized in the resident's plan of service? [MHC 726 [4)]		
		U9	Is there a provision that a limitations on communication do not apply to a resident and an attorney or court or any other individual if the communication involves matters that may be the subject of legal inquiry? (MHC 726 [5])		
		U10	Is a resident is able to secure the services of a mental health professional, he or she shall be allowed to see that person at any reasonable time. (MHC 715)		

Y e s	N o	(V)	SECLUSION (For hospitals, centers, and child caring institutions) {MHC 700,742, 752, 755; AR 7243; 42 CFR 482; 42 CFR 483}	COMMENTS	REQUIRED ACTION
		v1	Is there a policy? What is the date of the policy?		
		v2	Is seclusion defined using the most protective definition? [MHC 700 (j)]		
		v3	Is time out defined using the most protective definition? [AR 7001(x)]		
		v4	Is therapeutic de-escalation defined? [AR 7001(w)]		

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Y e s	N o	(V)	<p align="center">SECLUSION (For hospitals, centers, and child caring institutions) {MHC 700,742, 752, 755; AR 7243; 42 CFR 482; 42 CFR 483}</p>	COMMENTS	REQUIRED ACTION
		V5	<p><u>PLEASE NOTE: There are significant changes to the seclusion requirements. This includes allowing LPH policies to establish standards in some areas. Please review LPH policies carefully to ensure compliance with both state and federal regulations. This includes any LPH policy that establishes a standard allowed by the regulations.</u> <u>Currently the Michigan Mental Health Code only permits a physician to authorize or order seclusion in a LPH/U. No other category of licensed Independent Practitioner may authorize or order seclusion. Note that a physician may not delegate his/her authority to authorize or order seclusion to another category of Licensed Independent Practitioner or licensed health professional. These standards apply only to LPH/Us that are certified Medicaid/Medicare providers</u> For LPH/Us, does the policy minimally provide that:</p> <p>(a) All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.</p>		
			(b) The type or technique of seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.		
			(c) The use of seclusion must be-- (i) In accordance with a written modification to the patient's plan of care; and (ii) Implemented in accordance with safe and appropriate seclusion techniques (iii) If a patient is secluded repeatedly, the patient's individual plan of services shall be reviewed and modified to facilitate the reduction of the use of seclusion [MHC330.1742 (7)]		
			(d) The use of seclusion must be in accordance with the order of a physician. (i) Seclusion may be temporarily employed in an emergency without an authorization or an order. Immediately after the patient is placed in temporary seclusion, a physician shall be contacted. If, after being contacted, the physician does not authorize or order the seclusion, the patient shall be removed from seclusion. [MHC 330.1742 (3)]		
			(e) Orders for the use of seclusion must never be written as a standing order or on an as needed basis (PRN).		
			(f) The attending physician must be consulted as soon as possible if the attending physician did not order the seclusion.		
			(g) Orders (i) A patient may be secluded pursuant to an order by a physician made after personal examination of the patient. An order for seclusion shall continue only for that period of time specified in the order or for up to the following limits, whichever is less: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1 hour for children under 9 years of age; and (ii) When writing a new order for the use of seclusion for the management of violent or self-destructive behavior, a physician must see and assess the patient. (iii) The required examination by a physician shall be conducted not more than 30 minutes before the expiration of the expiring order for seclusion. [AR 330.7243 (6b)]		
			(h) Seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.		

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Y e s	N o	(V)	<p align="center">SECLUSION (For hospitals, centers, and child caring institutions) {MHC 700,742, 752, 755; AR 7243; 42 CFR 482; 42 CFR 483}</p>	COMMENTS	REQUIRED ACTION
			(i) A secluded patient shall: [MHC330.1742 (6), [AR 330.7243] (i) Continue to receive food (ii) Be given hourly access to toilet facilities (iii) Be bathed as often as needed, but at least every 24 hours (iv) Be clothed or otherwise covered (v) Be given the opportunity to sit or lie down		
			(j) The condition of the patient who is secluded must be monitored by a physician or trained staff that have completed the training criteria specified in paragraph [q] of this section at an interval determined by hospital policy.		
			(k) Physician training requirements must be specified in hospital policy. At a minimum, physicians must have a working knowledge of hospital policy regarding the use of seclusion.		
			(l) When seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention-- (i) By a-- (A) Physician. (ii) To evaluate-- (A) The patient's immediate situation; (B) The patient's reaction to the intervention; (C) The patient's medical and behavioral condition; and (D) The need to continue or terminate the seclusion.		
			(m) If the face-to-face evaluation specified in paragraph (l) of this section is conducted by a physician other than the attending physician, the physician must consult the attending physician who is responsible for the care of the patient as soon as possible after the completion of the 1-hour face-to-face evaluation.		
			(n) All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored-- (i) Face-to-face by an assigned, trained staff member; or (ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.		
			(o) When seclusion is used, there must be documentation in the patient's medical record of the following: (i) The 1-hour face-to-face medical and behavioral evaluation if seclusion is used to manage violent or self-destructive behavior; (ii) A description of the patient's behavior and the intervention used; (iii) Alternatives or other less restrictive interventions attempted (as applicable); (iv) The patient's condition or symptom(s) that warranted the use of the seclusion; and v) The patient's response to the intervention(s) used, including the rationale for continued use of the intervention. (vi) A provider shall ensure that documentation of staff monitoring and observation is entered into the medical record of the patient. [AR330.7243 (3)]		
			(p) A separate permanent record of each instance of seclusion shall be kept and shall comply with applicable standards.[AR330.7243(1)]		

LPH/U RIGHTS POLICY REVIEW

LPH/U _____

Date of Review _____ Name/Title of Reviewer _____

** The standards contained in this attachment are in summary language form and are not intended to represent full and exact statutory language. Please refer to the statutory citation(s) referenced for the full and comprehensive language and any potential amendatory language that may have occurred subsequent to the development of this attachment.*

Y e s	N o	(V)	SECLUSION (For hospitals, centers, and child caring institutions) {MHC 700,742, 752, 755; AR 7243; 42 CFR 482; 42 CFR 483}	COMMENTS	REQUIRED ACTION
			<p>(q) Standard: Seclusion: Staff training requirements. The patient has the right to safe implementation of seclusion by trained staff.</p> <p>(1) Training intervals. Staff must be trained and able to demonstrate competency in the implementation of seclusion, monitoring, assessment, and providing care for a patient in seclusion --</p> <p style="padding-left: 20px;">(i) Before performing any of the actions specified in this paragraph;</p> <p style="padding-left: 20px;">(ii) As part of orientation; and</p> <p style="padding-left: 20px;">(iii) Subsequently on a periodic basis consistent with hospital policy.</p>		
			<p>(2) Training content. The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:</p> <p style="padding-left: 20px;">(i) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of seclusion.</p> <p style="padding-left: 20px;">(ii) The use of nonphysical intervention skills.</p> <p style="padding-left: 20px;">(iii) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.</p> <p style="padding-left: 20px;">(iv) The safe application and use of all types of seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia);</p> <p style="padding-left: 20px;">(v) Clinical identification of specific behavioral changes that indicate that seclusion is no longer necessary.</p> <p style="padding-left: 20px;">(vi) Monitoring the physical and psychological well-being of the patient who is secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation.</p> <p style="padding-left: 20px;">(vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.</p> <p>(3) Trainer requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patient's behaviors.</p> <p>(4) Training documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.</p>		
			<p>(r) Standard: Death reporting requirements: Hospitals must report deaths associated with the use of seclusion.</p> <p>(1) The hospital must report the following information to CMS:</p> <p style="padding-left: 20px;">(i) Each death that occurs while a patient is in seclusion.</p> <p style="padding-left: 20px;">(ii) Each death that occurs within 24 hours after the patient has been removed from seclusion.</p> <p style="padding-left: 20px;">(iii) Each death known to the hospital that occurs within 1 week after seclusion where it is reasonable to assume that use of seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.</p> <p>(2) Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.</p> <p>(3) Staff must document in the patient's medical record the date and time the death was reported to CMS.</p> <p>[All citations from 42CFR482.13 unless otherwise indicated]</p>		