11. Survey Tools

MDHHS-ORR CMHSP Assignments & Assessment Schedule
Items Requested for CMH Assessment
CMH Compliance Standards with Suggested Sources
CMH Policy Review Standards
CMH Training Curriculum Checklist
CMH Site Visit Checklist with Guidance (Non-LPH sites)
CMH Annual Monitoring Form
LPH Compliance Standards with Guidance
LPH Policy Review Standards
LPH Curriculum Checklist
LPH Annual Site Visit Form (for use by LPH)
LPH Annual Monitoring Form
LPH Self-Review (optional)

All CMH Assessment files are available on the ORR website

2021 CMHSP ASSIGNMENTS & SCHEDULE

Cindy Shadeck Shadeckc@michigan.gov Phone: 517-230-4091	Janice Terry Terryj5@michigan.gov Phone: 517-599-5953
AuSable Valley	Allegan County
Bay-Arenac	Barry County
Centra Wellness Network (Manistee Benzie)	Pines Behavioral Health (Branch)
CMH of Ottawa County	CMH & SA Services of St Joseph County
CMHA of Clinton Eaton Ingham	CMH for Central Michigan
Detroit Wayne Integrated Health Network	Copper Country
Genesee Health System	Gogebic County
Gratiot Integrated Health Network	Hiawatha Behavioral Health
HealthWest (Muskegon)	Integrated Services of Kalamazoo
Huron Behavioral Health Services	Lapeer County
Lifeways	Lenawee County
Montcalm Care Network	Livingston County
network180	Macomb County
Newaygo County	Monroe County
North Country	Northpointe Behavioral Healthcare
Northeast Michigan	Oakland Community Health Network
Northern Lakes	Pathways
Saginaw County	Riverwood (Berrien)
Shiawassee Health and Wellness	Sanilac County
Summit Pointe	St. Clair County
The Right Door (Ionia)	Van Buren County
Tuscola County	Washtenaw County
West Michigan	Woodlands Behavioral Healthcare

2021 CMHSP RIGHTS SYSTEM ASSESSMENT SCHEDULE		
DATE	CMHSP	LEAD SPECIALIST
March 9-11*	Monroe	Terry
March 23-25*	Montcalm	Shadeck
April 6-8*	Woodlands	Terry
April 20-22	Allegan	Terry
May 4-6	St. Clair	Terry
May 18-20	Newaygo	Shadeck
June 8-10	Gratiot	Shadeck
June 22-24	Northpointe	Terry
July 13-15	West Michigan	Shadeck
July 27-29	Gogebic	Terry
August 17-19	Northeast	Shadeck
September 13-17	Huron	Shadeck
October 4-8	Oakland	Terry
November 2-4	Washtenaw	Terry
December 6-8	Integrated Services of Kalamazoo	Terry

*Assessment will be conducted virtually. Decisions on whether other assessments will be on-site or virtual will depend on guidance from the Governor's office.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF RECIPIENT RIGHTS

RECIPIENT RIGHTS SYSTEM ASSESSMENT
ITEMS REQUIRED BY MDHHS-ORR REVIEW TEAM - 2021

Please send the following items to MDHHS-ORR AT LEAST 30 DAYS PRIOR to your scheduled assessment date.

Complaint Logs

Complete the attached Excel template for all allegations received from the end of your last assessment to 60 days prior to your 2021 assessment date. Example: Your last assessment was March 2018, and your 2021 assessment begins March 1, 2021; the data required would be from April 1, 2018 to January 1, 2021.

Site Visit Logs

Complete the attached Excel template listing the site visit dates for all sites operated by the CMHSP and all sites contracted for service. Provide the dates of site visits for calendar years 2017, 2018, 2019 and 2020 and 2021 (up to the date you send in the materials).

Training

- Complete the attached Excel template listing all CMH employees and all employees of contracted service providers hired during the calendar years 2019, 2020 and 2021 (up to the date you send in the materials). **Data must include their dates of hire, and the date they received recipient rights training.**
- Using the attached checklist identify where each item can be found within your training materials. Provide the completed checklist along with any materials used in Recipient Rights training.

Contracts

Include one signed, current contract for each type of service provided:

- Residential providers (both in and out of service area)
- Other service providers
- Inpatient psychiatric units (both in and out of service area)
- Professional staff (psychiatrists, OTs, PTs, etc.)

Agency Policies

In order to expedite the review process and assure that all required elements are contained in your policies, please complete the attached ORR Policy Review Standards document, identifying the name and number of the policy as well as the page numbers where policy elements can be found. As part of your documentation please submit copies of the following policies **ONLY**:

- Complaint and Appeals Process
- Policy on Qualifications and Training of Rights Staff

Please have the following items available for review at the time of the assessment. If your assessment is going to be conducted virtually, these materials must be sent at least two weeks prior to the assessment start date.

1. Agency organization chart.
2. Job descriptions for rights officer and rights advisors.
3. A list of recipient rights advisory committee members and a separate list of the categories they represent.
4. Minutes of the RRAC committee for the assessment period.
5. Informational packets/brochures given to the public or consumers. (Include any poster which identifies the Rights Officer/Advisors and the means of contacting them).
6. Documentation from all site monitoring activities for the period covered in the excel spreadsheet.
7. Policies/procedures of any service providers allowed by contract to develop their own policies.
8. Records that document attendance at rights training for all agency staff and all contract employees.
9. Documentation which reflects approved training received by all staff employed by the rights office since the last assessment.
10. Copies of complaint documentation for all complaints of retaliation/harassment and all complaints filed against the Executive Director received during the assessment period.
11. Evidence that ORR staff attends Behavior Treatment Review Committee as “ex officio,” (i.e., sign-in sheets).
12. If there has been a change in the staffing of your Rights Director position since the last assessment, provide documentation/evidence that the Executive Director consulted with the RRAC when terminating (if applicable) the Rights Director and/or when hiring a replacement.

MDHHS
Michigan Department of Health & Human Services

OFFICE OF RECIPIENT RIGHTS
2021 RIGHTS SYSTEM ASSESSMENT REPORT

AGENCY:

ASSESSMENT DATES:

REVIEWERS:

SECTION	MAXIMUM POSSIBLE SCORE	WEIGHT	MAXIMUM POSSIBLE SCORE (WEIGHTED)	YOUR INITIAL SCORE	YOUR WEIGHTED SCORE
1. CMHSP RESPONSIBILITIES	21	3	63		
2. RIGHTS OFFICE OPERATIONS	16	3	48		
3. EDUCATION AND TRAINING	12	3	36		
4. POLICIES	6	1	6		
5. RIGHTS ADVISORY COMMITTEE	11	1	11		
6. COMPLAINT RESOLUTION - PROCESS	20	3	60		
7. COMPLAINT RESOLUTION – CONTENT	34	3	102		
8. COMPLAINT RESOLUTION - TIMEFRAMES	10	3	30		
9. APPEALS (No Appeals/Appeals)	2/25	2	4/50		
10. SEMI-ANNUAL AND ANNUAL REPORTING	9	2	18		
11. SITE VISITS	14	2	28		
TOTAL SCORE	**155/178**		**406/452**		

FULL COMPLIANCE = 386/430 SUBSTANTIAL COMPLIANCE = 365/407 LESS THAN SUBSTANTIAL COMPLIANCE = <365/<407

INSTRUCTIONS: This document is a GUIDELINE for recipient rights staff to use when preparing for the triennial recipient rights assessment. It describes possible sources where evidence to support compliance for each standard might be found. It also describes generally what assessors are looking at or looking for as evidence for compliance with each standard. Policy names and sources for evidence may vary between CMH organizations. Sources for evidence that a standard is being met may include, but are not limited to, the sources suggested below.

Citation	tandard	SECTION 1 - CMHSP RESPONSIBILITIES	SOURCES OF EVIDENCE
MHC 1755 (1)	1.1.1	The Agency has established a recipient rights office subordinate only to the executive director.	Policy; organizational chart; human resources records; Rights Director's job description.
MHC 1100 (a)(30) MHC 1782	1.1.2	The Agency has appointed a designee to act in place of the Executive Director in the absence of the Director.	Agency policy regarding duties of Executive Director; Board meeting minutes.
MHC 1755(2) (b)	1.2.1	The process for funding the rights office includes a review of the funding by the recipient rights advisory committee.	Office of Recipient Rights policy; RRAC policy; RRAC meeting minutes.
MHC 1755 (2) (c)	1.3.1	The recipient rights office is protected from pressures that could interfere with the impartial, even-handed and thorough performance of its duties.	Policy; RRAC meeting minutes; notes regarding contact with others (such as MDHHS-ORR) for consultation; CMH Board meeting minutes.
MHC 1755 (2) (d)	1.3.2	The rights office has had unimpeded access to: a) All programs and services operated by, or under contract to, the CMHSP; b) All staff employed by, or under contract to, CMHSP; c) All evidence necessary to conduct a thorough investigation or to fulfill its monitoring function.	Policy; language of CMH contracts with providers; case file notes and RIF language indicating provider/ respondent cooperation with investigations; RRAC meeting minutes notes regarding contact with others (such as MDHHS-ORR) for consultation; documentation of agency communications with contracted providers.
MHC 1755(3) (a)	1.3.3	Complainants, rights office staff, and any staff acting on behalf of a recipient will be protected from harassment or retaliation resulting from recipient rights activities.	Policy; case file notes and RIF/ Summary Report language for retaliation/ harassment complaints; agency and provider human resources records. RRAC and Board meeting minutes.
MHC 1755 (3)(a) AR 7035 (1)	1.3.4	Appropriate disciplinary action was taken if there was evidence of retaliation and harassment.	Policy, case file contents; remedial action verification forms; Summary Reports on retaliation/ harassment complaints; HR Records.
MHC 1755 (4) MHC 1757(2) (e)	1.4.1	The executive director has selected a director of the rights office who has the education, training and experience to fulfill the responsibilities of the office.	Policy; rights officer job description; rights officer resume; RRAC meeting minutes; HR Records.
MHC 1755 (4) MHC 1778 (1)	1.4.2	The Agency has established a process to assure ongoing rights protection in the absence of the rights director.	Policy; contract or written agreement with another qualified recipient rights provider; RRAC and Board meeting minutes.

Citation	tandard	SECTION 1 - CMHSP RESPONSIBILITIES	SOURCES OF EVIDENCE
MHC 1757(2) [e]	1.4.3	The executive director has consulted with the Recipient Rights Advisory Committee in the hiring of the Director of the office.	Policy; RRAC meeting minutes; documentation such as emails regarding consultation between executive director and RRAC members.
MHC 1755 (4)	1.4.4	The director of the rights office has no clinical service responsibilities.	Policy; rights officer job description; organizational chart (shows ORR separate from clinical services departments); BMC meeting minutes (rights staff act as consultants for Behavior Management Committee but do not "sign off on" or "approve" BTPs).
CMHSP 6.3.2.3A	1.5.1	All contracts with licensed private hospitals/units included language that required contractor's rights staff to comply with Attachment 6.3.2.3A of the CMHSP contract.	Language of contracts between CMH and LPHs requiring LPH rights staff to obtain continuing education; language of LPH policies regarding recipient rights; CMH Policy; copy of contract includes attachment.
MHC1755(2)(f)(ii)	1.5.2	Each contract between a CMHSP and a service provider requires that all recipients be protected from rights violations while receiving services.	Policies of contracted providers; Language of contracts between CMH and service providers; CMH Policy.
MHC 1722 [2]	1.5.3	The CMHSP ensured that each service provider under contract, including those allowed/required to have their own rights protection system, took appropriate disciplinary action against those who are engaged in abuse or neglect.	Policies of contracted providers; language of contracts between CMH and service providers; Summary Reports; ORR investigation files; provider- respondent human resources records; CMH Policy.

Citation	Standard	SECTION 2 – RIGHTS OFFICE OPERATIONS	SOURCES OF EVIDENCE
MHC 1706	2.1.1	At the time services are initiated, ORR ensured that recipients, parents of minor recipients, and guardians are notified, in an understandable manner, of the rights guaranteed by Chapter 7 and 7A of the Mental Health Code, and provided access to summaries of the rights guaranteed by Chapter 7 and 7A both at the time services are initiated and periodically during the time services are provided.	Policy; CMH website information for public; New admissions intake packet; consent to treatment forms and process; ORR contact information posters; ORR contact information in complaint resolution files; Your Rights Booklets; electronic medical record (EMR) documentation; customer service department activities and documentation; CMH website.
MHC 1776 (5)	2.2.1	ORR ensured there is a mechanism to advise recipients or other individuals that there are advocacy organizations available to assist in preparation of a written rights complaint and offered to make the referral.	Policy; New Admissions Intake Packet; ORR contact information posters; ORR contact information in complaint resolution files; notices to complainants in complaint resolution files such as complaint acknowledgement letters and summary report appeal notices; Your Rights Booklets; staff training curriculum; customer service department activities and documentation.

Citation	Standard	SECTION 2 – RIGHTS OFFICE OPERATIONS	SOURCES OF EVIDENCE
MHC 1776 (5)	2.3.1	As necessary, the office assists recipients or other individuals with the complaint process.	Policy; information in complaint resolution files; complaint logs; ORR activity logs; customer service notes and logs; ORR reports to RRAC, described in RRAC meeting minutes; Your Rights Booklets; CMH website.
MHC 1755[5][d][i]	2.4.1	ORR maintained a record system for all reports of apparent or suspected rights violations received including a mechanism for logging all complaints.	Policy; complaint log; ORR activity log; electronic records system.
MHC 1755[5][d]	2.4.2	ORR has established a mechanism for secure storage of all investigative documents and evidence.	Policy; FOIA, privacy and confidentiality policies; locked file cabinet; locked ORR staff offices; secure electronic records system; secure fax machine; secure email.
MHC 1755[5][h]	2.5.1	ORR serves as a consultant to the director and to agency staff in rights related matters.	Policy; staff training policy and curriculum; ORR activity log; customer service notes; complaint resolution files; documentation regarding training and monitoring visits at provider sites; documentation of meetings and communications with Executive Director regarding ORR activities; curriculum for staff trainings; documentation of ORR's consultative interactions with agency staff.
MHC 1755[5][i]	2.6.1	Ensure that all reports of apparent or suspected violations of rights within the community mental health services program system are investigated in accordance with section 778.	Policy; complaint resolution files; evidence of review of RIFs by Executive Director; evidence of effective monitoring and supervision of ORR activities by Executive Director; evidence of effective monitoring and supervision of ORR staff and their work product by ORR management; in-house checklists/sheets.
AR 7199 (g) CMHSP 6.8.3.1	2.7.1	The Rights Office attended meetings of the Behavior Treatment Review Committee as an ex-officio member.	Policy; rights officer job description; BTC policy and procedures; BTC meeting minutes showing ORR attendance (rights staff act as consultants for Behavior Treatment Committee but do not “sign off on” or “approve” BTPs).

Citation	Standard	SECTION 3 – EDUCATION AND TRAINING	SOURCES OF EVIDENCE
CMHSP 6.3.2	3.1.1	The staff of the rights office attended and successfully completed the Basic Skills Training programs within 90 days of hire.	Policy; ORR staff training records; Annual Report; ORR Annual Monitoring forms (for submission to MDHHS-ORR); RRAC meeting minutes; MDHHS-ORR training department records.
CMHSP 6.3.2	3.1.2	The Executive Director has completed the Executive Rights Training program with 180 days of hire.	Policy; CMH staff training records; Annual Report; RRAC meeting minutes; ORR Annual Monitoring forms (for submission to MDHHS-ORR); MDHHS-ORR training department records.
MHC 1755[2][e] CMHSP 6.3.2.3 (A)	3.2.1	The staff of the rights office have complied with the continuing education requirements identified in the contract attachment, including that a minimum of 12 of the required 36 hours were approved as either Category I or II.	Policy; ORR staff training records; Annual Report; ORR Annual Monitoring forms (for submission to MDHHS-ORR); RRAC meeting minutes; MDHHS-ORR training department records.
MHC 1755[5][f]	3.3.1	All individuals employed by the CMHSP or its contract agencies received training related to recipient rights protection before or within 30 days after being employed.	Policy; CMH staff training records; human resources department records; service provider annual site monitoring review forms and records; language of CMH contracts with providers; CMH website and server; CMH online training program.
CMHSP 6.3.2.3B	3.3.2	Training related to recipient rights protection addressed all training standards identified in the contract attachment.	Policy; CMH staff training policy; language of CMH contract with providers regarding required training for staff; MDHHS-CMH Master Contract; Curriculum of recipient rights training for new CMH staff; curriculum of recipient rights annual training for CMH staff; MDHHS-ORR training department records; CMH website and server; CMH online training program.
MHC 1755[2][a]	3.4.1	Education and training in recipient rights policies and procedures are provided to the recipient rights advisory committee and appeals committee.	Policy; RRAC policy; RRAC meeting minutes (this should be a standing agenda item).

Citation	Standard	SECTION 4 – POLICIES	SOURCES OF EVIDENCE
MHC 1752[1]	4.1.1	The policies and procedures provided a mechanism for prompt reporting, review, investigation and resolution of apparent or suspected rights violations and are designed to protect recipients from, and prevent repetition of, violations of rights guaranteed by Chapters 7 and 7A.	CMH recipient rights policies; Policy Standards worksheet; complaint resolution files; annual and semi-annual reports; CMH website and server.
MHC 1752[1]	4.1.2	Policies and procedures included, at a minimum, all those specifically delineated in this section of the MHC.	CMH recipient rights policies; MDHHS-ORR Policy Standards Worksheet prepared by CMH ORR for assessment; CMH website and shared drive.
MHC 1752 [1] MHC 1704 [1]	4.1.3	Policies and procedures meet the criteria established in the Mental Health Code, Administrative Rules, and Contractual Requirements and those reflected in the MDHHS-ORR Policy Review Standards.	CMH recipient rights policies; MDHHS-ORR Policy Standards Worksheet prepared by CMH ORR for assessment; CMH website and shared drive.

Citation	Standard	SECTION 5 – RECIPIENT RIGHTS ADVISORY COMMITTEE	SOURCES OF EVIDENCE
MHC 1757[1]	5.1.1	The board of each community mental health services program shall appoint a recipient rights advisory committee consisting of at least 6 members who represent the varied perspectives of the CMHSP's geographic area and meet the statutory requirements of the Mental Health Code.	RRAC policy; RRAC membership roster; Board records regarding appointment of RRAC members; RRAC meeting minutes and bylaws.
MHC 1757[2](a)	5.1.2	The RRAC met at least semiannually or as necessary to carry out its responsibilities.	RRAC policy; RRAC meeting minutes; RRAC meeting schedule; RRAC bylaws.
MHC 157[2](b)	5.1.3	The CMHSP maintains a current list of members' names. This list is available to individuals upon request.	RRAC policy; RRAC membership roster by name only; RRAC bylaws.
MHC 1757[2](c)	5.1.4	The CMHSP maintains a current list of categories represented by members. This list is available to individuals upon request.	RRAC policy; RRAC membership roster by category only; RRAC bylaws.
MHC 1757[2](d)	5.1.5	The RRAC acts to protect the recipient rights office from pressures which could interfere with the impartial, even-handed and thorough performance of its duties and serves in an advisory capacity to the CMH Director and the Director of the Office of Recipient Rights.	RRAC policy; RRAC meeting minutes; training materials presented to RRAC; RRAC bylaws.
MHC 1757[2][g]	5.1.6	The RRAC reviewed and provided comments on the annual rights report submitted by the executive director to the Board of the CMHSP.	RRAC policy; RRAC meeting minutes; training materials presented to RRAC; Annual Report; RRAC bylaws.
MHC 1757[2][i]	5.1.7	Meetings of the RRAC complied with the Open Meetings Act (Act 257 of 1976).	RRAC policy; RRAC meeting minutes; training materials presented to RRAC; CMH website and shared drive; RRAC bylaws.
MHC 1757[2][i]	5.1.8	Minutes of the RRAC meetings were maintained and made available to individuals upon request.	RRAC policy; RRAC meeting minutes; training materials presented to RRAC; CMH website and shared drive; log of instances of requests for meeting minutes; RRAC bylaws.

Citation	Standard	SECTION 6 – COMPLAINT RESOLUTION - PROCESS	SOURCES OF EVIDENCE
MHC 1776[3]	6.1.1	Each rights complaint was recorded upon receipt by the rights office.	Complaint resolution policy; Complaint log; complaint resolution files.
MHC 1776 [3]	6.1.2	For each rights complaint recorded, an acknowledgement letter and copy of the complaint was sent to the complainant.	Complaint resolution policy; Complaint log; complaint resolution files.
MHC 1776[6]	6.2.1	If a rights complaint had been filed regarding the conduct of the agency director, the rights investigation was conducted by the office of another CMHSP or, if requested by the CMHSP Board of Directors, by the MDHHS Office of Recipient Rights.	Complaint resolution policy; contract or agreement with another rights officer to conduct investigation; Complaint investigation files; Board meeting minutes; contract or agreement with another rights officer to conduct investigation.
MHC 1778[1]	6.3.1	The rights office immediately initiated investigation of apparent or suspected rights violations involving the death of a recipient, alleged abuse or neglect of a recipient, or the alleged retaliation or harassment of an individual using the rights system.	Complaint resolution policy; Complaint investigation files; RIF and Summary Report information. Standard: documentation of rights activity within 24 hours of notice of the event.

Citation	Standard	SECTION 6 – COMPLAINT RESOLUTION - PROCESS	SOURCES OF EVIDENCE
MHC 1778[1]	6.3.2	The rights office initiated investigation of apparent or suspected rights violations in a timely and efficient manner.	Complaint resolution policy; Complaint intervention and investigation files; RIF and Summary Report information. Standard: documentation of rights activity within 7 days of notice of the event.
MHC 1778 [2]	6.4.1	Investigation activities for each rights complaint were accurately recorded by the office. This includes interview notes, documents reviewed, policies, and other sources of evidence pertaining to the investigation being contained in the complaint case file.	Complaint resolution policy; Complaint intervention and investigation files; RIF and Summary Report information; interview notes, documents reviewed, policies and other sources of evidence pertaining to the investigation being contained in the complaint case file.
MHC 1776 [6] MHC 1778	6.5.1	At the completion of the investigation, the rights office notified the complainant of the option of mediation.	Complaint resolution policy; Complaint investigation files; notice accompanying Summary Report; Summary Report cover letter.
MHC 1778[5]	6.6.1	Upon completion of the investigation, the office completed a written investigative report and submitted it to the respondent and to the RMHA.	Office of Recipient Rights policy; complaint resolution policy; Complaint investigation file; RIF contents; Complaint log; RIF cover letter.
MHC 1782[1]	6.7.1	The executive director submitted a written summary report to the complainant, recipient if different, guardian/parent of a minor recipient.	Office of Recipient Rights policy; complaint resolution policy; Complaint investigation files; contents of Summary Report; Summary Report cover letters.
MHC 1782[2]	6.8.1	Information in the summary report did not violate the rights of any employee.	Bullard-Plawecki Employee Right to Know Act requirements met; Office of Recipient Rights policy. complaint resolution policy; human resources policy; Complaint investigation files; contents of Summary Report;
MHC 1784[3]	6.9.1	The rights office advised the appellant that there are advocacy organizations available to assist in preparing the written appeal and offered to make the referral. In the absence of assistance from an advocacy organization, the rights office assisted the appellant in meeting the procedural requirements of a written appeal.	Complaint resolution policy; appeal policy; complaint investigation files; appeal files; appeal notice accompanying Summary Report; cover letter of Summary Reports' appeals documents with report enclosure.

Citation	Standard	SECTION 7 – COMPLAINT RESOLUTION - CONTENT	SOURCES OF EVIDENCE
CMHSP 6.4.3.2	7.1.1	Complaints identified as out-of-jurisdiction or no right involved were correctly categorized and responded to. Sufficient rationale was provided to the complainant.	Policy; Complaint intervention files; acknowledgment and response letters for NRI/OJ complaints.
CMHSP 6.4.3.2	7.1.2	For complaints where the intervention process was utilized, the rights office conducted the intervention using a preponderance of evidence standard and in compliance with the standards established by MDHHS.	Policy; Complaint intervention files; acknowledgment and response letters for intervention complaints.
CMHSP 6.4.3.2	7.1.3	The results of the intervention indicated whether a rights violation was substantiated.	Policy; Complaint intervention files; acknowledgment and response letters for intervention complaints.

Citation	Standard	SECTION 7 – COMPLAINT RESOLUTION - CONTENT	SOURCES OF EVIDENCE
CMHSP 6.4.3.2	7.1.4	Correspondence providing information on the results of an intervention contained all required elements.	Policy; Complaint intervention files; acknowledgment and response letters for intervention complaints; interview notes and documents received are included in complaint files.
MHC 1778[4]	7.1.5	The communication clearly indicated that process for requesting an investigation if the complainant was not satisfied with the result of the intervention.	Policy; Complaint intervention files; acknowledgment and response letters for intervention complaints.
MHC 1778 [4]	7.2.1	Issued status reports contained all required elements.	Policy; 30 & 60 day status report contents.
MHC 1778 [4]	7.2.2	Status reports were sent to all required persons.	Policy; 30 & 60 day status report contents; SR Cover letters.
MHC 1778[5][a]	7.3.1	The written investigative report included a statement of allegations as required by MDHHS standards.	Policy; complaint resolution policy; RIF contents.
MHC 1778[5][c]	7.3.2	The written investigative report included citations to relevant provisions of the Mental Health Code, other applicable laws, rules, policies and guidelines.	Policy; complaint resolution policy; RIF contents.
MHC 778[5][b]	7.3.3	The written investigative report included a statement of the issues involved as required by MDHHS Standards.	Policy; RIF contents.
MHC 778[5][d]	7.3.4	The written investigative report included findings of the investigation that were sufficient to provide a detailed inquiry and systematic examination of the allegation.	Policy; RIF contents.
MHC 778[5][e]	7.3.5	The written investigative report included a conclusion section which provided an analysis of the findings and a decision as to whether a violation occurred using a preponderance of evidence standard.	Policy; RIF contents.
MHC 778[5][f]	7.3.6	When appropriate, the written investigative report included recommendations which provided for appropriate remedial action and attempted to prevent a recurrence of the violation.	Policy; RIF contents.
MHC 1722[2]	7.4.1	On substantiated rights violations involving abuse or neglect, the RMHA/ respondent took appropriate disciplinary action.	Policy; complaint investigation file; Summary Report contents; annual and semi-annual reports; HR records.
MHC 1755[3][b] MHC 1780[1]	7.4.2	On substantiated rights violations not requiring disciplinary action, the RMHA/respondent took appropriate remedial action.	Policy; Complaint intervention and investigation files; Summary Report contents; intervention response letter contents; annual and semi-annual reports; HR records.
MHC 1782 [1] (a-g)	7.5.1	Summary reports reflected the information from the allegation, citation, and issues, and recommendation sections of the RIF and provided a summary of the investigative findings of the rights office.	Policy; RIF and Summary Report contents.
MHC 1780	7.5.2	The Summary Report provided detailed information as to the action taken (or action planned to be taken) in order to meet the requirements stated in MHC 1780.	Policy; Summary Report contents.
MHC 1782[1][h]	7.5.3	As part of the Summary Report the complainant, recipient, if different, guardian or parent of a minor were informed of their right to appeal, the grounds for filing the appeal and information about where to send the appeal.	Policy; Summary Report contents; Appeal notice contents; Summary Report cover letter contents.

Citation	Standard	SECTION 7 – COMPLAINT RESOLUTION - CONTENT	SOURCES OF EVIDENCE
CMHSP 6.3.2.4 II. D	7.6.1	If the Summary Report included a "Plan of Action", written notice was issued to the potential appellants upon completion of the plan. If the action taken was different than the plan, the notice detailed the action that was taken and the date it occurred as well as informed potential appellants of the right to appeal on action only.	Policy; Complaint investigation files; contents of written notice to appellants; copy of amended Summary Report with cover letter indicating it was sent.

Citation	Standard	SECTION 8 – COMPLAINT RESOLUTION - TIMEFRAMES	SOURCES OF EVIDENCE
MHC 1776 (3)	8.1.1	For each complaint received, the Rights Office provided, to the complainant within 5 business days, an acknowledgement of receipt and a copy of the complaint.	Policy; complaint log; acknowledgement letters; complaint resolution files; customer services policy.
MHC 1776 (4)	8.1.2	For each complaint utilizing the intervention process, responses were provided to the complaint within 30 calendar days.	Policy; customer services policy; Complaint resolution files; acknowledgment and response letters for NRI complaints' complaint log.
MHC 1776 (4)	8.1.3	For each investigation, status reports were issued every 30 days, as required.	Policy; customer services policy; Complaint resolution files; acknowledgment and response letters for OJ complaints; complaint log.
MHC 1778 (1)	8.1.4	Subject to delays involving pending action by external agencies, the office completed investigations no later than 90 calendar days following receipt.	Policy; Complaint log; RIF and Summary Report contents; RIF cover letters; documentation of submission of RIFs to required parties.
MHC 1782 (1)	8.1.5	A written Summary Report was issued for each Report of Investigative Findings (RIF) within 10 business days after receipt of the RIF.	Policy; Complaint log; Summary Report contents; Summary Report cover letters; documentation of submission of Summary Reports to required parties.

Citation	Standard	SECTION 9 – APPEALS	SOURCES OF EVIDENCE
MHC 1774[2][a]	9.1.1	The Board of the CMHSP appointed an appeals committee to hear appeals of recipient rights matters **OR** designated the RRAC as the appeals committee. An appointed committee shall consist of seven individuals who meet the following criteria: (a) None are employed by DHHS or the CMHSP, (b) at least 3 are members of the RRAC c) At least 2 are board members and d) at least 2 are primary consumers.	Policy; Appeals committee roster; RRAC by-laws; Board and RRAC meeting minutes.
MHC 1774[4] CMHSP C 6.3.2.4.III.F	9.2.1	Within 5 business days after receipt of a written appeal, the assigned Committee members reviewed the appeal to determine whether it met criteria.	Policy; appeals log; notice or response letter to appellant; documentation in appeal file; RRAC meeting minutes.
MHC 1774[4] CMHSP C 6.3.2.4.III.F	9.2.2	Requests for appeal were correctly accepted or rejected in accordance with the standards established in the Code and contract language.	Policy; appeals log; notice or response letter to appellant; documentation in appeal file; RRAC meeting minutes.
CMHSP C 6.3.2.4.III.G	9.2.3	Within 7 business days of the receipt of the appeal, written notification was provided to the appellant as to the acceptance or denial of the appeal. A notice of rejection shall describe the reason for not accepting the appeal.	Policy; Appeals log; notice or response letter to appellant; appeal file.

Citation	Standard	SECTION 9 – APPEALS	SOURCES OF EVIDENCE
CMHSP C 6.3.2.4.III.G	9.2.4	A copy of the appeal was provided to the Rights Office, the respondent, and the RMHA.	Policy; Appeals log; notice or response letter to appellant, with evidence that copy of appeal request was copied to all required persons; appeal file.
MHC 1774[6]	9.3.1	A member of the Appeals Committee who has a personal or professional relationship with an individual involved in the appeal abstains from participating in the appeal.	Policy; Appeals Committee meeting minutes; notice or letter to appellant describing conclusion of committee; appeal file.
MHC 1784[5] CMHSP C 6.3.2.4.III.H	9.4.1	Within 30 days after the written appeal was received, the Appeals Committee met in a closed session and reviewed the facts as stated in all complaint investigation documents.	Policy; Appeals log; Appeals Committee meeting minutes; notice or letter to appellant describing conclusion of committee; appeal file.
MHC 1784[5] CMHSP C 6.3.2.4.III.H	9.4.2	The Appeals Committee took an action that was in compliance with the Code and contract requirements.	Policy; Appeals log; Appeals Committee meeting minutes; notice or letter to appellant describing conclusion of committee; appeal file.
MHC 1784[5] CMHSP C 6.3.2.4.III.H	9.4.3	The decision of the Appeals Committee was correct.	Policy; Appeals log; Appeals Committee meeting minutes; notice or letter to appellant describing conclusion of committee; appeal file.
MHC 1784[6] CMHSP C 6.3.2.4.III.J	9.5.1	The Appeals Committee documented its decision in writing and provided written justification for that decision.	Policy; Appeals log; notice or letter to appellant describing conclusion of committee; appeal file.
MHC 1784[6]	9.5.2	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 RMHA, and the rights office.	Policy; log; notice or letter to appellant describing conclusion of committee, with evidence that it was copied to all required persons; appeal file. Documentation shall include the justification for the decision of the committee.

Citation	Standard	SECTION 10 – SEMI-ANNUAL AND ANNUAL REPORTING	SOURCES OF EVIDENCE
MHC 1755[5][j] CMHSP 6.5.1.1	10.1.1	By June 30 of each year, the Rights Office provided to MDHHS and to the agency RRAC, a summary of complaint data together with a remedial action taken on substantiated complaints.	Policy; Semi-Annual and Annual Report, with evidence of date of submission; RRAC meeting minutes.
MHC 1755[6] CMHSP 6.5.1.1	10.2.1	By December 30 of each year, the CMHSP submitted to MDHHS, an annual report prepared by the recipient rights office on the current status of recipient rights in the agency and a review of the operations of the rights office for the preceding fiscal year.	Policy; Annual Report, with evidence of date of submission; RRAC meeting minutes; Agency Board meeting minutes.
MHC 1755[6] CMHSP 6.5.1.1	10.3.1	By January 15 of each year, the Rights Office submitted the ORR Annual Report Monitoring form for the preceding calendar year to MDHHS-ORR.	Policy; ORR Annual Report Monitoring form, with evidence of date of submission.

Citation	Standard	SECTION 11 – SITE VISITS	SOURCES OF EVIDENCE
MHC 1755 (5) (e) ORR Guidance 17-01	11.1.1	The agency ensured that for all service providers - *other than LPHs and other providers that have their own rights system* – the service site is visited with the frequency necessary for protection of rights but in no case less than annually.	Policy and procedure regarding provider site monitoring; language of CMH contracts with providers; CMH contract monitoring team activities; service provider annual site monitoring review forms, reports, and records; CMH website and server; documentation confirming completion of required remedial action and/or plans of correction.
MHC 1755(b)(c)(i) MHC 1776 (1) (5) MHC 1723	11.1.2	The agency ensured that for each site review of service providers - *other than LPHs and other providers that have their own rights system* – the review contained all elements required by Code, Rules, Contract and MDHHS-ORR standards.	Policy and procedure regarding provider site monitoring; language of CMH contracts with providers; CMH contract monitoring team activities; service provider annual site monitoring review forms and records; ORR contact information posters; Your Rights Booklet with ORR contact info; documentation confirming completion of required remedial action and/or plans of correction.
MHC 1755 (5) (g)	11.2.1	The agency ensured that for each site review of service providers - *other than LPHs and other providers that have their own rights system* – any necessary follow up or remedial action required to bring providers into compliance with ORR standards is addressed and completed.	Policy and procedure regarding provider site monitoring; language of CMH contracts with providers; CMH contract monitoring team activities; service provider annual site monitoring review forms and records; documentation confirming completion of required remedial action and/or plans of correction.
MHC 1755 (5) (e) ORR Guidance 18-01	11.2.2	The Agency ensured that the service sites of all LPHs and other providers that have their own rights system are visited with the frequency necessary for protection of rights but in no case less than annually.	Policy and procedure regarding provider site monitoring; language of CMH contracts with providers; CMH contract monitoring team activities; service provider annual site monitoring review forms and records; documentation confirming completion of required remedial action and/or plans of correction.
MHC 1755 (5)(e)	11.2.3	The Agency ensured that for site reviews of *LPHs and other providers that have their own rights system* the review contained all elements required by Code, Rules, Contract and MDHHS-ORR standards.	Policy and procedure regarding provider site monitoring; language of CMH contracts with providers; CMH contract monitoring team activities; service provider annual site monitoring review forms and records; ORR contact information posters; service provider annual site monitoring review forms and records; Your Rights Booklet with ORR contact info; documentation confirming completion of required remedial action and/or plans of correction.

Citation	Standard	SECTION 11 – SITE VISITS	SOURCES OF EVIDENCE
MHC 1755 (5)(e)	11.2.4	The Agency ensured that, for each site review of *LPHs and other providers that have their own rights system,* any necessary follow up or remedial action required to bring providers into compliance with ORR standards is addressed and completed.	Policy and procedure regarding provider site monitoring; language of CMH contracts with providers; CMH contract monitoring team activities; service provider annual site monitoring review forms and records; documentation confirming completion of required remedial action and/or plans of correction.
MHC 1755 (5)(e)	11.2.5	The Agency ensured that the recipient rights policies of *LPHs and other providers that have their own rights system* are reviewed, and that the reviews are done in compliance with applicable standards for rights policy reviews.	Policy and procedure regarding provider site monitoring; language of CMH contracts with providers; CMH contract monitoring team activities; service provider annual site monitoring review forms and records; policy review for LPHs.

BACKGROUND:
MHC 330.1752 (1) requires that community mental health services programs (CMHSPs) "…shall establish written policies and procedures concerning recipient rights and the operation of an office of recipient rights".

INSTRUCTIONS:
For each section of the worksheet indicate on the top line:

1) The name and number of the policy (or policies) that contain the language for each standard listed, and,
2) The date of the most recent revision, review, or approval of the policy or policies.

Then, for each standard, indicate, in the right column, specifically where in the policy the required language is found (such as by page and/or section
Submit the completed worksheet to the MDHHS-ORR lead assessor at least 30 calendar days prior to the assessment.

COMPLAINT AND APPEAL PROCESS

POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	
	A1	The process delineates a process to assure that all recipients receive a summary of rights. [MHC 1706]	LOCATION
	A2	The policy delineates 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 policy requires that the Rights Office assure that recipients, parents of minors, guardians and others had ready access to complaint forms. [MHC 1776 (1), (5)]	
	A4	The policy requires that each rights complaint is recorded upon receipt by the rights office. [MHC 1776 (3)]	
	A5	The policy requires that rights complaints filed by recipients, or anyone on their behalf, are provided to the rights office in a timely manner. [MHC 1776 (1); 1778 (1)]	
	A6	The policy requires that acknowledgment of the recording is sent along with a copy of the complaint to complainant within 5 business days. [MHC 1776 (3)]	
	A7	The policy requires that the rights office will notify the complainant within 5 business days after it received the complaint if it determined that no investigation of the complaint was warranted. [MHC 1776 (4)]	
	A8	The policy requires the rights office to assist the recipient or other individual with the complaint process, as necessary. [MHC 776 (5)]	
	A9	The policy requires 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 (5)]	
	A10	The policy requires that, 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	The policy requires that, if a rights complaint is received regarding the conduct of the executive director, 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)]	
	A12	The policy requires that, 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)]	
	A13	The policy requires that the rights office will initiate investigation of apparent or suspected rights violations in a timely and efficient manner. [MHC 1778 (1)]	
	A14	The policy requires that 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 agency (RMHA) 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)]	
	A15	The policy requires that investigations will be completed within 90 calendar days, unless awaiting action by external agencies. [MHC 1778 (1)]	
	A16	The policy requires that the rights office will conduct investigations in a manner that does not violate employee rights. [MHC 1755(3)(b)]	
	A17	The policy requires that investigation activities for each rights complaint will be accurately recorded by the office. [MHC 1778(2)]	

		COMPLAINT AND APPEAL PROCESS	LOCATION
	A18	The policy requires that 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	The policy requires that, upon completion of the investigation, the rights office will submit a written investigative report (RIF) to the respondent and to the RMHA. [MHC 1778(5)]	
	A20	The policy requires that 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)]	
	A21	The policy requires that, when rights violations are substantiated, the RMHA and/or respondent 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	The policy requires that remedial action taken on substantiated violations is documented and made part of the record maintained by the rights office. [MHC 1780(2)]	
	A23	The policy requires that the RMHA submit a written summary report to the complainant, recipient, if different than the complainant, parent of a minor, or guardian, within 10 business days after receiving the RIF from the rights office. [MHC 1782(1)]	
	A24	The policy requires that the summary report contain 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) 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. [MHC 1782(1)]	
	A25	The policy requires that the CMHSP and each service provider 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	The policy requires that 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	The policy requires that information in the summary report will not violate the rights of any employee (ex. Bullard-Plawecki Employee Right to Know Act, (Act 397 of the Public Acts of 1978). [MHC 1782(2)]	
	A28	The policy requires that, if CMHSP 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(1)]	
	A29	If the summary report contains a plan of action the director must send a letter indicating when the action was completed. [2018 technical requirement; recipient rights appeal process]	
	A30	If the letter indicating the plan of action describes an action that differs from the plan, the letter must indicate that an appeal may be made within 45 days on "action". [2018 technical requirement; recipient rights appeal process]	
	A31	The policy requires that the CMHSP Board appoint an Appeals Committee consisting of 7 individuals or designate the RRAC as the appeals committee. A committee designated separately from the RRAC will have at least 3 members from the RRAC, at least two members of the CMHSP Board and at least two primary consumers. Members can represent more than one of these categories. None of the members shall be employed by the CMHSP or MDHHS. [MHC 1774(2)]	
	A32	The appeals committee may request consultation and technical assistance from MDHHS-ORR. [MHC 1774 (5)]	
	A33	The policy requires that 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)]	
	A34	The policy requires that appeals may be filed no later than 45 days after receipt of the summary report. [MHC 1784(1)]	
	A35	The policy states that 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)]	
	A36	The policy requires that 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)]	

		COMPLAINT AND APPEAL PROCESS	LOCATION
	A37	The policy requires that, 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)]	
	A38	The policy requires that within 5 business days after receipt of a written appeal, at least 2 members of the Appeals Committee will review the appeal to determine whether it meets criteria (see a33). [MHC 1784(4)]	
	A39	The policy requires that the results of the review will be provided, in writing, to the appellant, within 5 business days. [MHC 1784(4)] [C6.3.2.4.III.G]	
	A40	The policy requires that, if the appeal is accepted, a copy of the appeal will be provided to the respondent and the CMHSP within 5 business days. [MHC 1784 (4)]	
	A41	The policy requires that, 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)]	
	A41	The policy requires that 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 respondent, 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 respondent take additional or different action to remedy the violation, or d) recommended that the Board of the CMHSP request an external investigation by the MDHHS Office of Recipient Rights. [MHC 1784(5) (a-d)]	
	A42	The policy requires that the Appeals Committee will document its decision and justification for the decision in writing. [MHC 1784(6), MDHHS/CMH Contract Attachment C6.3.2.4]	
	A43	The policy requires that, within 10 days after reaching its decision, the Appeals Committee will provide copies of the decision to the respondent, appellant, recipient if different than appellant, (parent of a minor recipient), recipient's guardian if one has been appointed, the CMHSP, and the rights office. [MHC 1784 (6)]	
	A44	The policy requires that, 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 for appeal (investigative findings of the rights office are inconsistent with facts, or with law, rules, policies or guidelines.). [MHC 1784 (6) (1786)]	
	A45	If an investigation is returned to the CMH by an appeals committee for reinvestigation, the office will complete **the reinvestigation within 45 days following the standards established in 330.1778. [2019 contract attachment**/technical requirement]	
	A46	If an investigation is returned to the CMH by an appeals committee for reinvestigation, upon receipt of the RIF, the director will take appropriate remedial action and will 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), 2019 contract attachment/technical requirement]	
	A47	If a request for additional or different action is sent to the Director, a response will be sent within30 days as to the action taken or justification as to why it was not taken. The response will be sent to the complainant, recipient, if different than the complainant, parent or guardian, and the appeals committee. [MHC 330.1784(5)(c), 2019 contract attachment/technical requirement]	
	A48	If the committee notifies the CMH Board chair of a recommendation to seek an external investigation from MDHHS-ORR, the board will send a letter of request to the director of MDHHS-ORR within 5-business days of receipt of the request from the appeals committee. The director of the CMH making the request will be responsible for the issuance of the summary report, which will identify the grounds and advocacy information as in A32-A34 of this document and MDHHS-ORR Appeal Committee as the committee for any Appeal. [MHC 330.1784(5)(d), 2019 contract attachment/technical requirement]	

		CONSENT AND INFORMED CONSENT	LOCATION
POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	
	B1	The policy contains a definition of consent in accordance with the definition in the Mental Health Code. [MHC 1100(a)(19)]	
	B2	The policy contains a definition of informed consent in accordance with the definition in the Administrative Rules. [AR 7003(1) (a-d)]	
	B3	The policy requires that the individual providing consent shall be made aware of the purpose of the procedure, the risks and benefits, alternative procedures available, and offered an opportunity to ask and receive answers to questions. [AR 7003(1)(b)]	
	B4	The policy states that provisions for making recipient/guardian aware that consent can be withdrawn at any time without prejudice to the recipient/guardian. [AR 7003(1)(d)]	

CONSENT AND INFORMED CONSENT

			LOCATION
	B5	The policy defines a procedure for evaluating comprehension. [AR 7003(2)]	
	B6	The policy indicates that an evaluation of the ability to give consent shall precede any guardianship proceedings. [AR 7003(2)]	
	B7	The recipient has free power of choice without force, fraud, deceit, duress, constraint, coercion, etc. [AR 7003 (1) (d)]	
	B8	Informed consent will be reobtained if changes in circumstances substantially change the risks, other consequences or benefits that were previously expected. [AR 7003 (3)]	
	B9	The policy has a provision which allows a minor 14 years of age or older to request and receive mental health services and mental health professional may provide services on an out-patient basis (excluding pregnancy termination referral services and use of psychotropic drugs) without the consent or knowledge of the minor's parent, guardian, or person in loco parentis, unless the treating mental health professional determines a compelling need for disclosure based upon substantial probability of harm to minor or another and if the minor is notified of the treating professional's intent to inform. [MHC 1707(1)]. [MHC 1707(1)]	
	B10	The policy indicates that services provided to the minor are limited to not more than 12 sessions or 4 months per request and after these expire, the mental health professional terminates the services or, with the consent of the minor, notifies the parent, guardian, or person in loco parentis to obtain consent to provide further out-patient services. [MHC 1707(3)]	

ABUSE/NEGLECT

POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	LOCATION
	C1	The policy defines abuse in accordance with the definitions in AR 7001 (a-c), (z). [AR7035(2)(a)]	
	C2	The policy defines neglect in accordance with the definitions in AR 7001 (i - k). [AR7035(2)(a)]	
	C3	The policy establishes procedures for the mandatory reporting of abuse or neglect to a) the rights office, b) administration, c) other agencies as required by law.	
	C4	The policy requires that investigations of abuse/neglect allegations are conducted by Rights Office. [MHC 1778(1)]	
	C5	The policy requires that, if an allegation is found to be substantiated, the agency will take firm and fair disciplinary action and remedial action as appropriate. (MHC 1722 (2)	
	C6	The policy clearly defines who is required to report abuse. [MHC 1723(1); P.A. 238 of 1978; P.A. 519 of 1982; and MHC 1722(2)]	
	C7	The policy required the reporting criminal abuse including vulnerable adult abuse and child abuse to local law enforcement. [MHC 1723]	
	C8	The policy defines who shall prepare written reports to law enforcement agencies regarding criminal abuse. [MHC 1723(2)	
	C9	The policy defines degrade and threaten using the definitions provided in the CMHSP Contract Attachment CMHSP 6.3.2.3 (B)	

DIGNITY AND RESPECT

POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	LOCATION
	D1	The policy requires that the CMHSP protect and promote the dignity and respect that a recipient of services is entitled. [MHC 1704(3), 1708(4)]	
	D2	The policy contains definitions of dignity and respect. [MHC 1704(3)	
	D3	The policy requires that family members be treated with dignity and respect. [MHC 1711]	
	D4	The policy requires that family members be given an opportunity to provide information to the treating professionals. [MHC 1711]	
	D5	The policy requires that family members be 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 LOCATION

POLICY NUMBER: Click or tap here to enter text.	POLICY DATE: Click or tap here to enter text.

	E1	The policy identifies the circumstances under which audiotapes, or photos may be taken, and 1-way glass used. [MHC 1724(7)(a-c)]	
	E2	The policy defines the parameters for use of fingerprints, photos, or audiotapes for purpose of recipient identification. [MHC 1724(4)]	
	E3	The policy requires prior written consent. [MHC 1724(2)] [AR 7003(1)(c)]	
	E4	The policy defines the procedures for withdrawing consent. [AR 7003 (1)(d)]	
	E5	The policy provides a means to object when photos are for personal information or social purposes. [MHC 1724(6)]	
	E6	The policy defines a method of safekeeping of fingerprints, photos, and audiotapes. [MHC 1724(4)]	
	E7	The policy requires that 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 one of the objectives set forth in subsection (2), or upon discharge of the resident, whichever occurs first. [MHC 1724(5)]	
	E8	The policy provides for a review of current need for audio taping, photographing/fingerprinting or use of 1-way glass. [MHC 1724(5]	
	E9	The policy prohibits video surveillance [MHC 1724 (9)]	

✓		**CONFIDENTIALITY/DISCLOSURE {MHC 1748, 1752; AR 7051}**	LOCATION

POLICY NUMBER: Click or tap here to enter text.	POLICY DATE: Click or tap here to enter text.

	F1	The policy states that all information in the record and that obtained in the course of providing services is confidential. [MHC 1748(1)]	
	F2	The policy requires that a summary of section 1748 of the Mental Health Code be made part of each recipient file. [AR 7051(1)]	
	F3	The policy states that, for case records made after March 28, 1996, information made confidential by Sec. 1748 shall be disclosed to a competent adult recipient upon the recipient's request and that 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 1748 (4)]	
	F4	The policy states that, except as otherwise provided in 1748 (4), 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 agency 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	The policy states that 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 place 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)]	
	F6	The policy establishes a procedure for the review by the director of the agency of a request for confidential information by a person or agency 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 if a part of the information requested may be released without detriment. [AR 7051(3)]	
	F7	The policy establishes a timeframe for the review and determination which shall not exceed 3 business days if record is on-site, or 10 business days if record is off – site. [AR 7051(3)]	
	F8	The policy allows the requestor to file a complaint with the agency's Office of Recipient Rights if he/she disagrees with the decision of the director. [AR 7051(3)]	

✓		CONFIDENTIALITY/DISCLOSURE {MHC 1748, 1752; AR 7051}	LOCATION
	F10	The policy states that, attorneys representing recipients may review records only upon presentation of identification and the recipient's consent or a release executed by the parent or guardian shall be permitted to review the record on the provider's premises. [AR 7051(4)(a)]	
	F11	The policy states that an attorney who has been retained or appointed to represent a minor pursuant to an objection to hospitalization of a minor shall be allowed to review the records. [AR 7051(4)(a)]	
	F12	The policy states that, 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)]	
	F13	The policy states that, attorneys shall be refused information by phone or in writing without the consent or release from the recipient or 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)]	
	F14	The policy states that 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 providers' 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 express waiver of privilege or because of other conditions that, by law permit or require disclosure. AR 7051(5) (a-b)]	
	F15	The policy states that 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)]	
	F16	The policy requires that 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)]	
	F17	The policy allows for the 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)]	
	F18	The policy requires the agency to grant a representative of Disability Rights of Michigan 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 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)]	
	F19	The policy states that 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)]	
	F20	The policy states that the agency, 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])	
	F21	The policy requires the agency, upon a written request from Child Protective Services, to review and provide pertinent records and information within 14 days of the request. [MHC 1748a (1)]	
	F22	The policy allows for a recipient, guardian, or parent of a minor recipient, after having gained access to treatment records, to challenge the accuracy, completeness, timeliness, or relevance of factual information in the recipient's record and allows the recipient or other empowered representative to insert **into the record** a statement correcting or amending the information at issue. (MHC 1749)	
	F23	A record is 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	

✓		CONFIDENTIALITY/DISCLOSURE {MHC 1748, 1752; AR 7051}	LOCATION
		persons receiving the disclosed information could only further disclose consistent with the authorized purpose for which it was released. [AR 7051 (2) (a-e)]	

✓		TREATMENT BY SPIRITUAL MEANS	LOCATION
POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	
	G1	The policy defines "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(y)]	
	G2	The policy allows for access to treatment by spiritual means on request by recipient, guardian, or parent of a minor recipient. [AR7135(1)]	
	G3	The policy allows for 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)]	
	G4	The policy defines a procedure to ensure recourse to court when there is refusal of medication or other treatment for a minor. [AR 7135(6)(a)]	
	G5	The policy defines 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)]	
	G6	The policy defines an administrative review or appeal process when treatment by spiritual means is denied. [AR 7135(7)]	
	G7	The policy allows 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	The policy includes right to 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 those decisions, c) the recipient is not imminently dangerous to self or others. [AR 7135(4)] (a) (b)	
	G9	The policy includes the 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)	

✓		CHANGE IN TYPE OF TREATMENT	LOCATION
POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	
	H1	The policy requires that the written IPOS 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)]	
	H2	The policy defines a procedure to assure that the plan is kept current and modified when indicated. (MHC 1712 (1), MHC 1752)	
	H3	The policy requires 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 1714)	
	H4	The policy requires that, 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 1712 [2])	
	H5	The policy requires that the review required in H4 is completed with 30 days and details the procedures for requesting and conducting the review. (MHC 1712[2])	

✓		MEDICATION PROCEDURES	LOCATION
POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	
	I1	The policy requires a doctor's order for medication. [AR 7158(1)]	
	I2	The policy requires that medication shall not be used as punishment or for staff's convenience. [AR 7158(3)]	
	I3	The policy requires periodic medication reviews as specified in a plan of service and based on recipient's clinical status. [AR 7158(4)]	
	I4	The policy requires that medications must be administered by or under supervision of personnel who are qualified and trained staff. [AR 7158(5)]	

✓		MEDICATION PROCEDURES	LOCATION
	I5	The policy establishes procedures on when and how documentation is to be placed in recipient's clinical record. [MHC 1752, AR 7158(6)]	
	I6	The policy requires reporting and documentation in the recipient's clinical record of medication errors and adverse reactions. [AR 7158(7)]	
	I7	The policy requires 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)]	

✓		USE OF PSYCHOTROPIC DRUGS	LOCATION
POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	
	J1	The policy defines psychotropic medication (psychotropic drug) in accordance with AR 330.7001(p). [AR 7001(p)]	
	J2	The policy states 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 1719)	
	J3	The policy requires that psychotropic chemotherapy shall not be administered unless the individual gives informed consent, or the administration is necessary to prevent physical injury to person or another, or with a court order. [AR 7158(8)(a-d)	
	J4	The policy indicates that the administration of psychotropic medication to prevent physical harm or injury occurs: 1) 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)]	
	J5	The policy limits the initial administration of psychotropic chemotherapy under 7158(8)(b) be limited to a maximum of 48 hours unless there is consent. [AR 7158(8)(c)]	
	J6	The policy specifies that the initial administration of psychotropic chemotherapy under 7158((8)(b) 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)]	
	J7	The policy establishes procedures for documentation of all medication in recipient's clinical record. [AR 7158(6)]	
	J8	The policy requires that medication errors and adverse drug reactions are immediately and properly reported to a physician and recorded in the recipient's record. [AR 7158(7)	

✓		STERILIZATION/ABORTION/CONTRACEPTION (FAMILY PLANNING)	LOCATION
POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	
	K1	The policy requires 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)]	
	K2	The policy provides 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)]	
	K3	The policy provides that the notice includes a statement that mental health services are not contingent upon receiving family planning services. [AR 7029]	

✓		SERVICES SUITED TO CONDITION	LOCATION
POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	
	L1	The policy provides for notification to an applicant, his or her guardian, or a minor applicant's parents, who has been denied services, that a second opinion to determine if the applicant has a serious mental illness, serious emotional disturbance, or a developmental disability, or is experiencing an emergency situation or urgent situation may be requested. [MHC 1705(1)(2)] **SECOND OPINION – DENIAL OF OUTPATIENT SERVICES**	

✓		SERVICES SUITED TO CONDITION	LOCATION
	L2	The policy requires that a person-centered planning process is used to develop a written IPOS in partnership with the recipient. [MHC 1712 (1)]	
	L3	The policy requires that 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)]	
	L4	The policy requires that the IPOS identify any restrictions or limitations of the recipient's rights and include documentation describing attempts to avoid such restrictions, as well as what action will be taken as part of the plan to ameliorate or eliminate the need for the restrictions in the future. [AR 7199(2)(g)]	
	L5	The policy requires that any restrictions, limitations or intrusive behavior treatment techniques are reviewed by a formally constituted committee of mental health professionals with specific knowledge, training and expertise in applied behavioral analysis. [AR 7199(2)(g)]	
	L6	The policy requires that the justification for exclusion of individuals chosen by the recipient to participate in the IPOS process shall be documented in the case record. [MHC 1712(3)]	
	L7	The policy requires that the CMHSP or service provider under contract with the CMHSP, ensures that a recipient is given a choice of physician or mental health professional within the limits of available staff. [MHC 1713]	
	L8	The policy establishes a process whereby a recipient, who is denied hospitalization by the pre-admission screening unit (PSU), may request a second opinion, and that 1) the Executive Director will arrange the second opinion to be performed within 3 days (excluding Sundays and holidays), 2) the Executive Director, in conjunction with the Medical Director, will review the second opinion if it differs from the opinion of the PSU, and 3) the Executive Director will make a decision to uphold or reject the findings of the second opinion, and 4) confirm that decision, in writing, to the requestor; the written decision will be signed by the Executive Director and by the Medical Director (or provide verification that the decision was made in conjunction with the Medical Director.) [MHC 1409(4)] **SECOND OPINION – HOSPITALZIATION**	

✓		RIGHT TO ENTERTAINMENT MATERIALS, INFORMATION & NEWS	LOCATION
POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	
	M1	The policy specifies that residents 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)]	
	M2	The policy specifies that 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)]	
	M3	The policy requires that limitations/restrictions to be removed when no longer clinically justified. [AR 7139(4)]	
	M4	The policy specifies that minors have the right to access material not prohibited by law unless the legal guardian of a minor object to this access. [AR 7139(5)]	
	M5	The policy describes the process for implementing general program restrictions on access to these materials. [AR 7139(6)(a)]	
	M6	The policy describes the process for determining resident's interest for provision of a daily newspaper. [AR 7139(6)(b)]	
	M7	The policy allows for the person in charge of the plan of service to attempt to persuade the parent/guardian of a minor to withdraw their objections to these materials. [AR 7139(6)(c)]	
	M8	The policy describes the process for residents to appeal the denial of their right to this material. [AR 7139(6)(d)	

✓		PERSONAL PROPERTY AND FUNDS	LOCATION
POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	
	N1	The policy defines the conditions under which a search for contraband items may be conducted. [AR 7009(7)]	
	N2	The policy requires that documentation be made in the record of the circumstances surrounding the search which includes:	

✓		PERSONAL PROPERTY AND FUNDS	LOCATION
		(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)]	
	N3	The policy requires that any property taken into possession by the residence/facility must be given to the recipient at the time the recipient leaves [MHC 1728 (7)]	
	N4	The policy requires a resident to be permitted to inspect personal property at reasonable times. [MHC 1728(2)]	
	N5	The policy allows for the plan of service to limit property in order to prevent the resident from physically harming himself, herself or others, or to prevent theft, loss, or destruction of the property, unless a waiver is signed by the resident. Limitations of property to be justified and documented in the record of the resident. [MHC 1728(5)] [MHC 1728(4)(a)]	

✓		FREEDOM OF MOVEMENT	LOCATION
POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	
	O1	The policy requires placement in the least restrictive setting. [MHC 1708 (3)]	
	O2	The policy requires 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. [MHC 1744(1)]	
	O3	The policy requires that any limitations to the freedom of movement must be justified in the record and be time limited. [MHC 1744(2)]	
	O4	The policy requires that any restriction on freedom of movement is removed when the circumstances that justified its adoption cease to exist. [MHC 1744(3)]	

✓		LEAST RESTRICTIVE SETTING	LOCATION
POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	
	P1	The policy requires that the CMHSP provide mental health services in the least restrictive setting that is appropriate and available. [MHC 1708(3)]	

✓		RESIDENT LABOR	LOCATION
POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	
	Q1	The policy requires 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, 1) the resident voluntarily agrees to perform the labor, 2) engaging in the labor would not be inconsistent with the IPOS for the resident, 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)]	
	Q2	The policy requires that a resident who performs labor that contributes to the operation and maintenance of the facility for which the facility 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)]	
	Q3	The policy requires compensation when performing labor which benefits another person/agency. [MHC 1736(3)]	
	Q4	The policy specifies that labor of personal housekeeping nature is not eligible for payment. [MHC 1736(5)]	
	Q5	The policy requires 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 1736(6)]	

✓		COMMUNICATION/MAIL/TELEPHONE/VISITS	LOCATION
POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	

✓		COMMUNICATION/MAIL/TELEPHONE/VISITS	LOCATION
	R1	The policy requires that telephones shall be reasonably accessible and that funds for telephone usage are available in reasonable amounts. [MHC 1726(2)]	
	R2	The policy requires that correspondence can be conveniently and confidentially received and mailed (i.e. postal box or daily pickup and deposit), and that writing materials and postage are provided in reasonable amounts. [MHC 1726(2)]	
	R3	The policy requires that space will be made available for visits. [MHC 1726(2)]	
	R4	The policy requires 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)]	
	R5	The policy contains a provision that 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 1726(5)]	
	R6	The policy requires that, if a resident 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]	

✓		RESTRAINT/PHYSICAL MANAGEMENT	LOCATION
POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	
	S1	The policy defines restraint in accordance with the definitions in the Mental Health Code and Administrative Rules. [MHC 1700(i); AR 7001(q)	
	S2	The policy defines physical management in accordance with the definition in the Administrative Rules [AR 7001(m); AR 7243]	
	S4	The policy expressly prohibits the use of restraint in all agency programs or sites directly operated or under contract where it is not permitted by statute and agency policy (. [MHC 1740(1)]	
	S5	The policy prohibits the use of physical management except in situations when a recipient is presenting an imminent risk of serious or non-serious harm to himself, herself or others, and lesser restrictive interventions have not reduced or eliminated the risk of harm. [AR 7243(11)]	
	S6	The policy states that physical management shall not be included as a component in the behavior treatment plan. [AR 7243(11)(i)]	
	S7	The policy prohibits the use of prone immobilization unless other techniques are medically contraindicated and documented in the record. [AR 7243(11)(ii)]	

✓		USE OF SECLUSION	LOCATION
POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	
	T1	The policy defines seclusion in accordance with the definition in the Mental Health Code. [MHC 1700(i)]	
	T2	The policy defines therapeutic de-escalation in accordance with the definition in the Administrative Rules. [AR 7001(w)]	
	T3	The policy defines timeout in accordance with the definition in the Administrative Rules. [AR 7001(x)]	
	T4	The policy prohibits the use of seclusion in all agency programs, directly operated sites, or contractual service locations unless permitted by statute. [MHC 1742 (1)]	

✓		QUALIFICATIONS AND TRAINING OF RECIPIENT RIGHTS STAFF	LOCATION
POLICY NUMBER: Click or tap here to enter text.		POLICY DATE: Click or tap here to enter text.	
	U1	The policy requires staff of the Office of Recipient Rights to receive annual training in recipient rights protection. [MHC 1755 (2)(e)]	
	U2	The policy requires that the director of the Office of Recipient Rights must have the education, training, and experience to fulfill the responsibilities of the office. [MHC 1755(4)]	
	U3	The policy indicates the education, training, and experience required (or this is indicated in the position description). [MHC 1755(4)]	
	U4	The policy requires that the rights officer, advisor and alternate attend and successfully complete ORR Basic Skills Training Programs within 3 months of hire. [CMHSP 6.3.2]	
	U5	The policy requires that the staff of the rights office will comply with the continuing education requirements identified in the contract attachment. MHC 1755[2][e], CMHSP 6.3.2.3 (A)	

✓		QUALIFICATIONS AND TRAINING OF RECIPIENT RIGHTS STAFF	LOCATION
	U6	The policy requires that a minimum of 12 of the required 36 hours were approved as either Category I or II. MHC 1755[2][e], CMHSP 6.3.2.3 (A)	
	U7	The policy requires that rights staff acquire at least 3 continuing education credits each calendar year MHC 1755[2][e], CMHSP 6.3.2.3 (A)	

In addition to the above, the following apply to Crisis Stabilization Units only

✓		RIGHT AFFECTED	**POLICY STANDARD**: The policy requires/includes the following:	LOCATION
		personal property & funds	POLICY NUMBER: Click or tap here to enter text.	POLICY Date:
	CS1	personal property & funds	The policy defines items that residents may not possess (including weapons, sharp objects, explosives, drugs and alcohol) in a crisis stabilization unit. [MHC 1728 (3)]	
	CS2	personal property & funds	The policy requires that any exclusions of personal property be in writing and posted in each crisis stabilization unit. [MHC 1728(3)]	
		communication/mail/telephone/visits	POLICY NUMBER: Click or tap here to enter text.	POLICY Date:
	CS3	communication/mail/telephone/visits	The policy requires 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 crisis stabilization unit. [MHC 726(3)]	
		right to entertainment materials, information & news	POLICY NUMBER: Click or tap here to enter text.	POLICY Date:
	CS4	right to entertainment materials, information & news	The policy describes a process for imposing specific restrictions {in a crisis stabilization unit} for the therapeutic benefit the residents as a group. [MHC 1100b(1), AR 7139(6)(e)]	
		restraint/physical management	POLICY NUMBER: Click or tap here to enter text.	POLICY Date:
	CS5	Restraint is defined, as in MHC 1700 (i); 42 CFR 482.13 (e) (1 A-C); 42 CFR 483.352 (1-3), as applicable.		
	CS6	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)		
	CS7	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)]		
	CS8	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 crisis stabilization unit policy in accordance with Michigan law, (iii) If a recipient is restrained repeatedly, the recipient's individual plan of services must be reviewed and modified to facilitate the reduction of the use of restraints. [MHC 330.1740 (9)]		
	CS9	Restraint may be initiated temporarily in an emergency. Immediately after the imposition of the restraint, a physician must be contacted. If, after being contacted, the physician does not order or authorize the restraint within 30 minutes, the restraint must be removed. [MHC 330.1740 (3)]		
	CS10	Orders for the use of restraint must 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)]		
	CS11	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)]		

✓		RIGHT AFFECTED	**POLICY STANDARD:** The policy requires/includes the following:	LOCATION
	CS12		A recipient may be restrained pursuant to an order by a physician made after personal examination. An order for restraint must 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)]	
	CS13		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)]	
	CS14		The required examination by a physician must be conducted not more than 30 minutes before the expiration of the expiring order for restraint .[MHC 1740 (5); AR 7243 (6) (b)]	
	CS15		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)]	
	CS16		A restrained recipient must: (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]	
	CS17		Restraints must be removed every 2 hours for not less than 15 minutes, unless medically contraindicated. [MHC 330.1740 (7)]	
	CS18		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)]	
	CS19		A recipient must not be restrained in a prone position unless medically contraindicated. [AR 7243 (11) (ii)]	
	CS20		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 crisis stabilization unit policy. [MHC 1742 (9); 42 CFR 482.13 (e) (12) (B) (ii) (A-D); 42 CFR 483.358 (f) (1-4)]	
	CS21		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 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)]	
	CS22		If the face-to-face evaluation specified in R16 of this section is conducted by a trained registered nurse or physician assistant, the trained RN or PA must consult the attending physician who is responsible for the care of the patient as specified in crisis stabilization unit policy as soon as possible after the completion of the 1-hour face-to-face evaluation. [42 CFR 482.13 (e) (14); 42 CFR 483.376]	
	CS23		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)]	
	CS24		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)]	
	CS25		A separate permanent record of each instance of restraint must be kept and must comply with applicable standards. [AR330.7243 (1)]	
	CS26		Physician training requirements must be specified. At a minimum, physicians must have a working knowledge of crisis stabilization unit policy regarding the use of restraint. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	

✓		RIGHT AFFECTED	**POLICY STANDARD:** The policy requires/includes the following:	LOCATION
	CS27		The recipient has the right to safe implementation of restraint by trained staff. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	CS28		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 crisis stabilization unit policy. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	CS29		The crisis stabilization unit 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 crisis stabilization unit, 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 crisis stabilization unit 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]	
	CS30		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]	
	CS31		The crisis stabilization unit 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]	
	CS32		The crisis stabilization unit must report deaths associated with the use of restraint: (1) The crisis stabilization unit 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 crisis stabilization unit 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. Crisis stabilization units 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). Crisis stabilization units should not call MDHHS to report a death. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	CS33		The crisis stabilization unit 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. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	CS34		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]	
			POLICY NUMBER: Click or tap here to enter text.	POLICY Date: Click or tap here to enter text.
	CS35		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.	
	CS36		Time out is defined using the most protective definition. [AR 7001(x); 42 CFR 483.368]	
	CS37		Therapeutic de-escalation is defined. [AR 7001 (w)]	
	CS38		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	

✓		RIGHT AFFECTED	**POLICY STANDARD:** The policy requires/includes the following:	LOCATION
			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)	
	CS39		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)]	
	CS40		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 crisis stabilization unit policy in accordance with Michigan law, (iii) If a recipient is secluded repeatedly, the recipient's individual plan of services must be reviewed and modified to facilitate the reduction of the use of seclusion. [MHC330.1742 (9)]	
	CS41		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 must be contacted. If, after being contacted, the physician does not order or authorize the seclusion within 30 minutes, the recipient must be removed from seclusion. [MHC 330.1742 (4)]	
	CS42		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)]	
	CS43		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)]	
	CS44		The condition of the recipient who is secluded must be monitored by a staff who has completed the training criteria specified in paragraph S20/21 of this section at an interval determined by crisis stabilization unit policy. [MHC 1740 (8); 42 CFR 482.13 (e) (12) (B) (ii) (A-D); 42 CFR 483.358 (f) (1-4)]	
	CS45		If the face-to-face evaluation specified in S11 of this section is conducted by a trained registered nurse or physician assistant, the trained RN or PA must consult the attending physician who is responsible for the care of the patient as specified in crisis stabilization unit policy as soon as possible after the completion of the 1-hour face-to-face evaluation. [42 CFR 482.13 (e) (14); 42 CFR 483.376]	
	CS46		Physician training requirements must be specified in crisis stabilization unit policy. At a minimum, physicians must have a working knowledge of crisis stabilization unit policy regarding the use of seclusion. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	CS47		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, and the physician was not present at the initiation of the seclusion, the recipient must be seen face-to-face within 1 hour after the initiation of the intervention by a physician. Additionally, the recipient must be seen at 1 hour 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)]	
	CS48		A recipient may be secluded pursuant to an order by a physician made after personal examination. An order for seclusion must 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 must 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)]	
	CS49		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)]	
	CS50		A secluded recipient must (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]	

✓		RIGHT AFFECTED	**POLICY STANDARD:** The policy requires/includes the following:	LOCATION
	CS51	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)]	
	CS52	The LPH must 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 must be kept and must comply with applicable standards. [AR330.7243 (1) (3)]	
	CS53	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 crisis stabilization unit policy. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	CS54	(2) Training content. The crisis stabilization unit 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 crisis stabilization unit, 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 crisis stabilization unit 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 crisis stabilization unit 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]	
	CS55	Death reporting requirements: Crisis stabilization units must report deaths associated with the use of seclusion: (1) The crisis stabilization unit 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 crisis stabilization unit 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. Crisis stabilization units 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). Crisis stabilization units should not call MDHHS to report a death. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	CS56	Psychiatric Notification of Death - Michigan Administrative Rule 330.1274 requires licensed psychiatric crisis stabilization units/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 crisis stabilization unit. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	CS57	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]	

CMH Curriculum Checklist 2021

ABUSE AND NEGLECT	
Abuse Definitions	
Neglect Definitions	
Definitions of threaten, degrade	
CIVIL RIGHTS	
Recipient shall be allowed to conduct business affairs to maximum extent possible	
A violation of a Civil Right is a violation of recipient rights	
Recipients should be asked if they wish to participate in an election	
Recipients must be allowed to exercise the right to practice their religion	
Recipients shall have the right to NOT have a religion prescribed for them	
Recipients shall be presumed competent unless a guardian has been appointed	
Recipients shall not be subject to illegal search or seizure.	
CONFIDENTIALITY	
Information shall be kept confidential	
Information shall not be disclosed unless germane to authorized purpose	
Individuals receiving information shall disclose only to extent of authorized purpose	
After 3/28/96 all information shall be provided to adult without a guardian	
Information shared as necessary per HIPAA	
For recipients with a guardian and those under 18 information can be withheld determined by a physician to be detrimental.	
Explain the difference between mandatory disclosure, discretionary with consent and discretionary	
Discuss agency policy on Correction of Record (statement by recipient)	
Preferred method for answering the phone so as not to disclose information	
Agency protocol for inquiries by law enforcement (what happens when the police show up at the door)	
Under circumstances allowed in the Code language this right may be limited.	
MPAS can access a recipient's record	
Discuss privileged communications	
DIGNITY & RESPECT	
Discuss what it means to treat someone with dignity and respect.	
Provide definitions of dignity and respect (Use dictionary definitions or agency's definitions)	
FAMILY RIGHTS	
Providing family members an opportunity to request and receive educational information	
Receive information from or provide information to family members within the confidentiality.	

Discuss agency protocols regarding family members who want to provide information	
Be aware of the location of these materials	
Assure that family members are treated with dignity and respect	
FINGERPRINTS, PHOTOGRAPHS, AUDIO-RECORDINGS, USE OF ONE-WAY GLASS	
Prior written consent from the recipient, the recipient's guardian or a parent with legal and physical custody of a minor recipient must be obtained before	
Procedures above shall only be utilized in order to provide services (including research) to identify, recipient, or for education and training purposes.	
Photographs include still pictures, motion pictures and videotapes.	
Photographs may to be taken for purely personal or social purposes and must be treated as the recipient's personal property	
Fingerprints, photographs and audio-recordings and any copies of these are to be made part of the recipient record	
Fingerprints, photographs and audio-recordings and any copies of these are to be destroyed or returned to the recipient when no longer essential or upon discharge	
If fingerprints, photographs or audio-recordings are done and sent out to others to help determine the name of the recipient, the individual receiving the items must be informed that return is required for inclusion in the recipient record.	
FREEDOM OF MOVEMENT; LEAST RESTRICTIVE SETTING	
Mental health services shall be offered in the least restrictive setting that is appropriate and available	
The freedom of movement of a recipient shall not be restricted more than necessary to provide mental health services, to prevent injury to himself, herself or others, or to prevent substantial property damage	
Seclusion and restraint are prohibited	
Time out, defined as a VOLUNTARY response to a therapeutic suggestion to a recipient to remove himself or herself from a stressful situation to another area to regain control	
Physical management, defined as a technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from harming himself, herself or others	
Physical management may only be used when a recipient is presenting an imminent risk of serious or non- serious physical harm to himself, herself or others and lesser restrictive interventions have been unsuccessful in reducing or eliminating an imminent risk of serious or non-serious physical harm.	
Physical management must not be included as a component of a behavior treatment plan	
Prone immobilization of a recipient for the purpose of behavioral control is prohibited	
This right can be limited but only as allowed in the individual plan of service (IPOS) following review and APPROVAL BY THE Behavior Treatment Committee	

INDIVIDUALIZED WRITTEN PLAN OF SERVICES	
The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient.	
A preliminary plan shall be developed within 7 days of the commencement of services	
The individual plan of services shall consist of a treatment plan, a support plan, or both	
A treatment plan shall establish meaningful and measurable goals with the recipient.	
The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation.	
The plan shall be kept current and shall be modified when indicated	
If a recipient is not satisfied with his or her individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of services, the guardian of the recipient, or the parent of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.	
An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process	
SAFE, SANITARY, HUMANE, TREATMENT ENVIRONMENT	
Mental Health Code requires safe, sanitary, humane treatment environment	
Discuss how Adult Foster Care Licensing Rules apply	
Provide for resident health, hygiene and personal grooming including assistance and training in personal grooming practices, including bathing, tooth brushing, shampooing, hair grooming, shaving and care of nails	
Provider must supply toilet articles, toothbrush and dentifrice, opportunity to shower or bathe at least once every 2 days, regular services of a barber or beautician and the opportunity to shave daily (males)	
PERTAINING TO THE RECIPIENT RIGHTS SYSTEM	
Discuss the operation of the Rights Office	
What are the various roles: Prevention, Monitoring, Education, Complaint Resolution	
Discuss the complaint process	
What is your (staff) role in complaints	
Employee Rights (retaliation/harassment (1755 3), Whistleblowers (Civil Action), Bullard-Plawecki (by HR or waived): emphasis on non-retaliation & disciplinary action)	
Basics of rights appeals - What do staff need to know and be able to explain about appeals?	
Access by ORR to all evidence	
Preponderance of Evidence standard	
Discuss the role of the Advisory Committee	
Discuss the provision of required notice of rights; availability of complaints	

CONSENT AND INFORMED CONSENT	
Identify the four elements of informed consent	
SUITABLE SERVICES – FAMILY PLANNING	
Discuss how family planning issues are addressed in your agency	
SUITABLE SERVICES – MENTAL HEALTH SERVICES SUITED TO CONDITION	
Discuss the procedures for how this is accomplished in your agency	
SUITABLE SERVICES – CHOICE OF PHYSICIAN/MHP	
Discuss the procedures for how this is accomplished in your agency	
SUITABLE SERVICES – NOTICE OF CLINICAL STATUS	
Discuss the procedures for how this is accomplished in your agency	
SUITABLE SERVICES – SERVICES OF MENTAL HEALTH PROFESSIONAL	
Discuss the procedures for how this is accomplished in your agency	
SUITABLE SERVICES – PSYCHOTROPIC DRUG TREATMENT	
Discuss the specifics of this section with medical professionals and those who pass medication.	
COMMUNICATIONS AND VISITS	
Residents are allowed to use mail and telephone services	
These communications must not be censored; staff should not open mail for residents without authorization.	
If necessary, funds must be provided (in reasonable amounts) for postage, stationary, telephone.	
If house rules are to be established regarding telephone calls and visits, these must be reasonable and must be posted in conspicuous areas for residents, guardians, visitors and others to see. (Only for those homes which still fall under this requirement)	
Limitations can be made on these rights for individuals, but only as allowed in the individual plan of service (IPOS) following review and approval by the Behavior Treatment Plan Review Committee and the special consent of the resident or his/her legal representative.	
Communication by mail, telephone and the ability to have visitors shall not be limited if the communications are between a resident and his/her attorney or a court, or between a resident and <u>any other individuals</u> when the communication involves legal matters or may be the subject of legal inquiry	
ENTERTAINMENT MATERIALS, INFORMATION AND NEWS	
Provider must never prevent a resident from exercising this right for reasons of, or similar to, censorship	
Provider must establish written policies and procedures that provide for all of the following:	
Any general program restrictions on access to material for reading, listening or viewing	
Determining a resident's interest in, and provide for, a daily newspaper	

OFFICE OF RECIPIENT RIGHTS
SITE VISIT MONITORING FORM

SERVICE SITE: _____ PROVIDER: _____

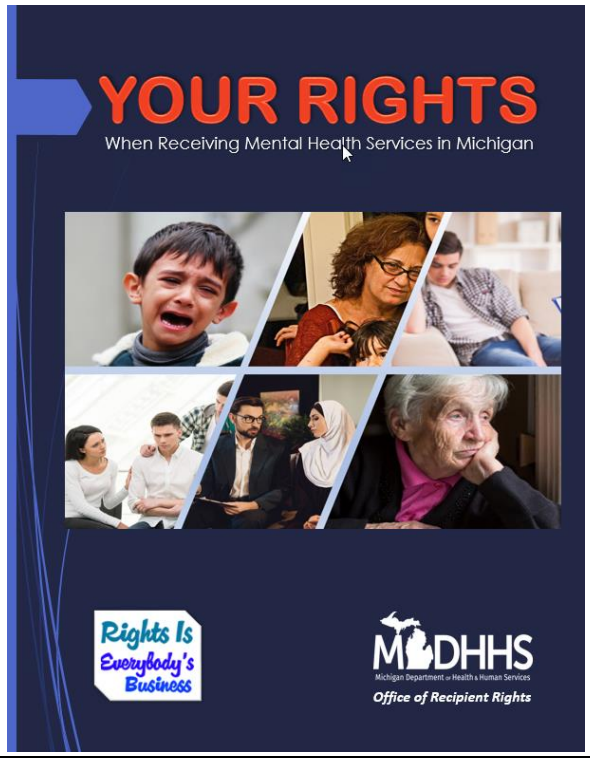
DATE OF VISIT: _____ ASSESSOR: _____

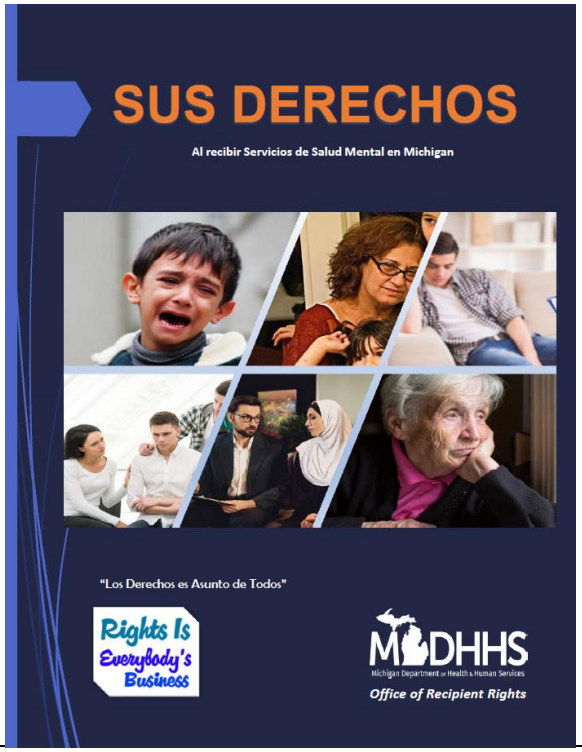
TYPE: Group Home: □MI □ DD _____ Number of Residents | Day Program: □ MI □ DD | Workshop: □ MI □ DD |□ACT Program | □ Outpatient | □ Clubhouse/Drop-in Center | □ Other: _____

YES	NO	STANDARD	COMMENTS	GUIDELINES
		Were rights books provided to consumers and readily available for review?		Rights book should be available to consumers; not stored in the office or other location that is not acceptable Rights Book should be the latest version (see below)
		Did the rights books provide the correct information for contacting the appropriate Rights Office?	List the CMHs and name(s) of Rights Staff observed on the books.	Consumers must be able to identify who their Rights Office is. If the home has consumers from more than one CMH each should have the appropriate information.
		Are posters providing contact information for the Rights Office conspicuously posted and visible to consumers and staff? (not applicable to SIP sites)		Poster identifying the appropriate Rights Office must be posted in conspicuous areas.
		Did the posters provide the correct information for contacting the appropriate Rights Office?	List the CMHs and name(s) of Rights Staff observed on the posters.	Same as above
		The most current version of the Abuse and Neglect Reporting Posters are posted where staff can see them.		The poster should be orange and white dated 4/2018 see below
		Were complaint forms readily available?		Complaint forms must be available in common areas; consumers should not have to ask staff for complaint forms.
		Were recipients aware of how to file a complaint?		Reviewer should ask at least 2 consumers
		Were staff aware of how to file a complaint?		Reviewer should ask at least 2 staff
		Were copies of Chapter 7 and 7A available?		Printed copies of Chapters 7 and 7A of the Mental Health Code should be available in a common area.
		Were House Rules posted and visible to consumers and visitors? (attach copy) *		

		Were House Rules reasonable and lawful? *		
		Were any exclusions to items able to be brought into the site (contraband) posted and visible to consumers and visitors?		
		Were records and other confidential information secured and not open for public inspection?		
		Were any health or safety concerns identified during the visit?		
		Were appropriate accommodations made for persons with physical disabilities?		
		Documentation that staff received RR training within 30 days of hire was reviewed?		The reviewer no longer has to check for this; CMH will be asked, at time of assessment, to provide this information
**These questions have been left on this form pending resolution of waiver requirements*				
Observations:				

Deficiencies Notes and Required Action:





Look for Booklets summarizing rights & Abuse & Neglect reporting posters

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

REQUIREMENTS FOR REPORTING ABUSE AND NEGLECT

	Section 723, Public Act 258 of 1974 as amended (Mental Health Code-Recipient Abuse)	Public Act 238 of 1975 (Child Protection Law)	Public Act 519 of 1982 (Adult Protective Services Law)	Section 723, Public Act 258 of 1974 as amended (Mental Health Code-Criminal Abuse)
WHERE is the report made?	To the OFFICE of RECIPIENT RIGHTS (ORR) at your Hospital or Community Mental Health Serivces Program (CMHSP) A list of local rights offices can be found at: http://tinyurl.com/orroffices	To the MDHHS Office of Childrens Protective Services (CPS)	To the MDHHS Office of Adult Protective Services (APS)	To the Michigan State Police (MSP) or Local Sheriff or Local Police Department
		ADULT OR CHILDRENS PROTECTIVE SERVICES HOTLINE 855-444-3911		MSP 517-332-2521
WHAT must be reported?	Sexual, Physical, Emotional or Verbal Abuse, Neglect, Serious Injury, Death, Retaliation or Harassment	Sexual, Physical or Mental Abuse, Neglect, Sexual Exploitation	Sexual, Physical or Mental Abuse, Neglect, Maltreatment, Exploitation	Assault (other than patient-patient assault/battery), Criminal Sexual Abuse, Homicide, Vulnerable Adult Abuse, Child Abuse
WHO is required to report?	All employees, contract employees, or volunteers of Michigan Department of Health and Human Services, Community Health Services Programs, Licensed Private Psychiatric Hospitals	Physicians, nurses, coroners, medical examiners, dentists, licensed emergency care personnel, audiologists, psychologists, social workers, school administrators, teachers, counselors, law enforcement officers, and child care providers.	Any person employed by an agency licensed to provide, anyone who is licensed, registered, or certified to provide health care, education, social, or other human services, law enforcement officers and child care providers.	All employees, contract employees of: Michigan Department of Health and Human Services, Community Mental Health Services Programs, Licensed Private Psychiatric Hospitals; All mental health professionals.
WHAT is the CRITERIA for reporting?	**You must report if you:** Suspect a recipient has been abused or neglected or any allegations of abuse or neglect made by a recipient.	**You must report if you:** Have reasonable cause to suspect a child has been abused, neglected, or sexually exploited.	**You must report if you:** Have reasonable cause to suspect or believe an adult has been abused, neglected, exploited or maltreated.	**You must report if you:** Suspect a recipient or vulnerable adult has been abused or neglected, sexually assaulted, or if you suspect a homicide has occurred. You do not have to report if the incident occurred more than one year before your knowledge of it.
WHEN must the report be made and in what format?	A verbal report must be made immediately. A written report on an incident report form must be made before the end of your shift.	A verbal report must be made immediately. A written report on DHS form 3200 must be made within 72 hours.	A verbal report must be made immediately. A written report at the discretion of the reporting person.	A verbal report must be made immediately. A written report must be made within 72 hours of the oral report
TO WHOM are reports made?	To your immediate supervisor **and** to the Recipient Rights Office at your agency or hospital	Report to Protective Services Reporting Hotline 855-444-3911	Report to Protective Services Reporting Hotline 855-444-3911	The law enforcement agency for the county or city in which the alleged violation occurred or the State Police. A copy of the written report goes to the chief administrator of the agency responsible for the recipient.
If there is more than one person with knowledge must all of them make a report?	Not necessarily. Reporting should comply with the policies and procedures set up by each agency.	**Someone** who has knowledge must report or cause a report to be made in the case of a school, hospital or agency, one report is adequate.	**Everyone** who has knowledge of a violation or an alleged violation must make a report. MDHHS has typically accepted one report from agencies.	**Someone** who has knowledge must report or cause a report to be made.
Is there a penalty for failure to report? YES	Disciplinary action may be taken and you may be held liable.	You may be held liable. Failure to report is also a criminal misdemeanor.	You may be held liable and have to pay a $500 fine.	The law states that failure to report or false reporting is a criminal misdemeanor.
Is it necessary to report to more than one agency? YES	Each of these laws requires that the designated agency be contacted, if an allegation is suspected to have occurred, which falls under its specific jurisdiction. There are several references in each law indicating that reporting to one agency does not absolve the reporting person from the responsibility of having to report to other agencies, as statutorily required.			
Are there other agencies to which a report can be made? YES	**The Bureau of Community and Health Systems (LARA)** is responsible for investigating abuse and neglect in **Nursing Homes, Hospitals and Home Health Care.** Call the **NURSING HOME ABUSE HOTLINE 1-800-882-6006** **The Michigan Attorney General's Office** has an **Abuse Investigation Unit** which may also investigate abuse in **Nursing Homes**. Call the **ATTORNEY GENERAL HEALTH CARE FRAUD HOTLINE 1-800-24-ABUSE/ 1-800-242-2873** **The LARA Adult Foster Care (AFC) Division** is responsible for investigating abuse or neglect in a licensed foster care home. Call **The Bureau of Community and Health Systems COMPLAINT INTAKE UNIT 1-866-856-0126**			

DCH-0727 4/2018

MDHHS Michigan Department of Health & Human Services

MDHHS OFFICE OF RECIPIENT RIGHTS
CMHSP ANNUAL MONITORING FORM FY 20

***Instructions**: This form must be completed and submitted to MDHHS-ORR by January 30, 2021. Data provided should cover the period from October 1, 2019 – September 30, 2020. MDHHS-ORR will review each submission as part of its annual review pursuant to MCL 330.1232a(6). The form should be electronically submitted to your CMH specialist (Cindy Shadeck or Janice Terry).*

AGENCY:

ADDRESS: CITY: ZIP:

HAS THE ADDRESS CHANGED SINCE LAST REPORT? ☐ YES ☐ NO

ORR DIRECTOR: PHONE: EMAIL:

SECTION A:

PLEASE IDENTIFY ANY RIGHTS OFFICE STAFF OR CEO CHANGES SINCE THE LAST REPORT.

STAFF NAME	POSITION (CEO/RIGHTS STAFF)	ENTER: (H) HIRED OR (D) DEPARTED	HIRE/DEPARTURE DATE	BASIC/CEO TRAINING date

SECTION B:

FOR EACH RIGHTS OFFICE STAFF, LIST ALL MDHHS APPROVED CEU CREDITS, INCLUDING THE APPROVAL NUMBER, EARNED DURING THE FISCAL YEAR.

You may cut and paste this information from the Annual Report (training chart tab) into the box below or attach a separate sheet with the required information.

SECTION C:

LIST THE NAMES AND EFFECTIVE DATES OF ANY RIGHTS RELATED POLICIES THAT WERE CREATED OR REVISED DURING THE FISCAL YEAR. (IT IS NOT NECESSARY TO INCLUDE A COPY OF THE POLICY.)

POLICY NUMBER	POLICY NAME	EFFECTIVE DATE

SECTION D:

DESCRIBE THE AGENCY'S PROCESS FOR THE PROVISION OF RIGHTS IN THE ABSENCE OF THE RIGHTS DIRECTOR.

SECTION E:

DESCRIBE THE AGENCY'S PROCESS FOR ADDRESSING THE RESPONSIBILITIES OF THE AGENCY DIRECTOR IN HIS/HER ABSENCE.

SECTION F:

LIST THE CASE NUMBERS AND CATEGORY OF ANY COMPLAINTS MADE AGAINST THE DIRECTOR OF THE AGENCY. INDICATE HOW THESE WERE INVESTIGATED. IF NONE, PLEASE CHECK HERE → ☐ *.*

CASE NUMBER	CATEGORY	SUBSTANTIATED (YES/NO)	INVESTIGATED BY

SECTION G:

LIST THE CASE NUMBERS OF ANY COMPLAINTS OF RETALIATION AND HARASSMENT. INDICATE IF THE ALLEGATION WAS SUBSTANTIATED OR NOT AND WHAT DISCIPLINARY ACTION WAS TAKEN. IF NONE, PLEASE CHECK HERE → ☐ *.*

CASE NUMBER	SUBSTANTIATED (YES/NO)	ACTION TAKEN (DISCIPLINARY OR REMEDIAL

SECTION H: APPEALS

TOTAL RECEIVED:	
NUMBER ACCEPTED:	
NUMBER REJECTED:	
REJECTED FOR IMPROPER STANDING/GROUNDS:	
REJECTED FOR TIMELINESS:	
NUMBER OF APPEALS ON FINDINGS:	
NUMBER UPHELD:	
NUMBER RETURNED FOR RE-INVESTIGATION:	
NUMBER REQUESTS FOR MDHHS INVESTIGATION:	
NUMBER OF APPEALS ON ACTION:	
NUMBER UPHELD:	
NUMBER RETURNED FOR FURTHER ACTION:	
NUMBER OF APPEALS ON TIMELINESS:	

:

:

:

LPH RIGHTS SYSTEM REVIEW Revised 4/20/20

HOSPITAL: _____

ASSESSMENT DATES: _____

REVIEWERS: _____

REVIEWERS' AGENCY _____

UPLOADED TO COLLOBORATION WEBSITE BY:_____ON_____
DATE

PLAN OF CORRECTION REQUIRED BY: _____

Citation	Standard #	Standard	Guidance	Findings
Section 1 LPH Responsibilities				
330.1755(1)	1.1.1	The Hospital has an assigned Rights Advisor.	Review Job Description of RR Advisor. Interview RR Advisor, Director.	
330.1755(1)	1.1.2	The Hospital has an assigned alternate Rights Advisor.	Review Job Description of RR Advisor Alternate. Interview RR Alternate, Director; Request an investigation completed by the alternate (redacted if necessary), request intervention by alternate. The "away message" from the rights officer references contact information for the alternate	
330.1755(4)	1.1.3	The rights advisor has the education and training required for the office.	Review Job descriptions of RR Advisor and Alternate. Interview RR Advisor; what were the requirements of the office? What qualified you for the job? Ascertain in interview that the rights staff do not have clinical responsibilities on the psychiatric unit.	

Citation	Standard #	Standard	Guidance	Findings
330.1755(1)(2)(c)	1.1.4	The Rights Advisor reports only to Chief Administrative Officer (CAO) of the Hospital.	Completed during site review: policy, job description of director, org chart, etc. Name on Annual report letter is the director's? Interview with Director; Has the director seen the annual report? Is the director familiar with the content, goals & recommendations? How often do you meet with the Rights Advisor? Are you their sole supervisor? Interview with the RR Advisor; Do you report only to the director (Chief Administrative Officer)? Is there a person in-between? How often do you meet with the director?	
330.1755(1)(2)(c)	1.2.1	In the absence of the CAO, there is a designee who can perform the duties required of the CAO.	Completed during site review by interview with Director, RR Advisor, (check policy, job descriptions, org chart, etc.) Is there a process for appointing the designee in policy? (Is the appointment made in writing?) Is the designee consulted on rights related matters?	
330.1755(2)(d)	1.3.1	The hospital assures that the Rights Advisor has unimpeded access to all information/areas necessary to conduct investigations and perform monitoring functions.	Interview RR Advisor, and ask them to explain the process of an investigation they have conducted as well as access to employees, EHR, etc. ☐ programs & services ☐ employees and all others ☐ any other evidence requested	
330.1776(1) Agency Policy	1.4.1	Staff are aware of the policy requiring staff to be knowledgeable of the complaint process, including how to file a complaint on behalf of a recipient and how to assist a recipient in filing a complaint.	Staff is interviewed. Staff is able to explain the policy regarding the rights process & can explain how to contact the rights advisor if needed. They can identify where the complaint box and complaint forms are located. They know who the rights advisor is.	
330.1776(1) Agency Policy	1.4.2	Staff are aware of this requirement and the process for carrying it out.	Staff can describe ways a complaint can be filed. They are required to list all of the possible ways. Staff are able to explain how to assist recipients in filing complaints.	

Section 2 – Rights Office Operations				
330.1776 (5)	2.1.1	As necessary, the office assists recipients or other individuals with the complaint process.	Interview with rights advisor, and, if possible, recipients. Rights advisor may provide an example of a complaint with which they assisted	
330.1776 (4)	2.1.2	Complaints are responded to within 5 days	On site review may include review of ORR log: Log indicates timeframes of response	

Citation	Standard #	Standard	Guidance	Findings
330.1755[5][d][i]	2.1.3	There is a mechanism for logging all complaints received by the office. Logs identify the responsible CMH.	All complaints received by the rights office are dated with a "received date" and logged into a complaint log.	
330.1778	2.2.1	Investigations and Interventions are completed within the timeframes required by law and contract.	On site review may include review of ORR log: Log indicates timeframes of responses.	
330.1778	2.2.2	Interventions are completed in accordance with the parameters established by law, rules, and guidelines established in Basic Skills training.	Complaint information may be solicited from CMHs with contracts with the LPH. RRO provides examples of complaints, acknowledgement, Intervention letter language. At minimum 5 interventions and 2 each of OOJ and "not code protected right" letters and complaint samples to be reviewed.	
330.1778 (5)	2.2.3	Investigations, and resultant reports, are completed in accordance with the parameters established by law, rules, and guidelines established in Basic Skills training.	Complaint information may be solicited from CMHs with contracts with the LPH. RRO provides examples of complaints, acknowledgement, status report and RIF language. At minimum 3 RIF files to be reviewed.	
330.1782	2.2.4	Summary Reports are completed in accordance with the parameters established by law, rule and guidelines established in Basic Skills training.	Summary Reports contain the required elements. Summary Reports describe the findings sufficiently to reflect all relevant evidence obtained during the investigation. Summary reports contain the required information regarding the accused, outcome, and action. There is evidence that the Director has reviewed the RIF and Summary Report. The Director's signature appears on the Summary Report.	
330.1755[5][d]	2.3.1	ORR maintains all reports of apparent or suspected rights violations received and evidence collected to support the decision in the investigation (file).	RRO provides examples of complaint file, indicating that the evidence is in the file, as is acknowledgement letters, interventions and investigations. Evidence of action taken is in the folder. (Additionally, Investigative files may be reviewed by the CMH Rights office over the course of the year as part of monitoring)	
330.1755[5][d]	2.4.2	ORR has established a mechanism for secure storage of all investigative documents and evidence, including files kept in the Rights Office, off-site and electronic files	The complaint log is kept securely by the recipient rights advisor. All complaints received, including evidentiary materials are kept in a case file in a locked cabinet located in the recipient rights advisor's secure office. (Files may be reviewed by the CMH Rights office over the course of the year as part of monitoring). Log and physical files and storage reviewed during site visit.	

Citation	Standard #	Standard	Guidance	Findings
330.1755[5][h]	2.5.1	ORR serves as a consultant to the director and to agency staff in rights related matters.	Interview with Director; – can any outcomes be pointed to as a result of the interactions between the advisor and director? Interview RR Advisor; what are some of the issues that have been discussed with the director – can any outcomes be pointed to as a result of the interactions between the advisor and director? between the advisor and staff?	
330.1755(5)(i)	2.6.1	ORR ensures that all reports of apparent or suspected violations of rights within the hospital are investigated in accordance with section 330.1778.	Case files/reports reflect immediate initiation of abuse, neglect, serious injury or death with an apparent or suspected violation. All other investigations are opened in a timely and efficient manner.	
330.1755(2)(d)	2.7.1	The Rights Advisor is able to access video surveillance tapes for the purposes of investigation.	Rights Advisor indicates that all video requested is made available without undo challenge. Policy reflects ORR access rights to video (timeframe as defined by ORR).	
330.1755 (2) (d) 330.1776 (1) 330.1778 (1)	2.7.2	The Rights Advisor is able to access incident reports for the purposes of ascertaining if a right may have been violated and as needed to conduct an investigation.	Rights Advisor indicates that all incident reports are provided to ORR on an ongoing basis. Policy reflects ORR access rights to incident reports	
0.1776 (1)	2.8.1	Recipients are aware of how to file a complaint.	Recipients are interviewed. Recipients can explain how to contact the rights advisor if needed. They can identify where the complaint box and complaint forms are located. They know who the rights advisor is. Reviewer should list initials.	

Section 3 Unit/Hospital Operations				
330.1708(2)	3.1.1	The Unit/Hospital is free of health and safety concerns.	Look for (Locked medications, cleaning supplies, etc.), view seclusion room (if applicable) for sanitary conditions, access to toilet facilities and opportunities to sit of lie down; check that ORR has communication with safety committee and QA/Risk Management	

Citation	Standard #	Standard	Guidance	Findings
330.1755(5)(c)	3.1.2	The name of the Rights Advisor, and a method for contact, are conspicuously posted in areas where recipients, family members, guardians and visitors have access.	The posters are on the wall of the unit. The poster should identify the recipient rights advisor's name and contact information.	
330.1755(5)(b)	3.1.3	There is a copy of Chapter 7 and 7a available to recipients.	Observation/ Interview Chapter 7&7A are found on the unit/units, or recipients have knowledge of their ability to request a complete copy of chapter 7 and 7A, and are able to identify the process or person to ask.	
330.1706, 330.1755(5)(b)	3.2.1	Recipient Rights booklets are provided to recipients, family members and guardians upon admission.	Interview individuals on unit, if they deny receiving one, request unit staff/ ORR show evidence it was provided. (form in record)	
330.1755(5)(c)	3.2.2	Contact information for the Rights Advisor is provided on the rights booklets.	Request a booklet from staff – is the contact information on it?	
AR 330.7011	3.2.3	The recipient's record identifies the person who provided the explanation of rights, and, when the recipient is unable to read, or their understanding is in question, an explanation of the materials used to explain rights.	Review (redacted if necessary), forms from recipient records indicating appropriate documentation of alternative communication (does the blank have a place for documentation?)	
330.1755(5)(i) 330.1776 (1)	3.3.1	There is unimpeded access to complaint forms.	There are complaint forms readily available and recipients do not have to request the form.	
330.1755(5)(i) 330.1776 (1)	3.3.2	There is a marked secure mechanism for filing complaints. (lock box or other confidential method).	There is a locked complaint box located on the unit, which is mounted on the wall. The rights advisor and alternate have access to the complaint box. No other staff have access to the complaint box.	
330.1776(5)	3.3.3	There is a poster advising recipients that there are advocacy organizations available to assist in preparation of a written rights complaint, and an offer to refer recipients to those organizations or for ORR to assist in creating a complaint.	Observe poster meeting the standard or ask for a copy of an actual letter with no PHI or the template letter.	
330.1723(1)	3.3.4	Current posters regarding the reporting of abuse and neglect present and visible in staff areas.	Posters for reporting abuse and neglect are found on the unit/units mounted on the wall. Typically found in area where staff chart or hold team.	

Citation	Standard #	Standard	Guidance	Findings
330.1723 (1)	3.4.1	Staff are aware of abuse and neglect reporting requirements.	Staff are able to describe when external agencies and ORR must be notified under the reporting requirements.	
330.1726(3), 330.1728(3)	3.5.1	If applicable Unit Rules (i.e., telephone usage, visitation, etc.), including any exclusions (i.e., weapons, glass, aerosol), are posted.	The rules are posted on the unit/units on the wall. (Phone hours, Visiting Hours, other Rules) A copy of the unit rules containing exclusions are provided at the time of admission on the unit. C. The is a "contraband list", separate from the unit rules, is posted on the wall & exterior to the unit and is provided in the admission packet. D. The auditor receives an admission packet to keep, which contains the unit rules and contraband list (if separate from the unit rules).	
330.1726(3), 330.1728(3)	3.5.2	The Rights Advisor has reviewed the Unit rules.	Review admission packet, Interview with Advisor: The auditor is provided a copy of the unit rules to keep for the purposes of the audit for review. ATTACH COPY OF RULES	
330.1726(3), 330.1728(3)	3.5.3	The Rights Advisor has determined that Unit Rules are reasonable and lawful.	Review admission packet, Interview with Advisor: Any issues as a result of the review of the unit rules are brought to the attention of the Rights Advisor - Are there any rules that the Auditor determines are not reasonable. Note them. ATTACH COPY OF RULES	
330.1724(9)	3.6.1	When video surveillance is utilized in common areas, recipients are notified of the existence and location of videotaping upon admission and by posted signs.	Request notification & observe posted notification. Rights Advisor is aware of the placement of video cameras and notification documents	
330.1724(9)	3.6.2	When video surveillance is utilized, private areas, such as bedrooms, bathrooms and showers are excluded from videotaping or surveillance.	Interview with Unit Manager, RRO tour of unit	
330.1406, 330.1415, 330.1416	3.7.1	Recipients are afforded an opportunity to sign into the hospital on a voluntary basis.	Rights Advisor is aware of the process for admissions and can explain how it is carried out on the unit.	
330.1406, 330.1415, 330.1416	3.7.2	Upon admission, rights, including rights pertaining to voluntary admission, are explained verbally and in writing.	ORR to show evidence it was provided. (form in record) Interview recipients on unit, if they deny offering of voluntary, request	

Citation	Standard #	Standard	Guidance	Findings
330.1406, 330.1415, 330.1416	3.7.3	There is a mechanism for noting who provided the explanation in 3.7.2 and, when the recipient is unable to read or their understanding is in question, a description of the explanation is in the recipient's record. The date of the completion of the explanation is noted in the record.	Review (redacted if necessary), forms from recipient records indicating appropriate documentation of alternative communication.	

Section 4 – Education and Training				
CMHS 6.3.2.3A	4.1.1	The primary and alternate rights staff have attended, and successfully completed, the Basic Skills Training program within 90 days of hire.	LPH can provide documented evidence. – certificate, email from MDHHS-ORR	
330. 1755[2][e] CMHSP 6.3.2.3A	4.2.1	The staff of the rights office have complied with the continuing education requirements identified in the contract attachment.	Request list of training attended with CEU number as assigned by MDHHS-ORR	
330.1755[2][e] CMHSP 6.3.2.3A	4.2.2	A minimum of 12 of the required 36 hours were approved as either Category I or II.	Request list of training attended with CEU number as assigned by MDHHS-ORR - Annual Report breakout is acceptable evidence	
330.1755[2][e] CMHSP 6.3.2.3A	4.2.3	Both the primary and alternate Rights staff have earned at least 3 continuing education credit during the calendar year.	Annual Report Listing, Certificate from training	
330.1755[5][f]	4.3.1	All persons employed (direct hire or contract) by the LPH, who will have contact with recipients, have been trained on basic rights within 30 days of hire.	Review New Hire Orientation Topics, training materials, List of Orientees with dates of training (may have brochure for "incidental staff, such as construction workers)	
330.1755[5][f]	4.3.2	All staff of the LPH (unit/hospital) have been trained on residential rights within 30 days.	Review training policy, copy of training materials; evidence provided of new hires, date of hire, date of initial training. Does the hospital HR provide the rights office a list of employees and start dates?	

Citation	Standard #	Standard	Guidance	Findings
330.1755[5][f] CMHSP 6.3.2.3B	4.3.3	Training related to recipient rights protection addressed all training standards identified in the MDHHS ORR Training Standards (all aspects of Chapters 4, 7, and 7a)	Rights Advisor has copy of training standards; Is the requirement for training content in the contract with the CMH? There is evidence provided of new hires, date of hire, date of residential (full) training.	
330. 1755[2][a]	4.4.1	Education and training in recipient rights policies and procedures are provided to the recipient rights advisory committee and appeals committee.	Interview Advisory committee chair. Minutes reflect evidence of training in policies. Interview Appeals committee chair. Minutes reflect evidence of training in policies.	

Section 5 – Rights advisory Committee				
MHC 1758	5.1.1	There is a Recipient Rights Advisory Committee in place either 1) by agreement with the local CMHSP or 2) appointment by the hospital of a committee which consists of a committee comprised of at least 1/3 of the membership shall be primary consumers or family members and, of that 1/3, at least 1/2 shall be primary consumers.	Documentation that the provider has a current agreement for the CMH to provide the RRAC. or Documentation that the hospital has an internally appointed RRAC that is made up of 1/3 primary consumers and/or family members, and of that 1/3 at least half of the members are primary consumers. None of the members work on the psychiatric unit or have a vested interest in the outcome of the committee's actions. There is a list of committee member names? There is a list of committee member types?	
330.1758(a)	5.1.2	RRAC Minutes reflect meeting held at least twice per year.	Interview committee chair if possible. Review minutes of RRAC to ensure it meets at minimum twice a year.	
330.1758(c)	5.1.3	The committee acts to protect ORR from pressures that could interfere with the impartial, even-handed, and thorough performance of its functions.	Interview committee chair. Minutes reflect evidence of issues are brought to the committee for discussion & resolution (if necessary) Also, interview with rights officer – is the committee responsive to issues?	
330.1755 (2)(b)	5.1.4	The committee reviews the funding for the Office at least annually.	Minutes reflect evidence of a review of rights office funding at least once a year	
330.1758(d)	5.1.5	The RRAC reviews the Semi-Annual and Annual reports and provide input for the Board of Directors on the Annual report.	Interview committee chair. Minutes reflect evidence of review of the semi-annual report; it is completed and submitted in a timely fashion & it is accurate. Minutes reflect evidence of a review of the annual report and an opportunity for recommendations to the Board; it is completed and submitted in a timely fashion. It is accurate. Also interview with rights advisor that both reports are discussed with the director	

Citation	Standard #	Standard	Guidance	Findings
Section 6 – Seclusion and Restraint				
330.1740 330.1742 R 330.7243 42CFR 482.13	6.1.1	If seclusion or restraint has been utilized within the past 12 months, the usage was compliant with policy (including timeframes as outlined by CMS).	Rights advisor is aware of Seclusion & Restraint Policy, and can demonstrate location of requirements: No initiation without evidence that a physician is contacted; Recipient removed from S or R if physician does not respond within 30 minutes; Ordered seclusion not to exceed 4 hours for adults, 2 hours for minors; 1 hour for minors 9 or under; physician must see recipient 30 minutes prior to reorder. Rights Advisor is aware of CMS and MHC requirements and can show reviewer where logs are kept	
330.1740 330.1742 R 330.7243 42CFR 482.13	6.1.2	If seclusion or restraint was utilized, the visit at 1 hour was completed by a physician or PA as required by state law.	Physician exam occurs within 60 minutes of authorized seclusion, if physician was not present at initiation.	
Section 7 – Appeals Committee				
MHC 1774[3]	7.1.1	*For recipients who are under the authority of a CMHSP,* 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.	Contract between CMH & LPH indicates 7.1.1	
MHC 1774[4]	7.1.2	*For recipients who are not under the authority of a CMHSP,* the Governing Body (Board) of Hospital appointed an appeals committee to hear appeals of recipient rights matters **OR** entered into an agreement with MDHHS to use that entities appeals committee.	LPH should have a current copy of the agreement that reflects that MDHHS will hear appeals on non-CMH recipients. (Current Director, or within 5 years) LPH must present list of members & list of categories of members. The committee must be 7 members. No members can be from MDHHS or the CMHSP. Two of the members shall be primary consumers and 2 shall be community members. *(Michigan Medicine only)*	
330.1774 (3)	7.1.3	Notices of appeal rights refer recipients to appropriate appeals committee.	Review notice of appeals rights for clear referral to appropriate CMH appeals committee or to MDHHS-ORR Appeals Committee.	

Citation	Standard #	Standard	Guidance	Findings
330.1774(6)	*7.1.4*	*Committee policy/bylaws require that a member of an appeals committee who has a personal or professional relationship with an individual involved in an appeal shall abstain from participating in that appeal as a member of the committee.*	Michigan Medicine only) Review bylaws. If none exist, recommend development of minimum documentation for review by committee members.	
330.1784	*7.1.5*	*Appeals heard by the LPH Appeals Committee meet the required timeframes and are based upon the standards established by law and contract.*	(Michigan Medicine only) Review appeal case files. Appeals are heard if the appellant has standing, names grounds and appeals within the designated timeframe. The committee addresses the concerns of the appellant. The committee sends follow up correspondence within the designated timeframe.	

Section 8 – Policy				
330.1752 (a-p)	8.1.1	The policies of the hospital have been reviewed and accepted.		

CASE COMPLIANCE CHECKLIST

Were the ORR investigation/intervention reports reviewed? YES NO	Number reviewed:	Review completed by:	Plan of correction for cases required: YES NO
Number of Complaint Files Reviewed by Type: Abuse/Neglect/Retaliation-Harassment (required opens) [ ] Other Cases Opened [ ] Interventions [ ] Not Opened (OOJ/NRI) [ ]			
INDICATE CATEGORIES OF CASES REVIEWED ⟶ (i.e.) 72221, 7050, 7044)			

NOTE: Only complaints and subsequent complaint resolution files/reports involving recipients of the reviewer's CMH were reviewed.

√		LPH 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:			
	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 must 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 must assist in preparing a written complaint. [MHC 1776 (2)(a-c); (5)]	
	A12	If a rights complaint is received regarding the conduct of the hospital director (CAO), the rights investigation must be conducted by the recipient rights office of another LPH, a 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 during hospitalization or including deaths that occurred within 48 hours after discharge and including all deaths by suicide or unknown cause, investigation must be immediately initiated. [MHC 1778 (1)]	
	A14	The rights office must initiate investigation of apparent or suspected rights violations in a timely and efficient manner. [MHC 1778 (1)]	
	A15	The rights office must 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 must 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 must be completed within 90 calendar days, unless awaiting action by external agencies. (CPS, law enforcement, etc.) [MHC 1778 (1)]	

√	LPH Policy Review		Location
	A17	The policy requires that the rights office must conduct investigations in a manner that does not violate employee rights. [MHC 1755(3)(b) added 1/11/21	
	A18	Investigation activities for each rights complaint must be accurately recorded by the office. [MHC 1778 2)]	
	A19	The rights office must use "preponderance of the evidence" as its standard of proof in determining whether a right was violated. [MHC 1778 (3)]	
	A20	Upon completion of the investigation, the rights office must submit a written investigative report (RIF) to the respondent [who is also the Director (Chief Administrative Officer)]. [MHC 1778 (5)]	
	A21	The RIF must 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)]	
	A22	When rights violations are substantiated, the Director (Chief Administrative Officer) must 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)]	
	A23	Remedial action taken on substantiated violations is documented and made part of the record maintained by the rights office. [MHC 1780 (2)]	
	A24	The Director (Chief Administrative Officer) must submit a written summary report to the complainant, recipient, if different than the complainant, parent of a minor, or guardian, within 10 business days after receiving the RIF from the rights office. [MHC 1782 (1)]	
	A25	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)]	
	A26	The hospital must ensure that appropriate disciplinary action was taken against those who have engaged in abuse or neglect [MHC 1722 (2)] or retaliation and harassment. [(hospital staff, any contract staff) MHC 1755 (3) (a)] [AR 7035 (1)]	
	A27	Information in the summary report must be provided within the constraints of the confidentiality/ privileged communications sections (1748, 1750) of the Mental Health Code. [MHC 1782 (2)]	
	A28	Information in the summary report must 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)]	
	A29	If the summary report contains a plan of action the director must send a letter indicating when the action was completed [APL 133; recipient rights appeal process III.d.]	
	A30	If the letter indicating the plan of action describes an action that differs from the plan, the letter must indicate that an appeal may be made within 45 days on "action". [2018 technical requirement; recipient rights appeal process]	
APPEAL PROCESS			
	A31	Appeals may be filed no later than 45 days after receipt of the summary report. [MHC 1784 (1)]	

√	LPH Policy Review		Location
	A32	The grounds for appeal must 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 must 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 must assist the complainant in meeting the procedural requirements of a written appeal. [MHC 1784 (3)]	
	A35	The governing body of a licensed hospital must 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 may (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. [MHC 1774 (4) (b)]	
		A36i through xi applies ONLY to LPHs who have their own appeals committee & don't use the MDHHS-ORR appeals committee Hospitals who use the state appeals committee should SKIP rows A36i-36xi	
	A36i	The governing body of a licensed hospital will (a) appoint an appeals committee consisting of 7 members, none of whom will be employed by the department or a community mental health services program, 2 of whom will be primary consumers and 2 of whom will be community members. [MHC 1774 (4) (a)]	
	A36ii	The appeals committee may request consultation and technical assistance from MDHHS-ORR. [MHC 1774 (5)]	
	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, at least 2 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]	
	A36vi	If the appeal is accepted, a copy of the appeal will be provided to 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)]	

√	LPH Policy Review		Location
	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, (parent of a minor recipient), 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, or with law, rules, polices or guidelines.). [MHC 1784 (6) (1786)]	
	A37	If an investigation is returned to the LPH by an appeals committee for reinvestigation, the office will complete **the reinvestigation within 45 days following the standards established in 330.1778. [2019 contract attachment**/technical requirement, APL 133; recipient rights appeal process]	
	A38	If an investigation is returned to the LPH by an appeals committee for reinvestigation, upon receipt of the RIF, the director will take appropriate remedial action and will 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), 2019 contract attachment/technical requirement, APL 133; recipient rights appeal process]	
	A39	If a request for additional or different action is sent to the Director, a response will be sent within30 days as to the action taken or justification as to why it was not taken. The response will be sent to the complainant, recipient, if different than the complainant, parent or guardian, and the appeals committee. [MHC 330.1784(5)(c), 2019 contract attachment/technical requirement, APL 133; recipient rights appeal process]	
	A40	If the committee notifies the LPH or CMH Board chair of a recommendation to seek an external investigation from MDHHS-ORR, the board will send a letter of request to the director of MDHHS-ORR within 5-business days of receipt of the request from the appeals committee. The director of the CMH or LPH making the request will be responsible for the issuance of the summary report, which will identify the grounds and advocacy information as in A32-A34 of this document and MDHHS-ORR Appeal Committee as the committee for any Appeal. [MHC 330.1784(5)(d), 2019 contract attachment/technical requirement, APL 133; recipient rights appeal process]	
CONSENT and INFORMED CONSENT			
		Policy Name/Number: Most Recent Policy Revision Date:	
THE POLICY REQUIRES:			
	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)	

√	LPH Policy Review		Location
	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. The procedures must include specific circumstances and the types of information that must be disclosed and steps that may be taken to protect voluntariness. **This is not required language for your policy but the policies addressing situations requiring informed consent, such as treatment planning or medication should indicate how they adhere to 4 requirements of informed consent [MHC 1702, AR330.7003 (1)]*	
	B4	A method is identified for evaluating comprehension and for assuring disclosure of relevant information and measures to ensure voluntariness before obtaining consent. The procedures shall include a mechanism for determining whether guardianship proceedings should be considered.	
	B5	The policy requires that the individual providing consent shall be made aware of the purpose of the procedure, the risks and benefits, alternative procedures available, and offered an opportunity to ask and receive answers to questions. [AR 7003(1)(b)]	
	B6	Information is presented in a manner the recipient understands and a mechanism for evaluating comprehension is utilized. [AR 7003(1)(c) (2) (4)]	
	B7	The recipient has free power of choice without force, fraud, deceit, duress, constraint, coercion, etc. [AR 7003 (1) (d)]	
	B8	The recipient/guardian is informed that if they withdraw consent this can be done without prejudice toward the recipient. [AR 7003 (1) (d)]	
	B9	Informed consent will be reobtained if changes in circumstances substantially change the risks, other consequences or benefits that were previously expected. [AR 7003 (3)]	
ABUSE and NEGLECT			
		Policy Name/Number: Most Recent Policy Revision Date:	
THE POLICY REQUIRES:			
	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 and 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 will prepare written reports to law enforcement agencies regarding criminal abuse. [MHC 1723 (2)]	

√	LPH Policy Review		Location
	C9	The policy defines degrade and threaten in a clear manner (not mandatory)	
DIGNITY and RESPECT			
		Policy Name/Number: Most Recent Policy Revision Date:	
THE POLICY REQUIRES:			
	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:			
	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 identification. [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, will 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)]	
	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)]	

√	LPH Policy Review		Location
	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)]	
	E15	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)]	
	E16	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:			
	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 will be disclosed to a competent adult recipient (adult without a guardian) 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 1748 (4)]	
	F4	Except as otherwise provided in F3[330.1748(4)], 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 1748 (6)]	

√	LPH Policy Review		Location
	F5	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 will 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. A full record may not be withheld. [AR 7051 (3)]	
	F6	The timeframe for the review and determination will not exceed 3 business days if the record is on-site, or 10 business days if the record is off–site. [AR 7051 (3)]	
	F7	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)]	
	F8	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]	
	F9	A record is 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)]	
	F10	Confidential information must be disclosed 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 must grant a representative of Disability Rights of Michigan Protection 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)]	

√	LPH Policy Review		Location
	F12	Attorneys representing recipients may review records only upon presentation of identification and the recipient's consent or a release executed by the parent or guardian. Attorney's must be permitted to review the record on hospital premises. [AR 7051(4)(b)]	
	F13	An attorney who has been retained or appointed to represent a minor pursuant to an objection to hospitalization must be allowed to review the records. [AR 7051 (4) (a)]	
	F14	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)]	
	F15	Attorneys will 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)]	
	F16	A private physician or psychologist appointed by the court or retained to testify in civil, criminal, or administrative proceedings must, 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 must 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. [AR 7051 (5) (a-b)]	
	F17	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)]	
	F18	Information must 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)]	
	F19	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])	
	F20	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 will accrue to the provider or will be subject to collection for liability for mental health service. [MHC 1748 (7) (a); AR 7051 (7)]	
	F21	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)]	
		The hospital, upon a written request from Child Protective Services, must 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:			

√	LPH Policy Review		Location
	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 must 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 must 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 must be a fully or limited-licensed psychologist with the formal training or experience in applied behavior analysis, and 1 of whom must 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 must 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 must 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), must 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 verbally to recipients, upon voluntary admission, is included in the explanation of rights and documented on the admission form, including documentation of delay and alternative methods utilized. [MHC 1416]	

√		LPH Policy Review	Location
		CHANGE IN TYPE OF TREATMENT	
		Policy Name/Number: Most Recent Policy Revision Date:	
THE POLICY REQUIRES:			
	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)]	
	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 must 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 H4 is completed within a reasonable period of time. (no later than 30 days or prior to d/c, whichever is sooner) 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:			
	J1	Recipients must 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 must 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 must place the calls for the individual if so requested. Staff must assist if the recipient is unable to independently complete the call. [MHC 1447 R 4045 (2)]	

√		LPH Policy Review	Location
	J2	Telephones must 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 must be established and must be in writing and posted on the unit. [MHC 1726 (3)]	
	J6	The right to communicate by mail or telephone or to receive visitors must 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 must 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:			
	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)]	
	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 must 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 must 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, must be returned at discharge [MHC 1728 (7)]	

√		LPH Policy Review	Location
		USE OF PSYCHOTROPIC DRUGS	
		Policy Name/Number: Most Recent Policy Revision Date:	
THE POLICY REQUIRES:			
	L1	Psychotropic drugs (medication) must 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]	
	L2	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)]	
	L3	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)]	
	L4	Initial administration of psychotropic chemotherapy (medication) as identified in L2 must be limited to a maximum of 48 hours unless there is consent. [AR 7158 (8) (c)]	
	L5	Medication must 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:	
THE POLICY REQUIRES:			
	M1	"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)]	
	M2	Access to treatment by spiritual means is upon request by a recipient, guardian, or parent of a minor recipient. [AR7135 (1)]	
	M3	Requests for printed, recorded, or visual material essential or related to treatment by spiritual means, and to a symbolic object of similar significance must be honored and made available at the recipient's expense. [AR7135 (3)]	
	M4	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)]	
	M5	There is a procedure for an administrative review or appeal process when treatment by spiritual means is denied. [AR 7135 (7)]	
	M6	There is a procedure to ensure 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)]	
	M7	On site 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)]	

√		LPH Policy Review	Location
	M8	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)]	
	M9	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:	
THE POLICY REQUIRES:			
	N1	Identification of items that recipients may not possess (including weapons, sharp objects, explosives, drugs, and alcohol). [MHC 1728 (3)]	
	N2	Any exclusions of personal property must be in writing and posted in each unit. [MHC 1728 (3)]	
	N3	A receipt for property taken for into possession by the hospital must be given to the recipient and to an individual designated by the recipient. [MHC 1728 (7)]	
	N4	A recipient is to be permitted to inspect personal property at reasonable times. [MHC 1728 (2)]	
	N5	The plan of service must 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 must be justified and documented in the record of the recipient. [MHC 1728 (4) (a), (5)]	
	N6	Conditions under which a search for contraband items may be conducted. [AR 7009 (7)]	
	N7	Documentation must 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)]	
	N8	Any property taken for into possession by the hospital must 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:			
	O1	Recipients must 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 must document each instance when a limitation is imposed in the recipient's record. [AR 7139 (2) (3)]	
	O3	Limitations/restrictions must 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)]	

√		LPH Policy Review	Location
	O5	The person in charge of the plan of service must 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	
		Policy Name/Number: Most Recent Policy Revision Date:	
THE POLICY REQUIRES:			
	P1	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 must discharge or privileges be conditioned upon the performance of labor. [MHC 1736 (1)]	
	P2	A recipient who performs labor that contributes to the operation and maintenance of the LPH, for which the hospital would otherwise employ someone, must be compensated appropriately and in accordance with applicable federal and state labor laws, including minimum wage and minimum wage reduction provisions. [MHC 1736 (2)]	
	P3	A process for providing compensation when performing labor which benefits another person or the hospital. [MHC 1736 (3)]	
	P4	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:			
	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 must 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)]	
	Q5	The policy requires 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 1736(6)]	
		RESTRAINT/PHYSICAL MANAGEMENT	
		Policy Name/Number: Most Recent Policy Revision Date:	

√		LPH Policy Review	Location
THE POLICY REQUIRES:			
		Policy standards that are highlighted below are from CMS, not the Mental Health Code or Administrative Rules	
	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 must 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 must be contacted. If, after being contacted, the physician does not order or authorize the restraint within 30 minutes, the restraint must be removed. [MHC 330.1740 (3)]	
	R6	Orders for the use of restraint must 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)]	
	R8	A recipient may be restrained pursuant to an order by a physician made after personal examination. An order for restraint must 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 must 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 must: (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 must be removed every 2 hours for not less than 15 minutes, unless medically contraindicated. [MHC 330.1740 (7)]	

√		LPH Policy Review	Location
	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 must 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 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	If the face-to-face evaluation specified in R16 of this section is conducted by a trained registered nurse or physician assistant, the trained RN or PA must consult the attending physician who is responsible for the care of the patient as specified in hospital policy as soon as possible after the completion of the 1-hour face-to-face evaluation. [42 CFR 482.13 (e) (14); 42 CFR 483.376]	
	R19	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)]	
	R20	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)]	
	R21	A separate permanent record of each instance of restraint must be kept and must comply with applicable standards. [AR330.7243 (1)]	
	R22	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]	
	R23	The recipient has the right to safe implementation of restraint by trained staff. [42 CFR 482.13 (e) (11); 42 CFR 483.376]	
	R24	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]	

√		LPH Policy Review	Location
	R25	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]	
	R26	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]	
	R27	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]	
	R28	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]	
	R29	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 including deaths that occurred within 48 hours after discharge. MHC 330.1720	
	R30	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:	
THE POLICY REQUIRES:			
	S1	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.	
	S2	Time out is defined using the most protective definition. [AR 7001(x); 42 CFR 483.368]	
	S3	Therapeutic de-escalation is defined. [AR 7001 (w)]	

√		LPH Policy Review	Location
	S4	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)	
	S5	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)]	
	S6	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 law, (iii) If a recipient is secluded repeatedly, the recipient's individual plan of services must be reviewed and modified to facilitate the reduction of the use of seclusion [MHC330.1742 (9)]	
	S7	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 must be contacted. If, after being contacted, the physician does not order or authorize the seclusion within 30 minutes, the recipient must be removed from seclusion. [MHC 330.1742 (4)]	
	S8	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)]	
	S9	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)]	
	S10	The condition of the recipient who is secluded must be monitored by a staff who has completed the training criteria specified in paragraph S20/21 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)]	
	S11	If the face-to-face evaluation specified in S11 of this section is conducted by a trained registered nurse or physician assistant, the trained RN or PA must consult the attending physician who is responsible for the care of the patient as specified in hospital policy as soon as possible after the completion of the 1-hour face-to-face evaluation. [42 CFR 482.13 (e) (14); 42 CFR 483.376]	
	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, and the physician was not present at the initiation of the seclusion, the recipient must be seen face-to-face within 1 hour after the initiation of the intervention by a physician. Additionally, the recipient must be seen at 1 hour 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)]	

√		LPH Policy Review	Location
	S14	A recipient may be secluded pursuant to an order by a physician made after personal examination. An order for seclusion must 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 must 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 must (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 must 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 must be kept and must 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]	
	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]	

√		LPH Policy Review	Location
	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). [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 from suicide o on the psychiatric unit or within 48 hours of discharge. [330.1274, 330.1720]	
	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:			
	T1	Within 24 hours of admission, each recipient must 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:			
	U1	Staff of the Office of Recipient Rights to receive annual training in recipient rights protection. [MHC 755 (2)(e)]	
	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 ORR Basic Skills Training Programs 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" (or comply with the continuing education requirements identified in the CMH contract{mirroring the MDHHS-CMHSP contract attachment} . [LPH/CMHSP Contract referencing the MDHHS/CMH Master Contract]	

√		LPH Policy Review	Location
	U6	The policy requires that a minimum of 12 of the required 36 hours were approved as either Category I or II. MHC 1755[2][e], CMHSP 6.3.2.3 (A)	
	U7	The policy requires that rights staff acquire at least 3 continuing education credits each calendar year MHC 1755[2][e], CMHSP 6.3.2.3 (A)	

DRAFT LPH training curriculum checklist 2021

If another staff trains on any of the items in this review document, please note it in the comments section so the reviewer is aware that this is not part of your training as it is covered elsewhere.	**comments**
ABUSE AND NEGLECT	
Abuse Definitions	
Neglect Definitions	
Definitions of threaten, degrade	
CIVIL RIGHTS	
Recipient shall be allowed to conduct business affairs to maximum extent possible	
A violation of a Civil Right is a violation of recipient rights	
Discuss how Federal Civil Rights must be honored in LPHs: discrimination & service animals should be specifically addressed	
Recipients must be asked if they wish to register to vote and whether they wish to participate in an election	
Recipients must be allowed to practice their religion	
Recipients will not be forced to practice any religion	
Recipients have the right to obtain materials that support their religious practice (at their own expense)	
Recipients have a right to see persons who support their religious practice at reasonable times	
Recipients must be presumed competent unless a guardian has been appointed. No guardian will be appointed unless necessary	
Any search of a recipients living area shall be performed & documented as described in 330.7009(7)	
Ask first to look with the recipient before initiating any search - if they say “yes” or invite you to look, it’s not “search”, but should still be clearly documented	
Must have: reasonable cause, witness and recipient (unless decline) present	
Document in the progress notes whenever there is a search: reason, names of those present, result	
CONFIDENTIALITY	
Information must be kept confidential whether written or verbal	
Information shall not be disclosed unless germane to authorized purpose	
Individuals receiving information shall disclose only to extent of authorized purpose	
All information shall be provided to adult without a guardian for their own record review or if a copy of the record is requested at or after discharge.	
For recipients with a guardian and those under 18 information can be withheld determined by a physician or MHP to be detrimental for a record review or if a copy of the record is requested at or after discharge.	
Information may be disclosed by the LPH 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.	
Information shared as necessary per HIPAA - cannot call families for information without consent	
Discuss hospital policy on Correction of Record (statement by recipient) - what is the procedure?	
Preferred method for answering the phone so as not to disclose information - what is the script?	

If another staff trains on any of the items in this review document, please note it in the comments section so the reviewer is aware that this is not part of your training as it is covered elsewhere.	**comments**
Discuss the hospital protocol for inquiries by law enforcement (what happens when the police show up at the door or call) Information cannot be disclosed to law enforcement without consent or a judge's order.	
What can staff reveal if the LPH has called law enforcement for a criminal abuse or crime on the unit?	
When does "police hold" apply? What does it allow?	
Disability Rights of MI can access a recipient's record and privileged information	
Discuss privileged communications - what happens if you are called to go to court?	
DIGNITY AND RESPECT	
Discuss what it means to treat someone with dignity and respect.	
Provide definitions of dignity and respect (Use dictionary definitions or hospital's definitions)	
RIGHTS OF FAMILY MEMBERS	
Providing family members an opportunity to request and receive educational information, within the confidentiality parameters (who is responsible for responding?)	
Discuss hospital protocols regarding family members who want to provide information (again, what is the script?)	
Assure that family members are treated with dignity and respect	
FINGERPRINTS, PHOTOGRAPHS, AUDIO-RECORDINGS, USE OF ONE-WAY GLASS	
Prior written consent from the recipient, the recipient's guardian or a parent with legal and physical custody of a minor recipient must be obtained	
Procedures above shall only be utilized in order to provide services (including research) to identify, recipient, or for education and training purposes.	
Photographs include still pictures, motion pictures and videotapes.	
Fingerprints, photographs and audio-recordings and any copies of these are to be made part of the recipient record (except for education)	
Fingerprints, photographs and audio-recordings and any copies of these are to be destroyed or returned to the recipient when no longer essential or upon discharge	
If fingerprints, photographs or audio-recordings are done and sent out to others to help determine the name of the recipient, the individual receiving the items must be informed that return is required for inclusion in the recipient record.	
Videotaping occurs in common areas of inpatient units including hallways therapy and community rooms when not in use for therapeutic purposes	
There must be notification, upon admission, of Video surveillance on any unit. Video will be stored in a secure location	
Video surveillance may be used by ORR, QA or Administration purposes for investigative purposes. Video surveillance cannot replace staff or be viewed in real time, with the exception of the seclusion room which must be viewed in its entirety.	
FREEDOM OF MOVEMENT; LEAST RESTRICTIVE SETTING	
Mental health services shall be offered in the least restrictive setting that is appropriate and available	
The freedom of movement of a recipient shall not be restricted more than necessary to provide mental health services, to prevent injury to himself, herself or others, or to prevent substantial property damage	

If another staff trains on any of the items in this review document, please note it in the comments section so the reviewer is aware that this is not part of your training as it is covered elsewhere.	**comments**
Time out, defined as a VOLUNTARY response to a therapeutic suggestion to a recipient to remove himself or herself from a stressful situation to another area to regain control	
Physical management, defined as a technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from harming himself, herself or others	
Physical management may only be used when a recipient is presenting an imminent risk of serious or non- serious physical harm to himself, herself or others and lesser restrictive interventions have been unsuccessful in reducing or eliminating an imminent risk of serious or non-serious physical harm.	
Physical management must be included in the treatment plan, when used as an emergency intervention	
Prone immobilization of a recipient for the purpose of behavioral control is prohibited	
Seclusion may only be used to prevent harm to others. There must be imminent risk of harm.	
Restraint may only be utilized to prevent harm to self or others. There must be imminent risk of harm.	
There needs to be an imminent risk before placing hands on a patient, and that lesser restrictive interventions are attempted and documented. In all cases of physical management or seclusion or restraint, documentation by staff is a critical element (justification/action)	
Role/requirements for various staff (direct care, SW, Physician) in the initiation, monitoring or termination of seclusion or restraint - (this is specific to your agency) initiating seclusion or restraint; direct care staff cannot initiate seclusion or restraint without approval, Monitoring; procedures for conducting 1 hour face-to face, termination of seclusion or restraint; once the seclusion or restraint is no longer needed, be sure to follow termination procedures. No one should EVER be asleep in seclusion.	
Restraint & Seclusion can only be ordered by a physician. Discuss when the physician must be involved	
What happens if the physician does not respond?	
Any limitations to freedom of movement in the hospital must be justified in the individual plan of service (IPOS).	
If a medication is not for ongoing use in treating the psychiatric illness and it is used when there is “a behavior“, it is chemical restraint. There must be an order. There must be a "CMS" visit. Chemical restraint or hands-on immobilization is restraint. PRN’s are prohibited when not agreed to by the recipient when offered or part of a recipient’s daily regimen.	
PERSON CENTERED PLANNING	
The LPH shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient.	
A preliminary plan shall be developed within 7 days of admission or prior to discharge from the hospital.	
The individual plan of services shall consist of a treatment plan, a support plan, or both	
The recipient must be allowed to identify people they want at the meeting	

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An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process	
A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services must address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation to the extent necessary for inpatient care.	
The plan shall be kept current and shall be modified when indicated.	
If a recipient is not satisfied with his or her individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of services, the guardian of the recipient, or the parent of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the LPH. Discuss the procedures for how this is accomplished in your hospital. Is there a written protocol?	
The plan will indicate when the recipient will be informed orally and in writing of their clinical status and progress, in a manner appropriate to his or her clinical condition, while in the hospital (who does - what's the process?)	
SAFE, SANITARY, HUMANE, TREATMENT ENVIRONMENT	
Mental Health Code requires safe, sanitary, humane treatment environment. Discuss how any Rules under CMS, or LARA apply	
Standards regarding safety must be followed. Where do the standards the LPH follows regarding safety come from?	
Provide for recipient health, hygiene and personal grooming including assistance and training in personal grooming practices, including bathing, tooth brushing, shampooing, hair grooming, shaving and care of nails	
Hospital must supply toilet articles, toothbrush and dentifrice, opportunity to shower or bathe at least once every 2 days, the opportunity to shave daily and regular services of a barber or beautician (especially if the recipient has been hospitalized for an extended period of time - at recipient’s expense).	
CONSENT AND INFORMED CONSENT	
Recipients consent to their own admission unless the guardian is given that specific power by the court	
Identify the four elements of informed consent	
SUITABLE SERVICES – FAMILY PLANNING	
Discuss how family planning referrals are addressed in your hospital.	
SUITABLE SERVICES – MENTAL HEALTH SERVICES SUITED TO CONDITION	
Discuss the procedures for how this is accomplished in your hospital.	
Remind staff that, in rights, we are looking for where everything is in the record. Documentation of services is critical, whether provided or not.	
SUITABLE SERVICES – CHOICE OF PHYSICIAN/MHP	
Discuss the procedures for how this is accomplished in your hospital. Is there a written process?	
SUITABLE SERVICES – NOTICE OF CLINICAL STATUS	

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This is required. Discuss the procedures for how this is accomplished in your hospital. Is there a written process?	
SUITABLE SERVICES – SERVICES OF MENTAL HEALTH PROFESSIONAL	
Discuss the procedures for how this is accomplished in your hospital. Is there a written process?	
SUITABLE SERVICES – PSYCHOTROPIC DRUG TREATMENT	
Discuss the specifics of this section with medical professionals and those who pass medication.	
ECT	
The recipient must consent to ECT. A guardian only consents to ECT on behalf of their ward if given that specific power by the court	
COMMUNICATIONS AND VISITS	
recipients are allowed to private and reasonable mail and telephone	
These communications must not be censored; staff should not open mail for recipients without authorization by the recipient	
If necessary, funds must be provided (in reasonable amounts) for postage, stationary, telephone.	
If rules are established regarding telephone calls and visits, these must be reasonable and must be posted in conspicuous areas for recipients, guardian and visitors	
Limitations can be made on these rights for individuals, but only as allowed in the individual plan of service (IPOS)	
Communication by mail, telephone and the ability to have visitors shall not be limited if the communications are between a recipient and his/her attorney or a court, or between a recipient and any other individuals when the communication involves legal matters or may be the subject of legal inquiry	
ENTERTAINMENT MATERIALS, INFORMATION AND NEWS	
Recipients can buy materials for their own use. The hospital must never prevent a recipient from exercising this right for reasons of, or similar to, censorship	
Any general program restrictions on access to material for reading, listening or viewing must be in policy & posted	
Does the hospital ask recipients about or automatically provide for a daily newspaper	
ADMISSION TO THE HOSPITAL	
Provide a summary of the involuntary process as it applies to the hospital; be aware of timeframes of involuntary documents. Staff need to offer voluntary status if 1st admission when the recipient arrives on the unit (not on deferral or court order).	
The recipient must be "suitable for voluntary". Define. A physician may not force a recipient to be hospitalized under the involuntary process if they are requesting voluntary treatment and not refusing treatment.	
Intent to terminate occurs when a voluntary patient indicates they would like to leave the psychiatric unit. The	
The assessment of an inpatient must begin within 8 hours of returning the form and must be completed & sent to the court within 72 hours.	
Is there a written process? Briefly review the process including who is responsible for giving the recipient the form and who is responsible for documenting that the form was given and received back.	

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If a recipient returns during their deferral period, the hospital (or CMH) will file a demand for hearing. The recipient will remain in the hospital until the hearing.	
If a recipient returns to the hospital after a court order is filed, they may file an objection to hospitalization with the court.	
Staff need to explain rights in full upon arrival; (documentation if explanation cannot be completed at admission, followed by documentation of completion); availability of complaints. If a voluntary patient - use the back of the form and in the record. If not, where is the information documented?	
The process for intent to terminate (requesting a "readiness for discharge" check) must be explained/stressed as part of rights. Remind staff who the recipient tells & where is documented	
If an alternative method is required for explaining rights or if there is a delay, that should also be indicated on the admission form. The admission form is not complete until the recipient is admitted agrees to hospitalization and rights are explained. Be sure to include in your rights training an explanation of the backside of the admission form. If you do not find out who is covering admission in the new hire training & note it.	
CMH must be notified of any admission of their Client. They must be notified prior to discharge.	
Social work staff must attend the Deferral Conference; CMH must be notified of the date & time.	
COURT HEARINGS & MEDICATION	
Psychotropic drugs shall not be administered to an individual who has been hospitalized by... petition under chapter 4 or 5 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.	
Signed documentation of the physician MUST FIRST be placed in the resident's clinical record before the medication is administered	
Initial administration of psychotropic chemotherapy may not be extended beyond 48 hours unless there is consent. The duration of psychotropic chemotherapy shall be as short as possible and at the lowest possible dosage that is therapeutically effective. The chemotherapy shall be terminated as soon as there is little likelihood that the recipient will pose a risk of harm to himself, herself, or others.	
PERTAINING TO THE RECIPIENT RIGHTS SYSTEM	
Discuss the operation of the Rights Office	
What are the various roles: Prevention, Monitoring, Education, Complaint Resolution	
Recipients should have access to chapter 7 & 7A upon request & ready access to complaint forms.	
Discuss the complaint process. What is the role of staff in that process? Discuss reporting requirements with respect to abuse, neglect or incident reports	
When is Remedial Action required, what it might be; when is disciplinary action required. Who makes that decision - stress that the Role of the Rights is to not to ensure discipline or other remedial action. That is why the Summary report that is sent to the recipient, complainant, parent of minor or guardian is signed by the Chief administrative Officer. They are the one ensuring appropriate action as required in the law.	

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Basics of rights appeals - What do staff need to know and be able to explain about appeals?	
Unimpeded access by ORR to all evidence for investigating or monitoring	
Preponderance of Evidence standard	
Recipients, complainants & guardians (parents of minors) may appeal the rights investigation. There are specific timeframes and grounds that must be adheared to, and a review of the investigative report is completed by an independent committee.	
Employee Rights (retaliation/harassment (1755 3), Whistleblowers (Civil Action), Bullard-Plawecki (by HR or waived): emphasis on non-retaliation & disciplinary action)	

OFFICE OF RECIPIENT RIGHTS
SITE VISIT MONITORING FORM

SERVICE SITE: _____

DATE OF VISIT: _____ ASSESSOR: _____

YES	NO	STANDARD	COMMENTS
		Were rights books provided to consumers and readily available for review?	
		Did the rights books provide the correct information for contacting the appropriate Rights Office?	
		Are posters providing contact information for the Rights Office conspicuously posted and visible to consumers and staff? (not applicable to SIP sites)	
		The most current version of the Abuse and Neglect Reporting Posters are posted where staff can see them.	
		Were complaint forms readily available?	
		Were recipients aware of how to file a complaint?	
		Were staff aware of how to file a complaint?	
		Were copies of Chapter 7 and 7A available?	
		Were any exclusions to items able to be brought into the site (contraband) posted and visible to consumers and visitors?	
		Were records and other confidential information secured and not open for public inspection?	
		Were any health or safety concerns identified during the visit?	
		Were appropriate accommodations made for persons with physical disabilities?	

Observations:
Deficiencies Noted and Required Action:

MDHHS OFFICE OF RECIPIENT RIGHTS
LPH ANNUAL MONITORING FORM FY 20

Instructions: This form must be completed and submitted to MDHHS-ORR by January 30, 2021, covering the period October 1, 2019 to September 30, 2020. MDHHS-ORR will review each submission. This form should be electronically submitted to Beverly Sobolewski sobolewskib@michigan.gov

LPH NAME:

ADDRESS: CITY: ZIP:

HAS THE ADDRESS CHANGED SINCE LAST REPORT? ☐ YES ☐ NO

ORR DIRECTOR: PHONE: EMAIL:

SECTION A:

Please identify the current CAO/Director (Chief Administrative Officer of the Psychiatric Unit). *PLEASE IDENTIFY ANY RIGHTS OFFICE STAFF* ***CHANGES*** *SINCE THE LAST REPORT.*

STAFF NAME	POSITION (CEO/RIGHTS STAFF)	ENTER: (H) HIRED OR (D) DEPARTED	HIRE/DEPARTURE DATE	BASIC TRAINING DATE

SECTION B:

LIST THE NAMES AND EFFECTIVE DATES OF ANY RIGHTS RELATED POLICIES THAT WERE CREATED OR REVISED DURING THE FISCAL YEAR. ***PLEASE ATTACH COPIES OF ALL POLICIES LISTED HIGHLIGHTING THE CHANGES MADE. IF THERE ARE NO POLICY CHANGES, CHECK HERE →*** ☐ NO POLICY CHANGES

POLICY NUMBER	POLICY NAME	EFFECTIVE DATE

SECTION C:

DESCRIBE THE LPH'S PROCESS FOR CONTINUATION OF RIGHTS PROTECTION AND COVERAGE IN THE ABSENCE OF THE RIGHTS ADVISOR.

SECTION D:

DESCRIBE THE AGENCY'S PROCESS FOR ADDRESSING THE RESPONSIBILITIES OF THE LPH DIRECTOR (Chief Administrative Officer) IN HIS/HER ABSENCE.

SECTION E:

LIST THE CASE NUMBERS AND CATEGORY OF ANY COMPLAINTS MADE AGAINST THE DIRECTOR OF THE HOSPITAL. INDICATE HOW THESE WERE INVESTIGATED (MDHHS-ORR, OTHER LPH ORR, OTHER CMH ORR). IF NONE, PLEASE CHECK HERE → ☐NO COMPLAINTS AGAINST CAO

CASE NUMBER	CATEGORY	SUBSTANTIATED (YES/NO)	INVESTIGATED BY

SECTION F:

LIST THE CASE NUMBERS OF ANY COMPLAINTS OF RETALIATION AND HARASSMENT. INDICATE IF THE ALLEGATION WAS SUBSTANTIATED OR NOT AND WHAT DISCIPLINARY ACTION WAS TAKEN. IF NONE, PLEASE CHECK HERE → ☒

CASE NUMBER	SUBSTANTIATED (YES/NO)	ACTION TAKEN (DISCIPLINARY OR REMEDIAL

RIGHTS OFFICE SELF ASSESSMENT *

Circle Applicable Answer - **T** [True] or **F** [False]

I have my own secure office: **T F**

I have a dedicated phone line with secure voice mail for patient rights issues: **T F**

I have lockable file cabinets: **T F**

I have a pager or cell phone by which I can be contacted in an emergency when away from my office or home: **T F**

I am immediately notified when an emergency or sentinel event [i.e. suicide, rape, assault with serious injury, etc] occurs: **T F**

I am included in the interviews initiated by the hospital to review the circumstances of a sentinel event: ***T F***

I routinely see all incident reports in real time [not 30 days after the fact] that concern the psychiatric program: **T F**

I provide the patient rights orientation to all new psych program staff when they are hired: **T F**

I am invited to present patient rights information to all new non-psychiatric program staff as part of the hospital's general orientation for new staff: **T F**

Unit staff recognize me and know my name when I come on the unit: **T F**

I know many of the psych program staff by sight and name: **T F**

Unit staff call me to intervene in order to resolve or defuse a potential resident formal complaint who may have concerns or complaints about his/her care: **T F**

Rights booklets are observable to be in the possession of residents: **T F**

Complaint forms are available on the unit: **T F**

Each unit has a secure box in which resident complaint allegations can be deposited: **T F**

Abuse/Neglect posters are posted in staff or conference rooms: **T F**

Poster with my name, phone number, and title is posted on each unit: **T F**

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* Please note that this questionnaire is not inclusive of all applicable Mental Health Code rights protection requirements.

A copy of Chapter 7 and 7A of the Mental Health Code is available on the unit for reference use by staff, residents, and visitors: **T F**

I review and approve any changes or modifications to the policies and procedures required by the Mental Health Code Sections 713 and 752: **T F**

I am familiar with the pattern [frequency and average duration] of the use of seclusion and restraint by the psych program: **T F**

The hospital director or designee is readily available to discuss any concern that I may have or quality and rights related finding: **T F**

My recommendations for corrective action are followed: **T F**

I have a yearly budget with provisions for purchasing rights related materials/resources and attending rights related conferences: **T F**

I have time to attend rights related conferences: **T F**

The back up rights adviser will do a credible job while I am on vacation or out of town and I will not have to pick up the pieces when I return to the office: **T F**

My reports and correspondence are completed in a timely manner: **T F**

I have time to come to the units and audit medical records for compliance with Code related requirements: **T F**

Total # of True Responses: _____ Total # of False Responses: _____

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(should be all T & 1 F)

Name/Title Facility Date

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* Please note that this questionnaire is not inclusive of all applicable Mental Health Code rights protection requirements.