✓		Hospital Policy Review	Location
When reviewing policies, in addition to reviewing for the elements contained in this document, be sure to monitor for language that should NOT be contained in policy, including limitations or restrictions.			
		COMPLAINT PROCESS	
		Policy Name/Number: Most Recent Policy Revision Date:	
		The policy requires/includes the following:	
	A1	A process to assure that all recipients receive a summary of rights.	
	A2	A process for explaining recipient rights to all recipients in an understandable manner, including documentation of alternative methods utilized, and the name of the person who provided the explanation. [MHC 1755 (5) (b); AR 7011	
	A3	The Rights Office assures that recipients, parents of minors, guardians and others had ready access to complaint forms. [MHC 1776 (1), (5)]	
	A4	Each rights complaint is recorded upon receipt by the rights office. [MHC 1776 (3)]	
	A5	Rights complaints filed by recipients, or anyone on their behalf, are placed in a secure receptacle accessed only by ORR. [MHC 1776 (1); 1778 (1)]	
	A6	Acknowledgment of receipt/recording of the complaint is sent along with a copy of the complaint to the complainant within 5 business days. [MHC 1776 (3)]	
	A7	The rights office will notify the complainant within 5 business days after it received/recorded the complaint if it determined that no investigation of the complaint was warranted. [MHC 1776 (3) (4)]	
	A8	The rights office to assist the recipient or other individual with the complaint process as necessary. [MHC 776 (5)]	
	A9	The rights office to advise 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 1776 (2) (a-c), (5)]	
	A10	In the absence of assistance from an advocacy organization, the rights office will assist in preparing a written complaint. [MHC 1776 (2)(a-c); (5)]	
	A11	At the time the investigation is initiated and completed (summary is sent), the rights office will inform the recipient or other individual of the option of mediation and under what circumstances and when it may be exercised. [MHC 1776 (5); (1788)]	
	A12	If a rights complaint is received regarding the conduct of the hospital director (CAO), the rights investigation will be conducted by the recipient rights office of another CMHSP or by the state office of recipient rights as decided by the board. [MHC 1776 (6)]	
	A13	In cases involving alleged abuse, neglect, serious injury, or when a rights violation is apparent or suspected in the death of a recipient, investigation will be immediately initiated. [MHC 1778 (1)]	
	A14	The rights office will initiate investigation of apparent or suspected rights violations in a timely and efficient manner. [MHC 1778 (1)]	
	A15	The rights office will issue a written Status Report every 30 calendar days during the investigation to the complainant, respondent and the responsible mental health hospital (LPH Director) and that the Status Report will contain the following: a) statement of the allegations, b) citations, c) statement of the issues, d) investigative progress to date and, e) expected date of completion. [MHC 1778 (4)]	
	A16	Investigations will be completed within 90 calendar days, unless awaiting action by external agencies. (CPS, law enforcement, etc.) [MHC 1778 (1)]	
	A17	Investigation activities for each rights complaint will be accurately recorded by the office. [MHC 1778 2)]	
	A18	The rights office will use “preponderance of the evidence” as its standard of proof in determining whether a right was violated. [MHC 1778 (3)]	
	A19	Upon completion of the investigation, the rights office will submit a written investigative report (RIF) to the respondent [who is also the Director (Chief Administrative Officer)]. [MHC 1778 (5)]	
	A20	The RIF will include all the following: a) statement of the allegations, b) citations to relevant provisions of applicable laws, rules, policies, and guidelines, c) statement of the issues involved, d) investigative findings, e) conclusions, and f) recommendations, if any. [MHC 1778 (5)]	

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	A21	When rights violations are substantiated, the Director (Chief Administrative Officer) will take appropriate remedial action that meets the following requirements: a) corrects or remedies the violation, b) is implemented in a timely manner, c) attempts to prevent a recurrence of the violation. [MHC 1780 (1)]	
	A22	Remedial action taken on substantiated violations is documented and made part of the record maintained by the rights office. [MHC 1780 (2)]	
	A23	The Director (Chief Administrative Officer) shall submit a written summary report to the complainant, recipient, if different than the complainant, parent or guardian, within 10 business days after receiving the RIF from the rights office. [MHC 1782 (1)]	
	A24	The summary report contains all of the following: a) statement of the allegations, b) citations to relevant provisions of applicable laws, rules, policies, and guidelines, c) statement of the issues involved, d) summary of investigative findings, e) conclusions, f) recommendations, if any, g) action taken or plan of action proposed by the respondent, and, h) information describing potential appellants' right to appeal, time frames and grounds for making an appeal, and process for filing an appeal to the appropriate appeals committee. [MHC 1782 (1)]	
	A25	Each service provider (the hospital, any contractees) will ensure that appropriate disciplinary action was taken against those who have engaged in abuse or neglect [MHC 1722 (2)] or retaliation and harassment. [MHC 1755 (3) (a)] [AR 7035 (1)]	
	A26	Information in the summary report will be provided within the constraints of the confidentiality/privileged communications sections (1748, 1750) of the Mental Health Code. [MHC 1782 (2)]	
	A27	Information in the summary report will not violate the rights of any employee (IE. PA 397 of 1978; Bullard-Plawecki Employee Right to Know Act). [MHC 1755 (3) (b), 1782 (2)]	
	A28	If the summary report contains a plan of action the director shall send a letter indicating when the action was completed [2018 technical requirement; recipient rights appeal process III.d.]	
	A29	If the letter indicating the plan of action describes an action that differs from the plan, the letter shall indicate that an appeal may be made within 45 days on "action". [2018 technical requirement; recipient rights appeal process III.d.]	
	A30	If hospital staff, contractual employees, or staff of contractual employers, fail to report apparent or suspected violations of rights, appropriate administrative action will be taken. [MHC 1152, MHC 1722 (2), AR 7035 C46(1)]	
		APPEAL PROCESS	
	A31	Appeals may be filed no later than 45 days after receipt of the summary report. [MHC 1784 (1)]	
	A32	The grounds for appeal shall be: a) the investigative findings of the rights office are not consistent with the facts, law, rules, policies or guidelines, b) the action taken, or plan of action proposed, by the respondent does not provide an adequate remedy, or c) an investigation was not initiated or completed on a timely basis. [MHC 1784 (2)]	
	A33	The rights office will advise the complainant that there are advocacy organizations available to assist in preparing the written appeal and offered to make the referral. [MHC 1784 (3)]	
	A34	In the absence of assistance from an advocacy organization, the rights office will assist the complainant in meeting the procedural requirements of a written appeal. [MHC 1784 (3)]	
	A35	The governing body of a licensed hospital shall designate the appeals committee of the local community mental health services program to hear an appeal of a decision on a recipient rights matter brought by or on behalf of a recipient of that community mental health services program. [MHC 1774 (4)]	
	A36	The governing body of a licensed hospital shall (b) by agreement with the department, designate the appeals committee appointed by the department to hear appeals of rights complaints brought against the licensed hospital. (If A36i is checked, skip A36ii-36xi) [MHC 1774 (4) (b)]	
	A36i	The governing body of a licensed hospital shall (a) appoint an appeals committee consisting of 7 members, none of whom shall be employed by the department or a community mental health services program, 2 of whom shall be primary consumers and 2 of whom shall be community members. [MHC 1774 (4) (a)] (If A36i is checked)	
	A36ii	The appeals committee may request consultation and technical assistance from MDHHS-ORR. [MHC 1774 (5)]	

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	A36iii	A member of the appeals committee who has a personal or professional relationship with an individual involved in an appeal will abstain from participating in that appeal as a member of the committee. [MHC 1774 (6)]	
	A36iv	Within 5 business days after receipt of a written appeal, members of the Appeals Committee will review the appeal to determine whether it meets criteria with respect to grounds, timeframe and appellant. [MHC 1784 (4)]	
	A36v	The results of the review will be provided, in writing, to the appellant, within 7 business days. [MHC 1784 (4)] [[2018 technical requirement; recipient rights appeal process III.G]	
	A36vi	If the appeal is accepted, a copy of the appeal will be provided to the respondent and the hospital within 5 business days. [MHC 1784 (4)]	
	A36vii	Within 30 days after the written appeal is received, the Appeals Committee will meet and review the facts as stated in all complaint investigation documents. [MHC 1784 (5)]	
	A36viii	The Appeals Committee will take one of the following actions in deciding upon an appeal: a) uphold the findings of the rights office and the action taken or plan of action proposed, b) return the investigation to the rights office with request that it be reopened or reinvestigated, c) uphold the investigative findings of the rights office but recommended that hospital take additional or different action to remedy the violation, or d) recommended that the Board of the hospital request an external investigation by the MDHHS Office of Recipient Rights. [MHC 1784 (5) (a-d)]	
	A36ix	The Appeals Committee will document its decision and justification for the decision in writing. [MHC 1784(6), [2018 technical requirement; recipient rights appeal process]	
	A36x	Within 10 days after reaching its decision, the Appeals Committee will provide copies of the decision to the appellant, recipient if different than appellant, recipient's guardian if one has been appointed, the hospital, and the rights office. [MHC 1784 (6)]	
	A36xi	If appropriate, the written decision of the Appeals Committee will include a statement of appellant's right to appeal to Level 2, the time frame for appeal (45 days from receipt of decision) and the ground (reason) for appeal (investigative findings of the rights office are inconsistent with facts, law, rules, policies or guidelines.). [MHC 1784 (6) (1786)]	
	A37	If an investigation is returned to the LPH by an appeals committee for reinvestigation, the office shall complete the reinvestigation within 45 days following the standards established in 330.1778. [2018 technical requirement; recipient rights appeal process III.d.]	
	A38	If an investigation is returned to the LPH by an appeals committee for reinvestigation, upon receipt of the RIF, the director shall take appropriate remedial action and shall submit a written summary report to the complainant, recipient, if different than the complainant, parent or guardian, and the appeals committee within 10 business days.[MHC 1780, 1782 (1), 1784 (5) (b), 2018 technical requirement; recipient rights appeal process III.d.]	
	A39	If a request for additional or different action is sent to the Director, a response shall be sent within 30 days as to the action taken or justification as to why it was not taken. The response shall be sent to the complainant, recipient, if different than the complainant, parent or guardian, and the appeals committee. [MHC 330.1784(5)(c), 2018 technical requirement; recipient rights appeal process III.d.]	
		CONSENT and INFORMED CONSENT	
		Policy Name/Number: Most Recent Policy Revision Date:	
		The policy requires/includes the following:	
	B1	Consent is defined in accordance with the definition in the Mental Health Code 330.1100a (19).	
	B2	Informed consent is defined in accordance with the definition in the Administrative Rules 330.7003 (1) (a-d)	
	B3	The individual is presumed to be competent, or application has been made for a guardian. The policy does NOT allow that the recipient be denied the right to make decisions in any other circumstances. [AR 7003 (1) (a)]	
	B4	The individual consenting shall be aware of the procedures, risks, other consequences and relevant information [AR 7003 (1) (b)]	
	B5	Information is presented in a manner the recipient understands and a mechanism for evaluating comprehension is utilized. [AR 7003(1) (c) (2) (4)]	
	B6	The recipient has free power of choice without force, fraud, deceit, duress, constraint, coercion, etc. [AR 7003 (1) (d)]	

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	B7	The recipient is informed that if they withdraw consent this can be done without prejudice toward them. [AR 7003 (1) (d)]	
	B8	Informed consent shall be reobtained if changes in circumstances substantially change the risks, other consequences or benefits that were previously expected	
		ABUSE and NEGLECT	
		Policy Name/Number: Most Recent Policy Revision Date:	
		The policy requires/includes the following:	
	C1	Abuse is defined in accordance with the definitions in AR 7001 (a-c), AR 7001 (z). [AR7035 (2) (a).	
	C2	Neglect is defined in accordance with the definitions in AR 7001 (i-k). [AR7035 (2) (a).	
	C3	Procedures are established for the mandatory reporting of abuse or neglect to: a) the rights office, b) administration, c) other agencies as required by law. [MHC 1723]	
	C4	Investigations of abuse/neglect allegations are conducted by the Rights Office. [MHC 1778 (1)]	
	C5	If an allegation is found to be substantiated, the hospital will take firm and fair disciplinary action or remedial action as appropriate. [MHC 1722 (2)]	
	C6	There is clear delineation as to who is required to report abuse. [MHC 1723(1); P.A. 238 of 1978; P.A. 519 of 1982; and MHC 1722 (2)]	
	C7	Reporting is required of criminal abuse including vulnerable adult abuse and child abuse to local law enforcement. [MHC 1723]	
	C8	There is delineation as to who shall prepare written reports to law enforcement agencies regarding criminal abuse. [MHC 1723 (2)]	
		DIGNITY and RESPECT	
		Policy Name/Number: Most Recent Policy Revision Date:	
		The policy requires/includes the following:	
	D1	The LPH protects and promotes the dignity and respect to which a recipient of services is entitled. [MHC 1704 (3), 1708 (4)]	
	D2	There are definitions of dignity and respect. [MHC 1704 (3)]	
	D3	Family members are treated with dignity and respect. [MHC 1711]	
	D4	Family members are given an opportunity to provide information to the treating professionals. [MHC 1711]	
	D5	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 1711]	
		FINGERPRINTING, PHOTOGRAPHS, AUDIOTAPE, OR USE OF 1- WAY GLASS	
		Policy Name/Number: Most Recent Policy Revision Date:	
		The policy requires/includes the following:	
	E1	Identification of the circumstances under which audiotapes or photos may be taken, and 1-way glass used. [MHC 1724 (7) (a-c)]	
	E2	Identification of the parameters for use of fingerprints, photos, or audiotapes for the purpose of recipient. [MHC 1724 (4)]	
	E3	Prior written consent to any of the above (E2). [MHC 1724 (2)] [AR 7003 (1) (c)]	
	E4	The procedures for withdrawing consent. [AR 7003 (1) (d)]	
	E5	The ability of recipients to object when photos are for personal use or social purposes. [MHC 1724 (6)]	
	E6	A method of safekeeping of fingerprints, photos, and audiotapes is identified. [MHC 1724 (4)]	
	E7	Fingerprints, photographs, or audiotapes, in the record of a recipient, and any copies of them, shall be given to the recipient, or destroyed, when they are no longer essential to achieve provision of services or obtain information regarding identity, or upon discharge of the recipient, whichever occurs first. [MHC 1724 (5)]	
	E8	The need for audio taping, photographing/fingerprinting or use of 1-way glass is reviewed periodically. [MHC 1724 (5)]	

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	E9	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 1724 (9)]	
	E10	Identification of the locations where the surveillance images will be recorded and saved. [MHC 1724 (9) (a)]	
	E11	How recipients and visitors will be advised of the video surveillance. [MHC 1724 (9) (b)]	
	E12	Security provisions include: (*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 1724 (9) (c)]	
	E13	Documentation, and maintenance of that documentation, regarding each instance of authorized access, viewing duplication, or distribution of a surveillance video. [MHC 1724 (9) (d)]	
	E14	A process to retrieve a distributed video when the purpose for which it was distributed no longer exists. [MHC 1724 (9) (e)]	
	E16	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 1724 (9) (f)]	
	E17	Prohibition on maintaining a recorded video surveillance image as part of a recipient's clinical record. [MHC 1724 (9) (g)]	
		CONFIDENTIALITY/DISCLOSURE	
		Policy Name/Number: Most Recent Policy Revision Date:	
		The policy requires/includes the following:	
	F1	All information in the record and that obtained in the course of providing services is confidential. [MHC 1748 (1)]	
	F2	A summary of section 1748 of the Mental Health Code is made part of each recipient file. [AR 7051 (1)]	
	F3	For case records made after March 28, 1996, information made confidential by 330.1748 shall be disclosed to a competent adult recipient upon the recipient's request. The information is released 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 1776 (4)]	
	F4	Except as otherwise provided in F3, if consent has been obtained from: a) the recipient, b) the recipient's guardian who has the authority to consent, c) a parent with legal custody of a minor recipient, or d) court appointed personal representative or executor of the estate of a deceased recipient, information made confidential by 1748 may be disclosed to: 1) a provider of mental health services to the recipient, or 2) the recipient, his or her guardian, the parent of a minor, or another individual or hospital unless, in the written judgement of the holder {of the record} the disclosure would be detrimental to the recipient or others. [MHC 1776 (6)]	
	F5	Is a record kept of disclosures including: a) Information released, b) To whom it is released, c) Purpose stated by person requesting the information, d) Statement indicating how disclosed information is germane to the state purpose, e) The part of law under which disclosure is made, f) Statement that the persons receiving the disclosed information could only further disclose consistent with the authorized purpose for which it was released. [AR 7051 (2) (a-e)]	
	F6	The process for record review by recipients. The process for amending the record by a recipient, guardian, or parent of a minor, who has gained access to the record and challenges the accuracy, completeness, timeliness or relevance of information. [MHC 1748 (4), (6) 1749]	
	F7	A procedure for the review by the director of the hospital of a request for confidential information by a person not covered under 1748(4). The procedure shall include a provision that requires the director, once the decision has been made not to release information based on detriment, to determine the part of the information requested that may be released. Afull record may not be withheld. [AR 7051 (3)]	
	F8	The timeframe for the review and determination shall not exceed 3 business days if the record is on-site, or 10 business days if the record is off–site. [AR 7051 (3)]	

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	F9	The requestor may file a complaint with the hospital's Office of Recipient Rights if he/she disagrees with the decision of the director regarding the portions of the record withheld. [AR 7051 (3)]	
	F10	Confidential information shall be disclosed only under one or more of the following circumstances: a) an order or subpoena of a court of record or a subpoena of the legislature, unless the information is privileged by law, b) to a prosecuting attorney as necessary for the prosecutor to participate in a proceeding governed by the MHC, c) to a recipient's attorney with the consent of the recipient, the recipient's legal guardian (if they have authority to consent) or parent of a minor who has legal and physical custody, d) to the Auditor General, e) when necessary to comply with another provision of law, f) to MDHHS as necessary for the department to discharge a responsibility placed upon it by law, or 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. [MHC 1748 (5) (a-g)]	
	F11	The hospital shall grant a representative of Michigan Protection and Advocacy Services access to the records of all of the following: a) a recipient, if the recipient, the recipient's guardian with authority to consent, or a minor's parents with physical and legal custody of the recipient, have consented to the access, b) a recipient, including a recipient who has died or whose location is unknown, if all of the following apply: (i) because of mental or physical condition, the recipient is unable to consent to the access, (ii) the recipient does not have a guardian or other legal representative or the recipient's guardian is the State, (iii) the protection and advocacy system 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, c) a recipient who has a legal guardian or other legal representative if all the following apply: (i) 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, (ii) upon receipt of the name and address of the recipient's legal representative, the protection and advocacy system has contacted the representative and offered assistance in resolving the situation, (iii) the representative has failed or refused to act on behalf of the recipient. [MHC 1748 (8)]	
	F12	An attorney who has been retained or appointed to represent a minor pursuant to an objection to hospitalization shall be allowed to review the records. [AR 7051 (4) (a)]	
	F13	Attorneys who are not representing recipients may review records only if the attorney presents a certified copy of an order from a court directing disclosure of information concerning the recipient to the attorney. [AR 7051 (4) (b)]	
	F14	Attorneys shall be refused information by phone or in writing without the consent or release from the recipient unless the request is accompanied or preceded by a certified copy of an order from a court ordering disclosure of information to that attorney. [AR 7051 (4) (c)]	
	F15	A private physician or psychologist appointed by the court or retained to testify in civil, criminal, or administrative proceedings shall, upon presentation of identification and a certified copy of a court order, be permitted to review the records of the recipient on the hospital premises. Before the review, notification shall be provided to the reviewer and to the court if the records contain privileged communication which cannot be disclosed in court, unless disclosure is permitted because of an expressed waiver of privilege or because of other conditions that, by law, permit or require disclosure. [+C134AR 7051 (5) (a-b)]	
	F16	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 the governing body. [AR 7051 (6) (a-c)]	
	F17	Information shall be provided as necessary for treatment, coordination of care, or payment for the delivery of mental health services, in accordance with the health insurance portability and accountability act of 1996, Public Law 104-191. [MHC 1748 (7) (b)]	
	F18	The 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 1748 [10])	
	F19	Disclosure of 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 1748 (7) (a); AR 7051 (7)]	

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	F20	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 1748 (9)]	
	F21	The hospital, upon a written request from Child Protective Services, shall grant access to review, and provide pertinent records and information within 14 days of the request. [MHC 1748a (1)]	
		SERVICES SUITED TO CONDITION/INDIVIDUAL PLAN OF SERVICE	
		Policy Name/Number: Most Recent Policy Revision Date:	
		The policy requires/includes the following:	
	G1	A person-centered planning process is used to develop a written IPOS in partnership with the recipient. [MHC 1712 (1)]	
	G2	There is documentation of the recipient's participation in the treatment planning meeting, or an explanation as to the reason the recipient did not attend.[MHC 1712 (1) AR 7199 (2) (a)]	
	G3	There is documentation of the persons that the recipient desired to be part of the planning process. There is a method for soliciting names of, and including persons of the recipient's choice in the IPOS. The justification for exclusion of individuals chosen by the recipient to participate in the IPOS process shall be documented in the record. [MHC 1712 (3)]	
	G4	The IPOS includes assessments of the recipient's need for food, shelter, clothing, health care, employment opportunities (when appropriate), educational opportunities (when appropriate), legal services and recreation. [AR 7199 (h)]	
	G5	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)]	
	G6	Any restrictions, limitations or intrusive behavior treatment techniques that are not related to the active diagnosis are reviewed by a formally constituted committee comprised of at least 3 individuals, 1 of whom shall be a fully or limited-licensed psychologist with the formal training or experience in applied behavior analysis, and 1 of whom shall be a licensed physician/psychiatrist (may include evaluation by a behavioral analyst from the CMH, as allowed by contract). [AR 7199 (2) (g)]	
	G7	The plan shall be agreed to by the hospital, the recipient, the guardian, or the parent with legal custody of a recipient, unless it is part of a court order. Objections shall be noted in the plan. [AR 7199 (4), (5)]	
	G8	The LPH ensures that a recipient is given a choice of physician or mental health professional within the limits of available staff. The process is documented. [MHC 1713]	
	G9	A process whereby a recipient, who is assessed in the LPH emergency room by LPH staff and denied hospitalization by the pre-admission screening unit (PSU), shall receive information on the ability to request a second opinion from the appropriate CMH. (Not required of LPHs without emergency room evaluations) [MHC 1409 (4)]	
	G10	An individual 18 years of age or over may be hospitalized as a formal voluntary recipient if the individual executes an application for hospitalization as a formal voluntary recipient or the individual assents and the full guardian of the individual, the limited guardian with authority to admit, or a recipient advocate authorized by the individual to make mental health treatment decisions under the estates and protected individuals code, 1998 PA 386, MCL 700.1101 to 700.8102, executes an application for hospitalization and if the hospital director considers the individual to be clinically suitable for that form of hospitalization. [MHC 1415]	
	G11	A process for explaining rights of admission and termination of voluntary hospitalization (not recipient rights as outlined in 7 and 7A) verbally to recipients, upon voluntary admission, including documentation of alternative methods utilized. [MHC 1416]	
		CHANGE IN TYPE OF TREATMENT	
		Policy Number: Policy date:	
		The policy requires/includes the following:	
	H1	The written IPOS has 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)]	

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	H2	There is a procedure to assure that the plan is kept current and modified when indicated, or when necessary. [MHC 1712 (1)]	
	H3	The recipient shall 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 1714]	
	H4	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 of implementing the plan. [MHC 1712 (2)]	
	H5	The review required in I4 is completed within a reasonable period of time. (no later than 30 days or prior to d/c) There are procedures for requesting and conducting the review. [MHC 1712 (2)]	
		STERILIZATION/ABORTION/CONTRACEPTION (FAMILY PLANNING)	
		Policy Name/Number: Most Recent Policy Revision Date:	
		The policy requires/includes the following:	
	I1	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)]	
	I2	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)]	
	I3	The notice includes a statement that mental health services are not contingent upon requesting or not requesting family planning or health information services. [AR 7029]	
		COMMUNICATION/MAIL/TELEPHONE/VISITS	
		Policy Name/Number: Most Recent Policy Revision Date:	
		The policy requires/includes the following:	
	J1	Recipients shall be offered 2 telephone calls upon admission (by petition and certification), and following submission of paperwork to court, initiating the involuntary admission process. A call shall not be limited to less than 5 minutes. Under circumstances in which the individual cannot make a call, or if it is necessary to restrict calls that are at hospital expense, the hospital shall place the calls for the individual if so requested. Staff shall assist if the recipient is unable to independently complete the call. [MHC 1447 R 4045 (2)]	
	J2	Telephones shall be reasonably accessible and funds for telephone usage are available in reasonable amounts. [MHC 1726 (2)]	
	J3	Correspondence can be conveniently and confidentially received and mailed (i.e. postal box or daily pickup and deposit), and writing materials and postage are provided in reasonable amounts. [MHC 1726 (2)]	
	J4	Space will be made available for visits. [MHC 1726 (2)]	
	J5	Reasonable time and place for the use of telephones and for visits shall be established and shall be in writing and posted on the unit. [MHC 1726 (3)]	
	J6	The right to communicate by mail or telephone or to receive visitors shall not be further limited except as authorized in the recipient's plan of service. [MHC 726 (4)]	
	J7	Limitations on communication do not apply to a recipient and an attorney or court, or any other individual, if the communication involves matters that may be the subject of legal inquiry. [MHC 1726 (5)]	
	J8	If a recipient can secure the services of a mental health professional, he or she shall be allowed to see that person at any reasonable time. [MHC 1715]	
		MEDICATION PROCEDURES	
		Policy Name/Number: Most Recent Policy Revision Date:	
		The policy requires/includes the following:	
	K1	Psychotropic medication (psychotropic drug) is defined in accordance with AR 330.7001 (p).	
	K2	A doctor's order for medication is required. [AR 7158 (1)]	

✓		Hospital Policy Review	Location
	K3	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 1719)	
	K4	There shall be periodic medication reviews as specified in the plan of service and based on recipient's clinical status. [AR 7158(4)]	
	K5	Medications must be administered by personnel who are qualified and trained. [AR 7158 (5)]	
	K6	Procedures on when and how documentation regarding medication administration is to be placed in recipient's clinical record. [MHC 1752, AR 7158 (6)]	
	K7	Medication errors and adverse drug reactions are immediately and properly reported to a physician and recorded in the recipient's record. [AR 7158 (7)]	
	K8	Only medications authorized by a physician are to be given at discharge. 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)]	
	K9	A procedure to ensure that medication brought by the recipient, and stored by the LPH, shall be returned at discharge [MHC 1728 (7)]	
		USE OF PSYCHOTROPIC DRUGS	
		Policy Name/Number: Most Recent Policy Revision Date:	
	L1	The policy requires/includes the following:	
	L2	Psychotropic drugs (medication) shall not be administered to an individual who has been hospitalized by medical certification or by petition under chapter 4 or 5 of PA 258 of 1974 on the day preceding and on the day of his or her court hearing unless the individual consents or unless the administration of the psychotropic drugs is necessary to prevent physical injury to the individual or others. [MHC 1718]	
	L3	The administration of psychotropic medication to prevent physical harm or injury occurs: ONLY when the actions of a recipient, or other objective criteria, clearly demonstrate to a physician that the recipient poses a risk of harm to himself, herself or others, and 2) ONLY after signed documentation of the physician is placed in the recipient's clinical record and [AR 7158 (8) (b)]	
	L4	Initial administration of psychotropic chemotherapy (medication) under L2 be as short as possible, at the lowest therapeutic dosage possible and be terminated as soon as there is no longer a risk of harm. [AR 7158 (8) (c)]	
	L5	Initial administration of psychotropic chemotherapy (medication) as identified in L2 shall be limited to a maximum of 48 hours unless there is consent. [AR 7158 (8) (c)]	
	L6	Medication shall not be used as punishment or for staff's convenience. [AR 7158 (3)]	
		TREATMENT BY SPIRITUAL MEANS	
		Policy Name/Number: Most Recent Policy Revision Date:	
	M1	The policy requires/includes the following:	
	M2	"Treatment by spiritual means" is defined as a spiritual discipline or school of thought that a recipient wishes to rely on to aid physical or mental recovery. [AR 7001 (y)]	
	M3	Access to treatment by spiritual means is upon request by a recipient, guardian, or parent of a minor recipient. [AR7135 (1)]	
	M4	Requests for printed, recorded, or visual material essential or related to treatment by spiritual means, and to a symbolic object of similar significance shall be honored and made available at the recipient's expense. [AR7135 (3)]	
	M5	There is a procedure for informing a person requesting treatment by spiritual means of a denial of the request and the reason for the denial. [AR 7135 (6) (b)]	
	M6	There is a procedure for an administrative review or appeal process when treatment by spiritual means is denied. [AR 7135 (7)]	
	M7	There is a procedure to insure recourse to court when there is refusal of medication or other treatment for a minor under the guise of treatment by spiritual means. [AR 7135 (6) (a)]	
	M8	Contact with agencies providing treatment by spiritual means is provided in the same manner as contact with private mental health professionals (reasonable times and space). [AR 7135 (2)]	

✓		Hospital Policy Review	Location
	M9	The recipient may refuse medications if: a) spiritual treatment predates current allegation of mental illness or disability, b) no court order empowering the guardian or facility to make decisions regarding medication, c) the recipient is not imminently dangerous to self or others and has not consented to medication. [AR 7135(4) (a) (b)]	
	M10	There are legal restrictions for a) mechanical, chemical, or organic compounds that are physically harmful, b) activity prohibited by law, c) activity harmful to self or others, d) activity inconsistent with court ordered custody or placement by person other than recipient. [AR 7135 (a – d)]	
		PERSONAL PROPERTY AND FUNDS	
		Policy Name/Number: Most Recent Policy Revision Date:	
	N1	The policy requires/includes the following:	
	N2	Identification of items that recipients may not possess (including weapons, sharp objects, explosives, drugs and alcohol). [MHC 1728 (3)]	
	N3	Any exclusions of personal property shall be in writing and posted in each unit. [MHC 1728 (3)]	
	N4	A receipt for property taken for into possession by the hospital shall be given to the recipient and to an individual designated by the recipient. [MHC 1728 (7)]	
	N5	A recipient is to be permitted to inspect personal property at reasonable times. [MHC 1728 (2)]	
	N6	The plan of service shall be utilized to limit property in order to prevent the recipient from physically harming himself, herself or others, or to prevent theft, loss, or destruction of the property, unless a waiver is signed by the recipient. Limitations of property shall be justified and documented in the record of the recipient. [MHC 1728 (4) (a), (5)]	
	N7	Conditions under which a search for contraband items may be conducted. [AR 7009 (7)]	
	N8	Documentation shall be made in the record of the circumstances surrounding searches which include: (i) the reason for initiating the search, (ii) the names of the individuals performing and witnessing the search, (iii) the results of the search, including a description of the property seized. [AR 7009 (7)]	
	N9	Any property taken for into possession by the hospital shall be given to the recipient at the time of discharge [MHC 1728 (7)]	
		RIGHT TO ENTERTAINMENT MATERIALS, INFORMATION & NEWS	
		Policy Name/Number: Most Recent Policy Revision Date:	
		The policy requires/includes the following:	
	O1	Recipients shall not be prevented from obtaining, reading, viewing or listening to entertainment, information or news related materials obtained at his/her own expense for reasons of, or similar to, censorship. [AR 7139 (1)]	
	O2	A limitation of access to entertainment materials, information, or news can occur only if such a limitation is specifically approved in the recipient's individualized plan of service. Staff in charge of the plan of service shall document each instance when a limitation is imposed in the recipient's record. [AR 7139 (2) (3)]	
	O3	Limitations/restrictions shall be removed when no longer clinically justified. [AR 7139 (4)]	
	O4	Minors have the right to access material not prohibited by law unless the legal guardian of a minor objects to this access. [AR 7139 (5)]	
	O5	The person in charge of the plan of service shall attempt to persuade the parent/guardian of a minor to withdraw their objections to these materials. [AR 7139 (6) (c)]	
	O6	There is a process for implementing general program restrictions on access to entertainment materials. [AR 7139 (6) (a)]	
	O7	There is a process for determining recipient's interest for provision of a daily newspaper. [AR 7139 (6) (b)]	
	O8	There is a process for recipients to appeal the denial of their right to entertainment, information, news material. [AR 7139 (6) (d)]	
	O9	There is a process for imposing specific restrictions for the therapeutic benefit the recipients as a group. [AR 7139 (6) (e)]	
		RECIPIENT LABOR	

✓		Hospital Policy Review	Location
		Policy Name/Number: Most Recent Policy Revision Date:	
	P1	The policy requires/includes the following:	
	P2	A recipient may perform labor that contributes to the operation and maintenance of the LPH, for which the LPH would otherwise employ someone,only if, 1) the recipient voluntarily agrees to perform the labor, 2) engaging in the labor would not be inconsistent with the IPOS for the recipient, 3) the amount of time or effort necessary to perform the labor would not be excessive, and 4) in no event shall discharge or privileges be conditioned upon the performance of labor. [MHC 1736 (1)]	
	P3	A recipient who performs labor that contributes to the operation and maintenance of the LPH, for which the hospital+C257 would otherwise employ someone, shall be compensated appropriately and in accordance with applicable federal and state labor laws, including minimum wage and minimum wage reduction provisions. [MHC 1736 (2)]	
	P4	A process for providing compensation when performing labor which benefits another person or the hospital. [MHC 1736 (3)]	
	P5	Labor of personal housekeeping nature is not eligible for payment. [MHC 1736 (5)]	
		FREEDOM OF MOVEMENT	
		Policy Name/Number: Most Recent Policy Revision Date:	
		The policy requires/includes the following:	
	Q1	There is a requirement that the recipient receives placement in the least restrictive setting appropriate and available.[MHC 1708 (3)]	
	Q2	The freedom of movement of a recipient shall not be restricted more than is necessary to provide mental health services to him/her, to prevent injury to him/her or to others, or to prevent substantial property damage. [MHC 1744 (1)]	
	Q3	Any limitations to the freedom of movement must be justified in the IPOS and be time limited. [MHC 1744 (2)]	
	Q4	Any limitation on freedom of movement is removed when the circumstances that justified its adoption cease to exist. [MHC 1744 (3)]	
		RESTRAINT/PHYSICAL MANAGEMENT	
		Policy Name/Number: Most Recent Policy Revision Date:	
		The policy requires/includes the following:	
	R1	Restraint is defined, as in MHC 1700 (i); 42 CFR 482.13 (e) (1 A-C); 42 CFR 483.352 (1-3), as applicable.	
	R2	All recipients have the right to be free from physical or mental abuse, and corporal punishment. All recipients have the right to be free from restraint 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 recipient, a staff member, or others and must be discontinued at the earliest possible time. MHC 1740 (2); 42 CFR 482.13 (e); 42 CFR 483.356 (a) (1)	
	R3	The type or technique of restraint used must be the least restrictive intervention that will be effective to protect the recipient, a staff member, or others from harm. [MHC 1740 (2); 42 CFR 482.13 (e); 42 CFR 483.356 (a) (1)]	
	R4	The use of restraint must be: (i) In accordance with a written modification to the recipient's plan of care; and (ii) Implemented in accordance with safe and appropriate restraint techniques as determined by hospital policy in accordance with Michigan law, (iii) If a recipient is restrained repeatedly, the recipient's individual plan of services shall be reviewed and modified to facilitate the reduction of the use of restraints. [MHC 330.1740 (9)]	
	R5	Restraint may be initiated temporarily in an emergency. Immediately after the imposition of the restraint, a physician shall be contacted. If, after being contacted, the physician does not order or authorize the restraint within 30 minutes, the restraint shall be removed. [MHC 330.1740 (3)]	
	R6	Orders for the use of restraint shall never be written as a standing order or on an as needed basis (PRN). [MHC 1740 (2); 42 CFR 482.13 (e) (6); 42 CFR 483.356 (2)]	
	R7	The attending physician of an adult recipient must be consulted as soon as possible if the attending physician did not order the restraint. The treatment team physician must be the one ordering the restraint if they are available. [MHC 1740; 42 CFR 482.13 (e) (7); 42 CFR 483.358 (b)]	

✓		Hospital Policy Review	Location
	R8	A recipient may be restrained pursuant to an order by a physician made after personal examination. 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; (C) 1 hour for children under 9 years of age. [MHC 1740; 42 CFR 482.13 (e) (8) (i); 42 CFR 483.358 (e) (2)]	
	R9	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 recipient. [MHC 1740 (5); AR 7243 (6) (b)]	
	R10	The required examination by a physician shall be conducted not more than 30 minutes before the expiration of the expiring order for restraint .[MHC 1740 (5); AR 7243 (6) (b)]	
	R11	Restraint must be discontinued at the earliest possible time, regardless of the length of time identified in the order. [MHC 1740 (7); 42 CFR 482.13 (e) (9); 42 CFR 483.358 (e) (2)]	
	R12	A restrained recipient shall: (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 [MHC 330.1740 (6), AR 330.7243]	
	R13	Restraints shall be removed every 2 hours for not less than 15 minutes, unless medically contraindicated. [MHC 330.1740 (7)]	
	R14	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)]	
	R15	A recipient shall not be restrained in a prone position unless medically contraindicated. [AR 7243 (11) (ii)	
	R16	The condition of the recipient who is restrained must be monitored by a physician or trained staff that have completed the training criteria specified in the paragraph below of this section at an interval determined by hospital policy. [MHC 1742 (9); 42 CFR 482.13 (e) (12) (B) (ii) (A-D); 42 CFR 483.358 (f) (1-4)]	
	R17	When restraint is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the recipient, a staff member, or others, the recipient must be seen face-to-face within 1 hour after the initiation of the intervention by a physician to evaluate: (A) The recipient's immediate situation; (B) The recipient's reaction to the intervention; (C) The recipient's medical and behavioral condition; and (D) The need to continue or terminate the restraint. [MHC 1740 (4)]	
	R18	All requirements specified in these standards are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the recipient is continually monitored--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 recipient. [42 CFR 482.13 (e) (15)]	
	R19	When restraint is used, there must be documentation in the recipient's medical record of the following: (i) The 1-hour face-to-face medical and behavioral evaluation by a physician if restraint is used to manage violent or self-destructive behavior; (ii) A description of the recipient's behavior and the intervention used; (iii) Alternatives or other less restrictive interventions attempted (as applicable); (iv) The recipient's condition or symptom(s) that warranted the use of the restraint; and (v) The recipient's response to the intervention(s) used, including the rationale for continued use of the intervention. [AR330.7243 (3)]	
	R20	A separate permanent record of each instance of restraint shall be kept and shall comply with applicable standards.[AR330.7243 (1)]	
	R21	Physician training requirements must be specified. At a minimum, physicians must have a working knowledge of hospital policy regarding the use of restraint. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	R22	The recipient has the right to safe implementation of restraint by trained staff. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	R23	Staff must be trained and able to demonstrate competency in the application of restraints, monitoring, assessment, and providing care for a recipient in restraint -- (i) before performing any of the actions specified in these standards; (ii) As part of orientation; and (iii) Subsequently on a periodic basis consistent with hospital policy. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	

✓		Hospital Policy Review	Location
	R24	The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the recipient population in at least the following:(i) Techniques to identify staff and recipient 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 recipient's medical, or behavioral status or condition, (iv) The safe application and use of all types of restraint used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia); (v) Clinical identification of specific behavioral changes that indicate that restraint is no longer necessary, (vi) Monitoring the physical and psychological well-being of the recipient 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. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	R25	Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address recipients' behaviors. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	R26	The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	R27	The hospital 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 recipient is in restraint:(ii) Each death that occurs within 24 hours after the recipient has been restrained. 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 recipient'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. Each death referenced in this standard must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the recipient's death. Staff must document in the recipient's medical record the date and time the death was reported to CMS. Hospitals reporting deaths to CMS should attach an additional page to the worksheet to further describe circumstances surrounding the death (e.g., reason for restraint, total length of time in restraints, how recipient was monitored, and frequency of monitoring while in restraint). Hospitals should not call MDHHS to report a death. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	R28	The hospital must report all deaths to the department utilizing "Psychiatric Notification of Death Report (BHCS-HFD-1036)". This form must be completed and submitted to LARA within five working days (recommended) from when the recipient died on the psychiatric unit; C280after transfer to an acute care hospital, Emergency Department or Medical Unit; or within 48 hours of discharge from the LPH. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	R29	Staff must document in the recipient's medical record the date and time the death was reported to CMS. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
		SECLUSION	
		Policy Name/Number: Most Recent Policy Revision Date:	
	S1	The policy requires/includes the following:	
	S2	Seclusion is defined using the most protective definition. [MHC 1700 (j); 42 CFR 482.13 (e) (1 A-C); 42 CFR 483.352 (1-3), as applicable.	
	S3	Time out is defined using the most protective definition. [AR 7001(x); 42 CFR 483.368]	
	S4	Therapeutic de-escalation is defined. [AR 7001 (w)]	
	S5	All recipients have the right to be free from physical or mental abuse, and corporal punishment. All recipients 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 a staff member, or others and must be discontinued at the earliest possible time. 1742 (3); 42 CFR 482.13 (e); 42 CFR 483.356 (a) (1)	
	S6	The type or technique of seclusion used must be the least restrictive intervention that will be effective to protect the recipient, a staff member, or others from harm. [42 CFR 482.13 (e); 42 CFR 483.356 (a) (1)]	

✓		Hospital Policy Review	Location
	S7	The use of seclusion must be:(i) In accordance with a written modification to the recipient's plan of care; and (ii) Implemented in accordance with safe and appropriate seclusion techniques as determined by hospital policy in accordance with Michigan+C243 law, (iii) If a recipient is secluded repeatedly, the recipient's individual plan of services shall be reviewed and modified to facilitate the reduction of the use of seclusion [MHC330.1742 (9)]	
	S8	The use of seclusion must be in accordance with the order of a physician. Seclusion may be initiated temporarily in an emergency. Immediately after the recipient is placed in seclusion, a physician shall be contacted. If, after being contacted, the physician does not does not order or authorize the seclusion within 30 minutes, the recipient shall be removed from seclusion. [MHC 330.1742 (4)]	
	S9	Orders for the use of seclusion must never be written as a standing order or on an as needed basis (PRN). [MHC 1742 (3); 42 CFR 482.13 (e) (6); 42 CFR 483.356 (2)]	
	S10	The attending physician must be consulted as soon as possible if the attending physician did not order the seclusion. . [MHC 1742 (4); 42 CFR 482.13 (e) (7); 42 CFR 483.358 (b)]	
	S11	The condition of the recipient who is secluded must be monitored by a physician who has completed the training criteria specified in paragraph S19/20 of this section at an interval determined by hospital policy. [MHC 1740 (8); 42 CFR 482.13 (e) (12) (B) (ii) (A-D); 42 CFR 483.358 (f) (1-4)]	
	S12	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. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	S13	When seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of a staff member, or others, the recipient must be seen face-to-face within 1 hour after the initiation of the intervention by a physician to evaluate; (A) The recipient's immediate situation; (B) The recipient's reaction to the intervention; (C) The recipient's medical and behavioral condition; and (D) The need to continue or terminate the seclusion. [MHC 1742 (5)]	
	S14	A recipient may be secluded pursuant to an order by a physician made after personal examination. 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 Before writing a new order for the use of seclusion for the management of violent behavior, a physician must see and assess the recipient. The required examination by a physician shall be conducted not more than 30 minutes before the expiration of the expiring order for seclusion. [MHC 1742; AR 330.7243 (6b); 42 CFR 482.13 (e) (8) (i); 42 CFR 483.358 (e) (2)]	
	S15	Seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. [MHC 1742 (8); 42 CFR 482.13 (e) (9); 42 CFR 483.358 (e) (2)]	
	S16	A secluded recipient shall (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 : [MHC330.1742 (6), [AR 330.7243]	
	S17	When seclusion is used, there must be documentation in the recipient's medical record of the following:(i) The 1-hour face-to-face medical and behavioral evaluation if seclusion is used to manage violent behavior; (ii) A description of the recipient's behavior and the intervention used; (iii) Alternatives or other less restrictive interventions attempted (as applicable); (iv) The recipient's condition or symptom(s) that warranted the use of the seclusion; and (v) The recipient's response to the intervention(s) used, including the rationale for continued use of the intervention. [AR330.7243 (3)]	
	S18	The LPH shall ensure that documentation of staff monitoring and observation is entered into the medical record of the recipient. And a separate permanent record of each instance of seclusion shall be kept and shall comply with applicable standards. [AR330.7243 (1) (3)]	
	S19	Training intervals. Staff must be trained and able to demonstrate competency in the implementation of seclusion, monitoring, assessment, and providing care for a recipient in seclusion: (i) Before performing any of the actions specified in this standard, (ii) As part of orientation; and, (iii) subsequently on a periodic basis consistent with hospital policy. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	

✓		Hospital Policy Review	Location
	S20	(2) Training content. The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the recipient population in at least the following: (i) Techniques to identify staff and recipient behaviors, events, and environmental factors that may trigger circumstances that require the use of seclusion. (ii) The use of nonphysical intervention skills. (iii) Choosing the least restrictive intervention based on an individualized assessment of the recipient's medical, or behavioral status or condition. (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); (v) Clinical identification of specific behavioral changes that indicate that seclusion is no longer necessary. (vi) Monitoring the physical and psychological well-being of the recipient 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. (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 recipient's behaviors. (4) Training documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed. 42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	S21	Death reporting requirements: Hospitals must report deaths associated with the use of seclusion: (1) The hospital must report the following information to CMS: (i) Each death that occurs while a recipient is in seclusion:(ii) Each death that occurs within 24 hours after the recipient has been removed from seclusion. 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 recipient'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. 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 recipient's death. Staff must document in the recipient's medical record the date and time the death was reported to CMS. Hospitals reporting deaths to CMS should attach an additional page to the worksheet to further describe circumstances surrounding the death (e.g., reason for restraint, total length of time in restraints, how recipient was monitored, and frequency of monitoring while in restraint). Hospitals should not call MDHHS to report a death. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	S22	Psychiatric Notification of Death - Michigan Administrative Rule 330.1274 requires licensed psychiatric hospitals/programs to report to the department all deaths - Psychiatric Notification of Death Report (BHCS-HFD-1036). This form must be completed and submitted to LARA within five working days (recommended) from when the recipient died on the psychiatric unit; after transfer to an acute care hospital, Emergency Department or Medical Unit; or within 48 hours of discharge from the LPH. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	S23	Staff must document in the recipient's medical record the date and time the death was reported to CMS. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
		COMPREHENSIVE EXAMINATIONS	
		Policy Name/Number: Most Recent Policy Revision Date:	
		The policy requires/includes the following:	
	T1	Within 24 hours of admission each recipient shall receive a comprehensive physical and mental examination. [MHC 1710}	
		QUALIFICATIONS AND TRAINING FOR RECIPIENT RIGHTS STAFF	
		Policy Name/Number: Most Recent Policy Revision Date:	
		The policy requires/includes the following:	
	U1	Staff of the Office of Recipient Rights to receive annual training in recipient rights protection. [MHC 755 (2)(e)]	

✓		Hospital Policy Review	Location
	U2	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)]	
	U3	The education, training, and experience required is identified either in policy or position description. [MHC 755(4)]	
	U4	All rights officers, advisors and alternates attend MDHHS-ORR Basic Skills I and II within 3 months of hire. Rights officers, advisors and alternates are encouraged to attend Building Blocks and DET (Developing Effective Training) [LPH/CMHSP Contract referencing the MDHHS/CMH Master Contract]	
	U5	Rights officers, advisors and alternates will attain 36 hours of continuing education every 3 years, with 12 credits in "operations" or "legal". [LPH/CMHSP Contract referencing the MDHHS/CMH Master Contract]	

end