Score	Standard	HOSPITAL POLICY REVIEW	Location	Comments/Required Action
		Complaint and Appeal Process		
		Policy Name/Number: Policy revision date: The policy contains the following:		
	A1	A process to assure that all patients receive a summary of rights.		
	A2	A process for explaining patient rights to all patients 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 individual representative 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	There is a mechanism for patients, or anyone on their behalf, to file rights complaints. [MHC 1776 (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 must assist the patient or other individual with the complaint process, as necessary. [MHC 776 (5)]		
	A9	The rights office must advise the patient 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)]		
	A11	If a rights complaint is received regarding the conduct of the hospital director (CAO), the rights investigation must be conducted by the patient rights office of another LPH, a CMHSP or by the state office of patient rights as decided by the board. [MHC 1776 (6)]		
	A12	In cases involving alleged abuse, neglect, serious injury, or death when a rights violation is apparent or suspected, investigation must be immediately initiated. [MHC 1778 (1)]		
	A13	The rights office must initiate investigation of apparent or suspected rights violations in a timely and efficient manner. [MHC 1778 (1)]		
	A14	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)]		
	A15	Investigations must be completed within 90 calendar days, unless awaiting action by external agencies. (CPS, law enforcement, etc.) [MHC 1778 (1)]		
	A16	Investigation activities for each rights complaint will be accurately recorded by the office. [MHC 1778(2)]		
	A17	The rights office must use "preponderance of the evidence" as its standard of proof in determining whether a right was violated. [MHC 1778 (3)]		
	A18	Upon completion of the investigation, the rights office must submit a written investigative report (RIF) to the Hospital Director (Chief Administrative Officer) and the respondent. [MHC 1778 (5)]		
	A19	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)]		
	A20	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)]		
	A21	The hospital must ensure that appropriate disciplinary action is taken against those who have engaged in abuse or neglect [MHC 1722 (2)] or retaliation and harassment MHC 1755 (3) (a)] [AR 7035 (1)].		
	A22	Remedial action taken on substantiated violations is documented and made part of the record maintained by the rights office. [MHC 1780 (2)]		
	A23	The Director (Chief Administrative Officer) must submit a written summary report to the complainant, patient, if different than the complainant, and the parent of a minor or guardian, within 10 business days after receiving the RIF from the rights office. [MHC 1782 (1)]		
	A24	The summary report contains all of the following: a) statement of the allegations, b) citations to relevant provisions of applicable laws, rules, policies, and guidelines, c) statement of the issues involved, d) summary of investigative findings, e) conclusions, f) recommendations, if any, g) action taken or plan of action proposed by the respondent. [MHC 1782 (1)]		
	A25	The summary report contains all of the following: 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	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)]		
	A27	Information in the summary report must not violate the rights of any employee. [MHC 1755 (3) (b), 1782 (2)]		
	A28	If the summary report contains a plan of action, the director must send an letter/amended summary report to the rights office, the complainant, the patient (if different) and a parent/guardian (if applicable) indicating that the action was completed and the date the action occurred. [MDHHS-APL133]		
	A29	If the plan of action describes action that differs from that indicated in the summary report, the letter/amended summary report to the rights office, the complainant, the patient (if different), and the parent or guardian (if applicable) must detail the action taken, the date of the action and indicate that an appeal on this action may be made within 45 days. [MDHHS-APL133]		
	A30	Appeals must be accepted if filed within 45 days after receipt of the summary report. [MHC 1784 (1)]		
	A31	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)]		
	A32	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 to an advocacy organization. [MHC 1784 (3)]		
	A33	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)]		
	A34	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 patient rights matter brought by or on behalf of a patient the receives services of that community mental health services program. [MHC 1774 (4)]		
	A35	The governing body of a licensed hospital may appoint an appeals committee in accordance with 330.1774 or, designate the MDHHS appeals committee, by agreement with the department, to hear appeals of rights complaints brought against the licensed hospital. [MHC 1774 (4) (b)]		

Score	Standard	HOSPITAL POLICY REVIEW	Location	Comments/Required Action
	A36	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. [MDHHS-APL 133]		
	A37	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, patient, if different than the complainant, parent or guardian, and the appeals committee within 10 business days. [MHC 1780, 1782 (1), 1784 (5) (b), MDHHS-APL 133]		
	A38	If a request for additional or different action is sent to the Director, a response will be sent, within 30 days, as to the action taken or justification as to why it was not taken. The response will be sent to the complainant, patient, if different than the complainant, parent or guardian, and the appeals committee. [MHC 330.1784(5)(c), MDHHS-APL 133]		
	A39	If the committee notifies the LPH 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 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), MDHHS-APL 133]		
	A40	If the appeal concerns the timeliness of the investigation and the committee confirms that the investigation was not initiated or completed in a timely manner, the committee recommends that the director of the LPH address the cause of the lack of timeliness with their rights advisor. [MHC 330.1784(5)(d), MDHHS-APL 133]		
	A41	The hospital has a mechanism in place to ensure complainants, staff of the office of patient rights, and any staff acting on behalf of a patient will be protected from harassment or retaliation resulting from patient rights activities and that appropriate disciplinary action will be taken if there is evidence of harassment or retaliation. [MHC 1755(3)(a)]		
		Consent to Treatment and Services		
		Policy Name/Number: Policy revision date: The policy contains the following:		
	B1	Consent is defined in accordance with the definition in the Mental Health Code 330.1100a (19).		
	B2	Informed consent is defined in accordance with the definitions of legal competency, knowledge, comprehension, and voluntariness found in the Administrative Rule 330.7003 (1) (a-d)		
	B3	The patient or their individual respresentative is informed that they can withdraw consent and discontinue participation or activity at any time this can be done without prejudice toward the patient. [AR 7003 (1) (d)]		
	B4	Informed consent will be reobtained if changes in circumstances substantially change the risks, other consequences or benefits that were previously expected. [AR 7003 (3)]		
	B5	An indication that a patient has free power of choice without force, fraud, deceit, duress, constraint, coercion, etc. [AR 7003 (1) (d)]		
		Abuse and Neglect (including detailed categories of type and severity) and Reporting Requirements		
		Policy Name/Number: Policy revision date: The policy requires the following:		
	C1	Abuse is defined in accordance with the definitions in AR 7001 (a-c), AR 7001 (z). [AR7035 (2) (a).		
	C2	Neglect is defined in accordance with the definitions in AR 7001 (i-k). [AR7035 (2) (a).		
	C3	Procedures are provided for prompt reporting, review, investigation, and resolution of apparent or suspected violations of the rights guaranteed by this chapter 7. [MHC 1752(1)]		
	C4	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 1752(1)]		
	C5	Investigations of abuse/neglect allegations are conducted by the Rights Office. [MHC 1778 (1)]		
	C6	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)]		
	C7	A process is identified to assure reporting of abuse in accordance with MHC 1723(1), P.A. 238 of 1978, and P.A. 519 of 1982.		
	C8	Reporting is required of criminal abuse including vulnerable adult abuse and child abuse to local law enforcement. [MHC 1723]		
	C9	There is delineation as to who will prepare written reports to law enforcement agencies regarding criminal abuse. [MHC 1723 (2)]		
		Right to be Treated with Dignity and Respect		
		Policy Name/Number: Policy revision date: The policy contains the following:		
	D1	The LPH protects and promotes the dignity and respect to which a patient 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, Photographing, Audiotaping, and Use of 1-way Glass		
		Policy Name/Number: Policy revision date: The policy contains the following:		
	E1	Identification of the circumstances under which audiotapes, or photos may be taken, and 1-way glass may be used. [MHC 1724 (7) (a-c)]		
	E2	Identification of the parameters for use of fingerprints, photos, or audiotapes for the purpose of patient 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 opportunity for patients 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 patient, and any copies of them, will be given to the patient, or destroyed, when they are no longer essential to achieve provision of services or obtain information regarding identity, or upon discharge of the patient, 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)]		
	E10	Identification of the locations where the surveillance images will be recorded and saved. [MHC 1724 (9) (a)]		
	E11	How patients and visitors will be advised of the video surveillance. [MHC 1724 (9) (b)]		

Score	Standard	HOSPITAL POLICY REVIEW	Location	Comments/Required Action
	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 patient 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 patient's clinical record. [MHC 1724 (9) (g)]		
		Confidentiality and Disclosure		
		Policy Name/Number: Policy revision date: The policy contains the following:		
	F1	Information in the record of a patient, and other information acquired in the course of providing mental health services to a patient, shall be kept confidential and is not open to public inspection. The information may be disclosed outside the hospital, only in the circumstances and under the conditions set forth in this section or section 748a. [MHC 1748 (1)]		
	F2	A summary of section 1748 of the Mental Health Code is made part of each patient file. [AR 7051 (1)]		
	F3	If information made confidential by this section is disclosed, the identity of the individual to whom it pertains shall be protected and shall not be disclosed unless it is germane to the authorized purpose for which disclosure was sought. When practicable, no other information shall be disclosed unless it is germane to the authorized purpose for which disclosure was sought. [MHC 1748 (2)]		
	F4	An individual receiving information made confidential by this section shall disclose the information to others only to the extent consistent with the authorized purpose for which the information was obtained. [MHC 1748(3)]		
	F5	For case records made after March 28, 1996, information made confidential by 330.1748 will be disclosed to a competent adult patient (adult without a guardian) upon the patient'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)]		
	F6	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 patient's attorney with the consent of the patient, the patient'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 patient 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.		
	F7	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)]		
	F8	Except as otherwise provided in 330.1748(4), if consent has been obtained from the patient, the patient's guardian who has the authority to consent, a parent with legal custody of a minor patient, or court appointed personal representative or executor of the estate of a deceased patient, information made confidential by 1748 **may be disclosed** to: a) a provider of mental health services to the patient, or b) the patient, 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 patient or others. [MHC 1748 (6)]		
	F9	Unless section 748(4) of the act applies to the request for information, the director of the provider may make a determination that disclosure of information may be detrimental to the patient or others. If the director declines to disclose information because of possible detriment to the patient or others, then the director shall determine whether part of the information may be released without detriment. A determination of detriment shall not be made if the benefit to the patient from the disclosure outweighs the detriment.		
	F10	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)]		
	F11	The director of the provider shall provide written notification of the determination of detriment and justification for the determination to the person who requested the information. 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)]		
	F12	Information may be disclosed by the holder of the record under 1 or more of the following circumstances: (a) As necessary in order for the patient to apply for or receive benefits. (b) 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. (c) As necessary for the purpose of outside research, evaluation, accreditation, or statistical compilation. The individual who is the subject of the information shall not be identified in the disclosed information unless the identification is essential in order to achieve the purpose for which the information is sought or if preventing the identification would clearly be impractical, but not if the subject of the information is likely to be harmed by the identification. (d) To a provider of mental or other health services or a public agency, if there is a compelling need for disclosure based upon a substantial probability of harm to the patient or other individuals. [MHC 1748(7)]		
	F13	Disclosure of information that enables a patient to apply for or receive benefits without the consent of the patient 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)]		
	F14	Attorneys representing patients may review records only upon presentation of identification and the patient'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)]		

Score	Standard	HOSPITAL POLICY REVIEW	Location	Comments/Required Action
	F15	Attorneys who are not representing patients may review records only if the attorney presents a certified copy of an order from a court directing disclosure of information concerning the patient to the attorney. [AR 7051 (4) (b)]		
	F16	Attorneys will be refused information by phone or in writing without the consent or release from the patient 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)]		
	F17	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 patient 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)]		
	F18	The hospital must grant a representative of protection and advocacy system designated by the governor (Disability Rights of Michigan) access to the records of all of the following: a) a patient, if the patient, the patient's guardian with authority to consent, or a minor's parents with physical and legal custody of the patient, have consented to the access, b) a patient, including a patient who has died or whose location is unknown, if all of the following apply: (i) because of mental or physical condition, the patient is unable to consent to the access, (ii) the patient does not have a guardian or other legal representative or the patient's guardian is the State, (iii) the protection and advocacy system has received a complaint on behalf of the patient, or has probable cause to believe, based on monitoring or other evidence, that the patient has been subject to abuse or neglect, c) a patient 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 patient is in serious and immediate jeopardy, (ii) upon receipt of the name and address of the patient'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 patient. [MHC 1748 (8)]		
	F19	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)]		
	F20	Records, data, and knowledge collected for or by individuals or committees assigned a peer review function including the review function under section 143a (1) of the Mental Health Code are confidential, are used only for the purpose of peer review, are not public records, and are not subject to court subpoena. [MHC 1748 (9)]		
	F21	The hospital, 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))		
	F22	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)]		
	F23	A patient, guardian, or parent of a minor patient, after having gained access to treatment records, may challenge the accuracy, completeness, timeliness, or relevance of factual information in the patient's record. The patient, guardian, or parent of a minor patient shall be allowed to insert into the record a statement correcting or amending the information at issue. The statement shall become part of the record. The process for amending the record is defined. [MHC 1749]		
Change in Type of Treatment				
		Policy Name/Number: Policy revision date: The policy contains the following:		
	G1	The LPH has a process to ensures that a patient is given a choice of physician or mental health professional within the limits of available staff. [MHC 1713]		
Services suited to condition/Person-centered planning				
		Policy Name/Number: Policy revision date: The policy contains the following:		
	H1	A person-centered planning process is used to develop a written IPOS in partnership with the patient.[MHC 1712 (1)]		
	H2	There is documentation of the patient's participation in the treatment planning meeting, or an explanation as to the reason the patient did not attend.[MHC 1712 (1) AR 7199 (2) (a)]		
	H3	There is documentation of the persons that the patient desired to be part of the planning process. There is a method for soliciting names of, and including persons of the patient's choice, in the IPOS. The justification for exclusion of individuals chosen by the patient to participate in the IPOS process must be documented in the record. [MHC 1712 (3)]		
	H4	The IPOS includes assessments of the patient's need for food, shelter, clothing, health care, employment opportunities (when appropriate), educational opportunities (when appropriate), legal services and recreation. [AR 7199 (h)]		
	H5	The IPOS identified any limitations of the patient'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)]		
	H6	Limitations of the recipient's rights, any intrusive behavior treatment techniques, or any use of psycho-active drugs for behavior control purposes shall be reviewed and approved by a specially constituted body (behavior treatment plan review committee) comprised of at least 3 individuals, 1 of whom shall be a fully- or limited- licensed psychologist with the formal training or experience in applied behavior analysis, and 1 of whom shall be a licensed physician/psychiatrist, unless the behavior is due to an active substantiated serious mental illness or emotional disturbance. [AR 7199 (2) (g)]		
	H7	The plan must be agreed to by the hospital, the patient, the guardian, or the parent with legal custody of a patient, unless it is part of a court order. Objections must be noted in the plan. [AR 7199 (4), (5)]		
	H8	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)]		
	H9	There is a procedure to assure that the plan is kept current and modified when indicated, or when necessary. [MHC 1712 (1)]		
	H10	The patient 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]		
	H11	If the patient is not satisfied with his/her individual plan of services, the patient or his/her guardian, or parent of a minor patient may make a request for review to the designated individual in charge of implementing the plan. [MHC 1712 (2)]		
	H12	The review required in sec. 712(2) is completed within a reasonable period of time. (no later than 30 days or prior to discharge, whichever is sooner) There are procedures for requesting and conducting the review. [MHC 1712 (2)]		
Sterilization, Contraception, and Abortion				

Score	Standard	HOSPITAL POLICY REVIEW	Location	Comments/Required Action
		Policy Name/Number: Policy revision date: The policy contains the following:		
	I1	Notice by the individual in charge of the patient's written plan of service to patients, their guardians, and parents of minor patients, 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 patient, guardian, or parent of a minor patient. [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 and Visits		
		Policy Name/Number: Policy revision date: The policy contains the following:		
	J1	Telephones must be reasonably accessible and funds for telephone usage are available in reasonable amounts. [MHC 1726 (2)]		
	J2	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)]		
	J3	Space will be made available for visits. [MHC 1726 (2)]		
	J4	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)]		
	J5	The right to communicate by mail or telephone or to receive visitors must not be further limited except as authorized in the patient's plan of service. [MHC 726 (4)]		
	J6	Limitations on communication do not apply to a patient 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)]		
	J7	If a patient 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: Policy revision date: The policy contains the following:		
	K1	A doctor's order for medication is required. [AR 7158 (1)]		
	K2	There must be periodic medication reviews as specified in the plan of service and based on patient's clinical status. [AR 7158(4)]		
	K3	Medications must be administered by personnel who are qualified and trained. [AR 7158 (5)]		
	K4	Procedures on when and how documentation regarding medication administration is to be placed in patient's clinical record. [MHC 1752, AR 7158 (6)]		
	K5	Medication errors and adverse drug reactions are immediately and properly reported to a physician and recorded in the patient's record. [AR 7158 (7)]		
	K6	Only medications authorized by a physician are to be given at discharge. Enough medication is made available to ensure the patient has an adequate supply until he or she can become established with another provider. [AR 7158 (9)]		
	K7	A procedure to ensure that medication brought by the patient, and stored by the LPH, must be returned at discharge [MHC 1728 (7)]		
		Use of Psychotropic Drugs		
		Policy Name/Number: Policy revision date: The policy contains the following:		
	L1	Psychotropic medication (psychotropic drug) is defined in accordance with AR 330.7001 (p).		
	L2	Before initiating a course of psychotropic drug treatment for a patient, 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)		
	L3	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]		
	L4	The administration of psychotropic medication to prevent physical harm or injury occurs: ONLY when the actions of a patient, or other objective criteria, clearly demonstrate to a physician that the patient poses a risk of harm to himself, herself, or others, and 2) ONLY after signed documentation of the physician is placed in the patient's clinical record and [AR 7158 (8) (b)]		
	L5	Initial administration of psychotropic chemotherapy (medication) must 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)]		
	L6	Initial administration of psychotropic chemotherapy (medication) must be limited to a maximum of 48 hours unless there is consent. [AR 7158 (8) (c)]		
	L7	Medication must not be used as punishment or for staff's convenience. [AR 7158 (3)]		
		Treatment by Spiritual Means		
		Policy Name/Number: Policy revision date: The policy contains the following:		
	M1	"Treatment by spiritual means" is defined as a spiritual discipline or school of thought that a patient 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 patient, guardian, or parent of a minor patient. [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 patient'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)]		
	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)]		
	M8	The patient 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 patient 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 patient. [AR 7135 (a – d)]		
		Property and Funds		

Score	Standard	HOSPITAL POLICY REVIEW	Location	Comments/Required Action
		Policy Name/Number: Policy revision date: The policy contains the following:		
	N1	Identification of excluded items that patients 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 patient and to an individual designated by the patient. [MHC 1728 (7)]		
	N4	A patient is to be permitted to inspect personal property at reasonable times. [MHC 1728 (2)]		
	N5	The individual in charge of the plan of service may only limit access to personal property if essential to (i) prevent the patient from physically harming himself, herself, or others, or (ii) to prevent theft, loss, or destruction of the property, unless a waiver is signed by the patient. Limitations of property must be justified and documented in the record of the patient. [MHC 1728 (4) (a), (5)]		
	N6	A patient's property or living area shall not be searched unless such a search is authorized in the patient's plan of service or there is reasonable cause to believe that the recipient is in possession of contraband or property that is excluded from the recipient's possession. [AR 7009(7)]		
	N7	Conditions under which a search for contraband items may be conducted. [AR 7009 (7)]		
	N8	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)]		
	N9	Any property taken for into possession by the hospital must be given to the patient at the time of discharge [MHC 1728 (7)]		
		Right to Entertainment Material, Information, and News		
		Policy Name/Number: Policy revision date: The policy contains the following:		
	O1	patients 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 patient's individualized plan of service. Staff in charge of the plan of service must document each instance when a limitation is imposed in the patient's record. [AR 7139 (2) (3)]		
	O3	Limitations 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)]		
	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 patient's interest for provision of a daily newspaper. [AR 7139 (6) (b)]		
	O8	There is a process for patients 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 patients as a group. [AR 7139 (6) (e)]		
		Patient Labor		
		Policy Name/Number: Policy revision date: The policy contains the following:		
	P1	A patient 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 patient voluntarily agrees to perform the labor, 2) engaging in the labor would not be inconsistent with the IPOS for the patient, 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 patient 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	There is a process for providing compensation in an appropriate amount 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)]		
	P5	The policy requires that one-half of any compensation paid to a patient for labor performed shall be exempt from collection for payment of mental health services provided. [MHC 1736(6)]		
		Least Restrictive Setting / Freedom of Movement		
		Policy Name/Number: Policy revision date: The policy contains the following:		
	Q1	There is a requirement that the patient receives treatment in the least restrictive setting that is appropriate and available.[MHC 1708 (3)]		
	Q2	The freedom of movement of a patient 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)]		
		Use of Restraint		
		Policy Name/Number: Policy revision date: The policy contains the following: ***MHC 1740(1) states that a patient shall not be placed in physical restraint except in the circumstances and under the conditions set forth in this section or in other law. Therefore, these standards address compliance with both state and federal regulations.***		
	R1	Restraint is defined, as in [MHC 1700 (i)]		
	R2	Physical management is defined, as in [AR 7243]. For the purposes of this policy physical management is restraint.		
	R3	A patient shall not be placed in restraint except in the circumstances and under the conditions set forth in this sec. 740 or in other law. Restraint must not be imposed as a means of coercion, discipline, or retaliation by staff members. [MHC 1740(1); 42 CFR 482.13]		
	R4	The patient has the right to safe implementation of restraint by trained staff. The hospital has a process to ensure that staff are trained and able to demonstrate competency in the application of retraint, monitoring, assessment and providing care for a patient in restraint in complaince with 42 CFR 482.13(f).		

Score	Standard	HOSPITAL POLICY REVIEW	Location	Comments/Required Action
	R5	A patient may be restrained after less restrictive interventions have been considered, and only if restraint is essential in order to prevent the patient from physically harming themselves or others. Consideration of less restrictive measures shall be documented in the medical record. If restraint is essential in order to prevent the patient from physically harming themselves or others, the patient may be physically held with no more force than is necessary to limit the patient's movement, until a restraint may be applied. [MHC 1740 (2)]		
	R6	A patient may be temporarily restrained for a maximum of 30 minutes without an order or authorizationin 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, the restraint must be removed. [MHC 330.1740 (3)]		
	R7	A patient may be restrained prior to examination pursuant to an authorization. An authorized restraint may continue only until a physician can personally examine the patient or for 2 hours, whichever is less. If it is not possible for the physician to examine the patient within 2 hours, a physician may reauthorize the restraint for another 2 hours. Authorized restraint may not continue for more than 4 hours. [MHC 1740(4)]		
	R8	A patient may be restrained pursuant to an order by the physician who is responsible for the care of the patient after personal examination of the patient. The attending physician must be consulted as soon as possible if they did not order the restraint. 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: (i) 4 hours for adults 18 years of age or older; (ii) 2 hours for children and adolescents 9 to 17 years of age; (iii) 1 hour for children under 9 years of age. [(MHC 1740(5); 42 CFR 483.358]		
	R9	If the order is verbal, the order must be received by a registered nurse or other licensed staff (such as an LPN). The physician must verify verbal order in a signed written form in the patient's record and must be available for consultation throughout the emergency safety situation.		
	R10	The patient must be seen, face-to-face, within 1 hour after the initiation of the restraint by a qualifed staff to evaluate at a minimum: (i) the patient's physical and psychological status; (ii) the patient's behavior that warranted the intervention, the intervention used; (iii) alternative or less restictive measures attempted (if applicable) and the appropriateness of the intervention measures; and (iv) the patient's response to the intervention used, including rationale for continued use; and (v) any complications resulting from, the intervention. [42 CFR 483.358]		
	R11	A patient who is in restraint shall be inspected at least once every 15 minutes by designated personnel. The hospital shall ensure that documentation of staff monitoring and observation is entered into the medical record of the patient. The condition of the patient who is restrained must be monitored by a physician or trained staff that have completed the training criteria specified in by hospital policy. [MHC 330.1740 (6); AR 330.7243 (3); 42 CFR 483.358]		
	R12	An assessment of the circulation status of restrained limbs is conducted and documented at each 15 minute interval or more often if medically indicated. [AR 330.7243 (9)]		
	R13	A restrained patient shall: (i) continue to receive food, (ii) kept in sanitary conditions, (iii) be given hourly access to a toilet, (iv) have an opportunity to bathe as often as needed, but at least every 24 hours, (v) be clothed or otherwise covered, (vi) Be given the opportunity to sit or lie down. [MHC 1740(6), AR 7243(4)(5)]		
	R14	A patient must not be restrained in a prone position unless medically contraindicated. [AR 7243 (11) (ii)]		
	R15	Restraints must be removed every 2 hours for not less than 15 minutes, unless medically contraindicated or whenever they are no longer essential in order to achieve the objective which justified their initial application. Restraint must be discontinued at the earliest possible time, regardless of the length of time identified in the order. [MHC 330.1740 (7); 42 CFR 483.358]		
	R16	If a patient is removed from restraint for more than 30 minutes, then the order or authorization shall terminate. [AR 7243(7)]		
	R17	A physician who orders or reorders restraint shall do so in accordance with sections 740(5) of the act. The required examination by a physician shall be conducted not more than 30 minutes before the expiration of the expiring order for restraint. [[AR 7243 (6) (b)]		
	R18	If a patient is restrained repeatedly, the patient's individual plan of services must be reviewed and modified to facilitate the reduction of the use of restraints. [MHC 330.1740 (9)]		
	R19	Each instance of restraint requires full justification for its application, and the results of each periodic examination shall be placed promptly in the record of the patient. [MHC 1740(8)]		
	R20	A separate permanent record of each instance of restraint must be kept and shall include: (a) The name of the patient. (b) The type of restraint. (c) The name of the authorizing and ordering physician. (d) The date and time placed in temporary, authorized, and ordered restraint (e) The date and time the patient was removed from temporary, authorized, and ordered restraint. [AR330.7243 (1)]		
	R21	The hospital must report deaths associated with the use of restraint per 42 CFR 482.13(g).		
		Use of Seclusion		
		Policy Name/Number: Policy revision date: ***These standards address compliance with both state and federal regulations.*** The policy contains the following:		
	S1	Seclusion is defined. [MHC 1700 (j)		
	S2	Time out is defined. [AR 7001(x)]		
	S3	Therapeutic de-escalation is defined. [AR 7001 (w)]		
	S4	A patient may be placed in seclusion only if it is essential in order to prevent the patient from physically harming others. Restraint must not be imposed as a means of coercion, discipline, or retaliation by staff members.[MHC 1742(3); 42 CFR 482.13]		
	S5	The patient has the right to safe implementation of seclusion by trained staff. The hospital has a process to ensure that staff are trained and able to demonstrate competency in the application of seclusion, monitoring, assessment and providing care for a patient in seclusion in complaince with 42 CFR 482.13(f).		
	S6	Seclusion may be temporarily employed for a maximum of 30 minutes in an emergency without an authorization or an order. Immediately after the patient is placed in temporary seclusion, a physician shall be contacted. If, after being contacted, the physician does not authorize or order the seclusion, the patient shall be removed from seclusion. [MHC 1742(4)]		
	S7	A patient may be placed in seclusion under an authorization by a physician. Authorized seclusion shall continue only until a physician can personally examine the patient or for 1 hour, whichever is less. [MHC 1742(5)]		
	S8	A patient may be secluded pursuant to an order by the physician who is responsible for the care of the patient after personal examination of the patient. The attending physician must be consulted as soon as possible if they did not order the seclusion. 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: (i) 4 hours for adults 18 years of age or older; (ii) 2 hours for children and adolescents 9 to 17 years of age; (iii) 1 hour for children under 9 years of age. [(MHC 1742(6); 42 CFR 483.358]		

Score	Standard	HOSPITAL POLICY REVIEW	Location	Comments/Required Action
	S9	If the order is verbal, the order must be received by a registered nurse or other licensed staff (such as an LPN). The physician must verify verbal order in a signed written form in the patient's record and must be available for consultation throughout the emergency safety situation.		
	S10	The patient must be seen, face-to-face, within 1 hour after the initiation of the seclusion by a qualifed staff to evaluate at a minimum: (i) The patient's physical and psychological status; (ii) The patient's behavior that warranted the intervention, the intervention used; (iii) Alternative or lesser restictive measures attempted (if applicable) and the appropriateness of the intervention measures; and (iv) The patient's response to the intervention used, including rationale for continued use; and (v) Any complications resulting from, the intervention. [42 CFR 483.358; 42CFR 482.13)]		
	S11	The hospital shall ensure that documentation of staff monitoring and observation is entered into the medical record of the patient. The condition of the patient who is secluded must be monitored by a physician or trained staff that have completed the training criteria specified in by hospital policy. [AR 7243(3); 42 CFR 483.358]		
	S12	Simultaneous use of restraint and seclusionis only permittted if the patient is continually monitored, (i) face to face by an assigned, trained staff member; or (ii) by trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient. [42 CFR 482.13]		
	S13	A secluded patient must (i) continue to receive food, (ii) be given hourly access to toilet facilities, (iii) be bathed as often as needed, but at least once every 24 hours, (iv) be clothed or otherwise covered unless, their actions make it impractical or inadvisable, (v) be kept in sanitary conditions, and (vi) be provided a bed or similar piece of furniture unless his or her actions make it impractical or inadvisable. [MHC330.1742 (7), [AR 330.7243]		
	S14	A secluded patient shall be released from seclusion whenever the circumstance that justified its use ceases to exist and must never be written as a standing order or on an as needed basis (PRN). Seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.[MHC 1742(8); 42 CFR 483.358]		
	S15	If a patient is removed from seclusion for more than 30 minutes, then the order or authorization shall terminate. [AR 7243(7)]		
	S16	A physician who orders or reorders seclusion shall do so in accordance with sec. 742 of the act. The required examination by a physician shall be conducted not more than 30 minutes before the expiration of the expiring order for seclusion. [AR 7243(6)(b)]		
	S17	If a patient is secluded repeatedly, the patient's individual plan of services shall be reviewed and modified to facilitate the reduced use of seclusion. [MHC 1742(10)]		
	S18	Each instance of seclusion requires full justification for its use, and the results of each periodic examination shall be placed promptly in the record of the patient. [MHC 1742(9)]		
	S19	A separate permanent record of each instance of restraint must be kept and shall include: (a) The name of the patient. (b) The conditions of seclusion. (c) The name of the authorizing and ordering physician. (d) The date and time placed in temporary, authorized, and ordered seclusion. (e) The date and time the patient was removed from temporary, authorized, and ordered seclusion. [AR330.7243 (1)]		
	R20	The hospital must report deaths associated with the use of seclusion per [42 CFR 482.13(g)].		
		Comprehensive Examinations		
		Policy Name/Number: Policy revision date: The policy contains the following:		
	T1	Within 24 hours of admission, each patient must receive a comprehensive physical and mental examination. [MHC 1710}		
		Qualifications and Training of Rights Office Staff		
		Policy Name/Number: Policy revision date: The policy contains the following:		
	U1	Staff of the Office of Recipient Rights to receive annual training in patient 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. [LPH/CMHSP Contract]		
	U5	Rights officers, advisors and alternates will attain 36 hours of continuing education every 3 years, with 12 credits in "operations" or "legal". The policy requires that rights staff acquire at least 3 continuing education credits each calendar year (CMHSP/LPH Contract)		