MUNSON HEALTHCARE

D6 MENTAL HEALTH UNIT GUIDELINES

We wish you to have a good treatment stay. The following guidelines are for the safety and well-being of all patients and their families. Thank you for your cooperation. If you have questions, please feel free to contact your nurse, unit manager or Recipient Rights Officer - **231-935-2335**.

VISITING HOURS

Monday - Friday: 6 pm - 7 pm / Saturday - Sunday: 1 pm - 2 pm and 6 pm - 7 pm

*****Holidays may affect the hours listed above, please confirm visiting hours with staff*****

- Only 2 people may visit a patient at one time.
- Children under the age of 16 years are not allowed on the unit. Minors ages 16-17 must be accompanied by a responsible adult. Proof of age is required (Drivers License, School ID)
- Visitors suspected by D6 staff to be intoxicated and/or impaired due to substance misuse will not be allowed on the unit. Future visits for this individual may be denied.
- For privacy reasons, recently discharged patients are not allowed to visit other patients on the unit for 6 months.
- Visitors must leave all belongings in an assigned locker upon entering the unit, including cell phones, jackets, hats, purses, wallets, and keys.
- Any items brought to patients will be searched by staff.
- Visitation will take place only in common areas designated by D6 staff.
- No visitors are allowed in patient rooms or unit hallways.
- For the safety of the patients and the unit, visitors and patients are not allowed to have physical contact e.g. kissing, hugging, sitting on laps, etc. Failure to follow this guideline may result in loss of visiting privileges and visitor being escorted off the unit.

TELEPHONE

- No calls are allowed during scheduled group/activity times to prevent interference with your treatment groups.
- Telephones are available from 7:30 AM to 10:00 PM.
- Phone calls are allowed once per hour, with a maximum 10 minutes per call, whether it is an incoming or outgoing call.
- No cell phones are allowed on the unit.
- Messages will be taken for any incoming calls for patients. The caller will be asked to leave a name and number and your presence on this unit will not be revealed to the caller. The caller will be told that if you are here and wish to, you will return the call.

PROHIBITED ITEMS

- All sharp items including razor blades, knives or weapons of any type *(Illegal items will be turned over to security as outlined by hospital policy).*
- Non-prescribed drugs, recreational drugs including Medical Marijuana *(Illegal items will be turned over to security as outlined by hospital policy)*.
- Prescription medications will be placed in a valuables envelope and kept in the hospital safe.
- Glass or breakable items.
- Lighters or matches.
- Tobacco or smoking items *(chew, snuff, and dip, snus, water vapor cigs, e-cigs, or any other smoking/tobacco product)*.
- Personal electronic or electrical devices *(computers, cellphones, tablets, IPODs, curling irons, hair dryers, heating pads, radios, etc.)*
- Perfume or other scented products.
- D6 staff may prohibit any item that has the potential to cause harm.

*** If a patient accepts any prohibited items from visitors, the visitor may be prohibited from visiting in the future and/or patient's visiting privileges may be restricted, in accordance with the "Restricting Patient Rights" section of Michigan Mental Health code.**

BEHAVIOR

- We promote a safe and calm environment. We do not tolerate any form of violence. Aggressive, disruptive, or violent behaviors will not be tolerated by patients or visitors. Hospital Security and/or Law Enforcement will be called for any form of violence or aggression.
- Patients are not allowed in other patients' rooms. Please tell staff immediately if any patient enters or attempts to enter your room. Your room is your own personal space.

CONTINUE TO NEXT PAGE ➔

BEHAVIOR CONTINUED...

- For safety and therapeutic reasons physical contact (hugging, kissing, hitting, etc.) is not allowed between patients. If a patient touches you or attempts to touch you, please tell staff immediately.
- If your behavior is disruptive during a therapy group you may be asked to leave.
- The following behaviors are not allowed: illegal activities, vulgarities, obscenities, profanity, sexually explicit language, ethnic, race, religious, or gender intimidation or any other behavior that interferes with the therapeutic milieu.

* **D6 staff maintains the right to determine if behaviors are disruptive, aggressive or otherwise inappropriate.**

CLOTHING/BELONGINGS

Patient dress on D6 is casual street clothes and footwear. Shoes are allowed only with a doctor's order. Clothing should be comfortable, safe, and must not disrupt the therapeutic environment of the unit. All belongings will be searched during admission to D6 and stored. You may elect to be present during this search. Patients may keep a maximum of 3 changes of clothing in their room.

- The hospital is not responsible for lost, stolen or damaged property kept in your possession. Please identify all valuable items to staff. You may choose to send home the valuables, request they be securely stored in the hospital safe or documented on the waiver of responsibility form and kept in your possession.
- Not Permitted: Mini-skirts, short shorts, hats, hoods, sunglasses, or bandanas. Clothing that promotes or encourages the use of drugs, alcohol or tobacco, exhibits illegal activities, vulgarities, obscenities, profanity, sexually explicit language, or ethnic or gender intimidation.

FOOD/DRINK

- Meals and snacks should be consumed in the community dining room. Unless staff directs otherwise.
- All drinks must have lids on them.
- No outside food may be brought onto the unit except a limited amount of individually wrapped hard candy. Meals and snacks will be provided on the unit.
- Please keep food and drinks in your room while attending groups.
- No food can be saved from meal trays or kept in the room. Please order only what you plan to eat for each meal.
- Meals cannot be shared. Other patients may be on a special diet.
- Two cups of caffeinated coffee and/or soda may be ordered on breakfast and lunch trays from the dietary department. No caffeine is allowed **after 2:00 pm** due to possible reactions with medications and impact on mood and sleep.

COMMON AREAS

- Common areas for socializing include dining and multipurpose room or patient lounge.
- To protect everyone's confidentiality and privacy please do not loiter at nurses station or in front of patient rooms.
- Dining and activity room and patient lounge will be open daily from 6 am to Midnight.
- The doors to the dining and activity room and patient lounge will remain open with the lights on at all times. The doors may be closed for group sessions with the therapist present.
- For sanitary reasons, no pillows or blankets are allowed in common areas. They must be kept in your room.
- Do not lie on the floors or on the furniture in the common areas.
- Yoga mats must remain in the exercise equipment area.

SECURITY CAMERAS

For patient and staff safety, the common areas of this unit are monitored by video surveillance cameras. To ensure patient privacy, video cameras are not permitted in patient rooms or bathrooms.

PATIENT SIGNATURE ____________ DATE ____________ TIME ____________

PATIENT NAME *(PRINTED)* ____________

Quick Start Checks

Do policies need to be updated?

Any new procedures since 3/6/26

Any unit policies, guideline, forms changes, Lippincott procedures?

Skin Assessment/Contraband Examination

Munson's Mental Health Inpatient Unit (D6) is committed to providing a safe therapeutic environment that promotes the safety, wellbeing, and recovery of patients. The safety of patients, visitors, and staff of D6 is our priority and everyone's responsibility. The unit implements several measures to support ongoing safety (versus badge, security cameras, 15-minute safety checks). An important step in keeping the environment of care safe starts with the patient on admission.

Patients who are admitted to the unit may conceal items (contraband) which could be dangerous or may lead to harm to self or others. This includes items that are in their personal belongings and items concealed on or in their body. There are a variety of reasons patients choose to bring contraband on the unit e.g. concerned they won't get the medicine they want, self-harm to manage distress, plan to overdose, wanting to smoke. Items patients have concealed and brought include medications, razor blades and lighters and cigarettes. The razor blade and medications were concealed on the patient's body, i.e. under tongue, in underwear and socks, and internally inserted. When a patient is in crisis, their judgement may be impaired, which can result in not making good choices. With this knowledge, it is D6 staff's responsibility to remain diligent to the potential for patients to bring contraband onto the unit.

To uphold the safety of patients and staff, patients are examined upon arriving to the unit. On admission, all patients are required to receive a complete assessment which includes assessing the skin. It is during this time that the patient is also examined for contraband. The skin assessment/examination for contraband is a review of the skin. A cavity search is not part of this examination. The only time a cavity search would be conducted would be due to strong suspicion that the patient had a harmful item concealed. A doctor's order would be required and the search would be conducted by a physician with staff present.

It is understandable that there would be concern for the patient's privacy, dignity, and respect and concern for how the patient may respond. As providers of mental health care, D6 staff are sensitive to the needs of the patients and make every effort to support the patient during the examination. This includes explaining the purpose of the examination and why it is required, examining a patient in privacy, exposing only one area at a time during the examine, having the same gender staff conduct and witness examination (exception may need to be made with male patients if male staff are not working).

Effective communication is at the core of reducing the patient's anxiety. This involves making eye contact with the patient, being present (mindfulness, body language), not rushing and addressing any concerns the patient may have prior to staff beginning the assessment and examination. During the assessment, it can be helpful to inform the patient as you prepare to move to each section and as appropriate, periodically ask the patient how they are doing. It's appropriate to take a brief break if the patient is displaying signs of anxiety, agitation, etc. It may be appropriate to provide a PRN medication if ordered. Engaging the patient in an unrelated

topic can be another skill that can be effective in reducing anxiety, e.g. asking questions from the BH assessment, discussing a topic that is picked up in conversation such as children, pets, etc. It can provide a welcome distraction for the patient.

As a provider of care, it may be anxiety producing for you as this can be interpreted by you or the patient as intrusive. This is not an unreasonable perspective. As a rule, no one would want to have their body searched. If you have strong feelings or any level of anxiety re: conducting the examination, please discuss this with your preceptor, the clinical nurse specialist and/or the manager. It is important that you are aware of your feelings and be able to effectively manage any emotions as this could inadvertently negatively impact the patient and your interaction.

Included in this module are the guidelines for conducting a skin assessment/examination for contraband. Please review and discuss with your preceptor. Take the opportunity to be a second witness in the skin assessment/contraband check. Thank you for your diligence and commitment to safety.

Skin Assessment/Contraband Examination

Whenever possible, two staff of the same gender will be present during the skin and body inspection. Every effort will be made to have at least one staff member of the same gender as the patient present. Searches can be conducted in the patient's room, patient's bathroom, or shower room. Please remember if you are searching the patient in their room to ensure the door is closed and if necessary to close the window blinds.

- D6 Staff introduce themselves and escort the patient to their room.
- BHT remains with patient until RN completes skin assessment/search (BHT is 2nd witness)
- BHT will complete vital signs and weight if RN is not immediately available
- RN will explain to the patient the importance of skin and contraband check

Example introduction:

"It's important that we provide safe care and a safe environment for you and others. One part of this is completing a skin assessment and to check you for items that have potential to bring harm to you or others. I will look at all of your skin and document if you have bruises, breaks in your skin and other things such as tattoos. _________ will be here while I complete the assessment. You will keep your gown on, but I will reposition parts of the gown as I look at all the areas of your skin. I will also ask you to lower your underwear and bend your knees. Let me know if you need to take a brief break during the assessment. Do you have any contraband that you would want to give me before I start the assessment? Do you have any questions?"

- Check hair, head and face
- Ask patient to open mouth & check under tongue and inside of cheeks
- Check arms, back, chest and stomach
- Ask patient to lift skin folds and check areas (this includes Stomach, Breasts, Scrotum)
- Check legs
- Check feet (in between toes)
- Ask patient to stand with feet shoulder width apart to lower underwear to thighs and bend knees for 3-5 seconds (patient can place hands on top of thighs or staff can provide assistance to maintain balance if needed)
- Document findings in I-view and "2nd set of eyes for search (BHT)". Any variations e.g. blisters, lacerations, burns, pressure ulcers, etc. initiate a plan of care.
- If skin breakdown is suspected or a pressure ulcer present, a second RN will be needed to visualize the area and be documented as the 2nd set of eyes.
- Document completed search in the admit note in the comment section

For patients that have considerations e.g. paranoid, history of sexual or physical abuse, etc. consider slowing the pace of the assessment, checking in periodically on how they are doing, announce as you move to the next section, giving the patient the option to say when they are ready to move to the next section, providing a PRN to reduce anxiety or other coping skills that help with distraction e.g. ask questions from the nursing assessment, etc.

The patient will be a 1:1 until the assessment/search is completed. If the patient refuses inform them that for their safety and others safety, they will be unable to leave their room. If they become agitated, contact security to stand by and consider having them move to the seclusion room &/or offer medication. If the patient continues to refuse after a prolonged time period (> 1 hr.) discuss with team

(charge nurse, manager, asst manager, CNS and/or physician) to determine next steps. Patients' own clothes will be given to the patient after skin assessment/body check unless otherwise determined by team (as outlined above).

Violence Reduction Protocol (VRP)

The D6 MENTAL HEALTH staff initiated a Violence Reduction Protocol (VRP) at the beginning of 2016. The protocol guidelines were created by an interdisciplinary panel of physicians, nurses, behavioral health technicians, social workers and unit clerks. Since that time, the VRP has undergone some changes and revisions, including a name change. The VRP is currently known as the: **Violence Reduction and Prevention** program. Regardless, the initial goal of the program remains the same: patient and staff safety.

Other past and current VRP goals include the following:

- Ensure a uniform, comprehensive, orderly and proactive approach to inpatient violence.
- Improve effectiveness of staff communication.
- Eliminate all avoidable restraint and seclusion events.
- Respond to the Joint Commission patient safety initiatives, including:
    - Identification of safety risk in the patient population.
    - Improve effectiveness of staff communication.
    - Support patients' collaboration in their own care.
- Build on current use of the Broset Violence Checklist (BVC)

During your orientation, your preceptor will teach you the current VRP guidelines in more detail. You will be able to initially observe, and eventually complete, the VRP procedures for your assigned patients.

Here is a **brief overview and explanation** of the VRP process on D6 MENTAL HEALTH:

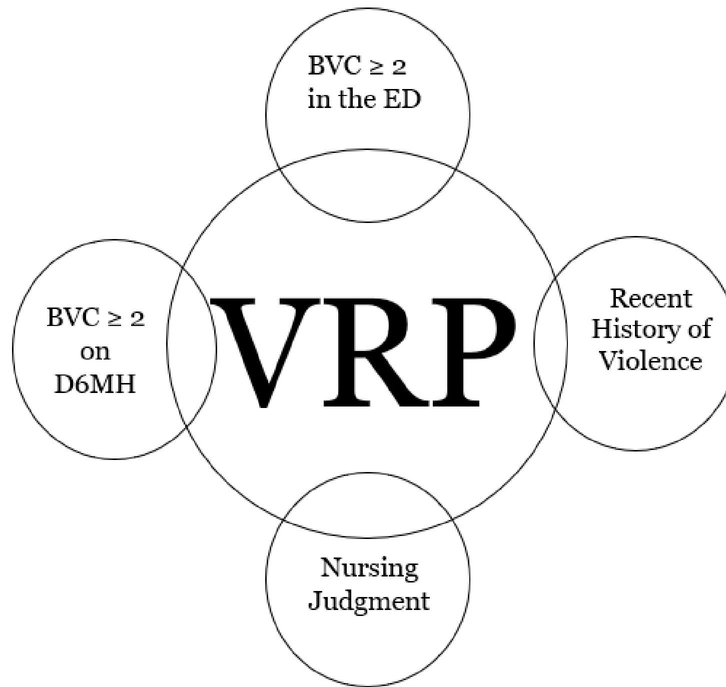
- Typically, VRP status is determined by a patient's Broset Violence Checklist (BVC) score at any time during the current hospital stay. This includes the BVC score when the patient presents to the hospital (E.D.), or during a stay on other units.
- If a patient has been placed in restraints in the E.D., they should be automatically enrolled in the VRP.
- The nurse can also use ***nursing judgment*** to determine a patient's VRP status. This is useful when the nurse has first-hand knowledge of a patient's behavior from a prior inpatient psychiatric stay. This scenario also applies to knowledge obtained from security or law enforcement concerning a patient's behavior immediately prior to MMC admission.

  BVC ≥ 2 = VRP enrollment. NOTE: A patient can exhibit this score at any time during the current admission. OR: Nursing judgment based on first-hand knowledge about patient's behavior.

- VRP status will be visually conveyed on the whiteboard and on patient charts. The laminated red stop sign, MMC's universal sign for violence risk, will be displayed on the whiteboard in the report room and on the binders of the green patient charts. Use of a visual tool makes it easier for ancillary staff to quickly survey VRP patients.
- VRP status will be included in all nursing reports. Your preceptor will instruct you on this process and in the use of the ***VRP Report form (see below).***

VRP Criteria

The following situations result in VRP enrollment:



Special Considerations:

1. **BVC ≥ 2 in ED:** the D6MH RN will use the ED-D6MH Handoff template to ascertain the patient's BVC ED stay.
2. **BVC ≥ 2 on D6MH**: the patient will be enrolled in the VRP anytime he/she has been involved in a violent event within the last 6 months.
3. **History of Violence:** a patient will be enrolled in the VRP if he/she has been involved in a violent event within the last 6 months
   Note: patients who have been involved in a violent event in the past (more than 6 months since admission) will receive MMC's universal symbol for "history of violence."
4. **Nursing Judgement:** RNs may utilize other methods to place a patient on the VRP. Some of these methods may include intuition about a patient, other medical diagnoses, information obtained from family/friends, etc. In some cases, this may mean temporary VRP until new information has been investigated.

MUNSON HEALTHCARE
Behavioral Health Services

Form 12154 (02/20)

12154

POTENTIAL FOR VIOLENCE BEHAVIORAL PLAN

Patient Name: ______________________________ Room Number: ____________

Pt Diagnosis: ____

Date plan was initiated: ______________ Primary RN: ______________________________

Reviewed/Updated: (PCC, CHARGE NURSE, PRIMARY NURSE - ***UPDATE ONCE PER SHIFT)***

Date:	Mon:	Tues:	Wed:	Thurs:	Fri:	Sat:	Sun:
AM:							
PM:							
MN:							

1. Reason(s) the patient has potential for violence (hx of violence, behaviors this admission, nsg judgement):

2. What triggers the patient's behavior?

3. What are the early signs that the patient is starting to escalate?

4. How will staff intervene to de-escalate the patient's behavior?

Important Considerations

- Security Alert - Gray Team sign posted on door
- Intervene with early signs of agitation
- Call a Security Alert - Gray Team **EARLY** (55555)
- Be aware of your position in relation to the patient
- Bring a peer into the room when providing care
- Don't allow the patient to get between you and the exit.
- Complete room check every shift
- Keep room clutter free
- Create a low stimulation environment
- Evaluate if a procedure can wait
- Consult with BH CNS (56596 or page)
- Request a patient care conference

DONT WRITE INSIDE BOX

PATIENT ID LABEL HERE

Lippincott Procedure, Skills Checklist:
Management of Inpatient Behavioral Health Unit Patient Property (MUNSON)

To search patient belongings for presence of contraband, inventory and document items brought with patient on admission to the Inpatient Behavioral Health Unit, document valuables sent to Nursing Administration or placed on the waiver form, and return all personal belongings to the patient at discharge.

Admission

__ Confirm the patient's identity using at least two patient identifiers.

__ Explain the procedure for managing patient belongings.

__ Take the patients' belongings and place a blank label on all belongings and write their name and room number on the label.

__ Ask the patient if they have any medication, valuables, or other items that could be considered contraband.

__ Ask the patient if they have any valuables they would prefer be kept in a secure, locked area off the unit (Nursing Administration).

__ If the patient wants their valuables to remain with them on the unit, complete the waiver form.

__ Ask the patient to review and sign the waiver.

__ If the patient refuses to send valuables to Nursing Administration, be locked in their assigned locker, and/or sign a waiver form, indicate on the waiver form the patients refusal and what valuables they are keeping with them on the unit.

__ Inform the patient that refusal to secure valuables in their assigned locker or Nursing Administration, Munson Medical Center will not be responsible for loss, theft, and/or damage of the valuables.

__ Put on gloves to comply with universal precautions.

__ Before leaving the Sally Port, search the patients' belongings for non-prescribed and prescribed medication. Take care for potential sharp items as you search the belongings.

__ If the patient does not have prescription drugs, contraband or valuables, continue on.

__ Contact security per policy ("Weapons and Contraband Policy") if there are non-prescribed drugs or other contraband in the patients' belongings.

Valuables

__ Place prescription medications and/or valuables the patient has requested be sent to Nursing Administration in a valuables bag.

__ Seal closed the valuables envelope.

__ Sign the envelope flap of the closed valuables envelope, along with the patient.

__ Place a patient label on the valuables envelope.

__ Complete a Valuables Form (#4679).

__ Place a patient label on the Valuables Form.

__ Take the valuable envelope and form to Nursing Administration. (You will bring back the valuables form to the unit.)

__ Place the valuables form in the patients' chart under the discharge section.

__ Document what patient items are being stored in Nursing Administration on the belongings form.

Search, inventory, and documentation

__ Place the belongings in the laundry room, if they cannot be searched at the time of admission.

__ Place a patient label on all belongings with patient ID label and “Not searched” label that are to be stored in the laundry room, or workshop.

__ Perform hand hygiene in preparation of searching the patients' belongings.

__ Put on gloves to comply with universal precautions.

__ Ask the patient if they would like to be present during the belongings search.

__ If the patient declines to be present during the search, document in a focus note, patient refusal and the reason the patient declined to be present (if given).

__ Two staff will search the patient's belongings to provide a witness.

__ If the patient requests to be present, the belongings will be searched in the multipurpose room, conference room, or consult room in view of the video camera.

__ If the patient declines to be present for the search, two staff will search the items in view of a video camera.

__ Carefully search each patient item, the patient will be given to have in their room, for contraband (empty pockets, turn clothing inside out, look for strings, flip book pages, etc.)

__ Large items or items that have multiple items (e.g., suitcase, duffel bag, purse, backpack, et.) will not be searched.

__ Label the unsearched item(s) with patient name and room and "not searched".

__ Document the unsearched item(s) on the Belongings Form and "not searched" and the item(s) location.

__ Document each patient item in PowerChart on the belongings form located in the adhoc form ("Belongings - BH")

__ Document which staff were present for the search in a focus note.

__ Print two copies of the completed belongings from once the patients' belongings have been searched, inventoried, and documented.

__ Ask the patient to sign one copy of the Belongings Form.

__ Place the signed Belongings Form in the discharge section of the chart.

__ Give the second copy of the Belongings Form to the patient.

AFTER ADMISSION

__ **If a patient is given an item that is documented as being in their locker, open a new Belongings Form (adhoc) and indicate the patient is in possession of the item. Do not add to the original Belonging Form from admission!

__ **If an item that is documented on the Belongings Form is sent home, open a new Belongings Form (adhoc) and indicate that the item was sent home. Do not add to the original Belongings Form from admission!

__ **When additional belongings are brought to the patient after admission, open a new Belongings Form (adhoc) and update Belongings Form. Do not add to the original Belongings Form from admission!

__ **When a patient requests an item that is listed on the Belongings Form as “with the patient” to be kept in their locker, open a new Belongings Form (adhoc) and update the Belongings Form to indicate the item is in their locker. Do not add to the original Belongings Form from admission!

__ **When a patient requests any valuables in their possession, in their assigned locker and/or in Nursing Administration be moved to a different location e.g. sent home, sent to nursing administration, etc. Indicate the new location on the waiver form and update the

location of the valuables on the Belongings Form. Do not add to the original Belonging Form from admission!

__ Print a new belongings inventory list each time the belongings list is updated.

__ Have the patient sign the most recent Belongings Form.

__ Make a copy of the updated Belongings Form.

__ Place the original in the chart and give the copy to the patient

Discharge

__ Remove all patient Belongings Forms from the patient's chart (discharge section)

__ Affix discharge sticker on the most up-to-date Belongings Form.

__ Remove patient belongings from □room, □locker, □bathroom, □soiled utility room, □Nursing Administration (valuables), □medication room (discharge medications, patient's own medication administered while hospitalized).

__ In a secure area, give the patient their belongings and the Belongings Forms.

__ Encourage the patient to use the most recent Belongings Form (based on date) to compare to belongings being returned to the patient with the Belongings Form.

__ Complete the discharge sticker.

__ Inform the patient once they sign the form, they are acknowledging that they have received all their belongings.

__ Make a copy of the signed Belongings Form and place in the patient chart.

__ If the patient reports an item listed on the Belongings Form is missing ,document the missing item in a focus note.

__ Provide the patient with the Recipient Rights Officers phone number.

Not Searched Label

NOT SEARCHED
SEARCHED
DATE: STAFF:

Discharge Label

Locations checked for patient belongings:

- ❑ Belongings Locker
- ❑ Patient's room
- ❑ Bathroom container
- ❑ Personal Medication prescribed during admission
- ❑ Valuables sent to nursing administration
- ❑ Soiled Utility

My signature indicates that I have received all my belongings upon discharge and my acknowledgement that Munson is not responsible for and shall not be liable to me for any missing items that I have not raised at the time this acknowledgement was signed.

Patient signature:

Staff signature:

Date:

Form# 12558 (09/22)

MUNSON MEDICAL CENTER
MUNSON HEALTHCARE

D6 PERSONAL PROPERTY WAIVER OF RESPONSIBILITY

I ____ confirm there are no valuable items in my possession.
PATIENT NAME (PRINTED)

	Name (Printed)	Signature	Date
PATIENT			
STAFF			

Item	Description of Items in the Patient's Possession They Identified As Valuable
1.	
2.	
3.	
4.	
5.	
6.	
If the patient later decides to return any of the above listed items in order to move them to the unit locker, hospital safe, or to send them home, please enter the change in the table below and also in the patient's chart	

I ____, am requesting to keep the above valuable items in my possession, and by signing this form, I assume full responsibility for these items and I understand that Munson Medical Center will not be responsible for the replacement or reimbursement of any of the above items if they are lost, stolen, or damaged.
PATIENT NAME (PRINTED)

	Name (Printed)	Signature	Date
PATIENT			
STAFF			
If Applicable: ☐ *Patient's Guardian or Patient Advocate Notified of the Above Information*		*Date Notified:*	

Movement of Valuable Items

Item	Date	New Location			Patient Initials	Staff Name (Printed)	Staff Signature
		Unit Locker	Hospital Safe	Sent Home			

MUNSON HEALTHCARE

Form #4679 (05/19)

A. Place Patient ID Label on "Valuables Envelope"
B. Place Patient ID Label on the space provided below

C. Have the patient or 2 staff members sign on the seal of the bag

TAKE "VALUABLES ENVELOPE" TO ADMITTING (LOCATION: C1 ADMINISTRATION)

SECTION 1 - Admitting completes when accepting "Valuables Envelope."

Date	Time	Admitting (printed name) handling transaction

FILE THIS FORM IN PATIENT'S CHART UNTIL PATIENT OR DESIGNEE EXCHANGES IT FOR THE "VALUABLES ENVELOPE."

SECTION 2 - RELEASE NOTE - Complete when "Valuables Envelope" is being picked up by MMC Staff.

Give____ permission to pick up my "Valuables Envelope"
MMC Staff

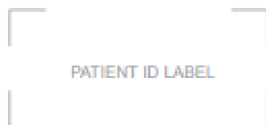
Date	Signature of patient requesting the return of his/her "Valuables Envelope" *NAME MUST MATCH PATIENT ID LABEL ON THIS FORM*

TAKE THIS FORM TO ADMITTING TO EXCHANGE FOR "VALUABLES ENVELOPE."

SECTION 3 - Admitting completes after "Valuables Envelope" has been returned to patient or designee.

Date	Admitting (printed name) handling transaction

- Munson Medical Center will not accept responsibility for personal belongings including valuables of admitted patients. Patients are encouraged to send valuables home. When situations do not make this possible, "Valuables Envelopes" are provided and are secured in Admitting 231-935-6340. (Refer to ***Patient Personal Belongings and Valuables Policy # 042.P001***)
- Valuables include, but are not limited to; wallets, money, important papers, jewelry, electronic devices, cell phones, and items that have sentimental value.
- This form indicates that patient's personal belongings (considered valuables) were surrendered to MMC, sealed in a "Valuables Envelope," labeled with patient ID, and secured in Admitting.
- Items surrendered to Munson Medical Center and secured in Admitting, may only be returned to patient/patient designee with photo ID.
- Valuables bag will be opened and disposed of if not picked up within 30 days post discharge.
- Questions concerning verification of designee are referred to Risk Management & Patient Relations.



PATIENT VALUABLES RECORD

Policy: "Patient Property Handling, Search, and Prohibited Items." View it at:

https://pstat-live-media.s3.amazonaws.com/pdf_cache/policy/19584143/53edf04d-89f6-4c8f-a3b6-8ac18f50899b/Patient%20Property%20Handling-%20Search-%20and%20Prohibited%20Items.pdf

Broset Violence Checklist

Background

Violence towards health care workers, especially in higher risk areas like mental health, has become increasingly common. Research suggests that the quality of patient care as well as nurses' satisfaction with work-life, are both affected when nurses fear violence from their patients (Clarke, Brown, & Griffith, 2010).

Violence has been defined as *"an act that includes physical force such as slapping, punching, kicking and biting; use of an object as a weapon; aggressive behavior such as spitting, scratching and pinching; or verbal threat involving no physical contact"* (Nolan et al., 2001, p. 421).

Risk factors for violence in the mental health setting have been classified as: **internal, external,** or **interactional.**

Internal factors: Inherent characteristics of the patient; further divided into two categories:

- **Static:** Demographics, history, diagnosis, personality; or
- **Dynamic:** Untreated psychiatric symptoms such as psychosis.

External factors: Environmental factors, such as privacy and unit design.

Interactional factors: Staff/patient relations.

Most research has focused on the determination of internal risk factors most highly predictive of violence. Risk factors *most indicative* of violence include (Clarke, Brown, & Griffith, 2010):
.

- Age (younger);
- Sex (male);
- Past history of antisocial and violent behavior, and
- Substance abuse.

Interestingly, major psychiatric disorders and associated mental disturbances are *poor predictors* of violence (Clarke, Brown, & Griffith, 2010).

Several researchers have discovered that violence (especially assault) is *more likely to occur:* (Lanza et al., 1994; Ng et al., 2001).

- During mealtimes;
- During the afternoon, and
- In more congested areas on the unit, such as hallways and social rooms.

Common precursors to violence include:
(Powell et al., 1994; Yassi et al., 1998; Alexander & Bowers, 2004).

- Agitation;
- Placing restrictions on the patient's behavior (e.g. enforcing unit rules), and
- Provocation from other patients or visitors.

Current research is beginning to investigate violence that arises from conflicts between staff and patients.

Broset Violence Checklist (BVC)

Predicting violence in the health care setting has long created challenges for health care professionals. The traditional approach includes unstructured clinical risk assessments in the form of clinical judgment and intuition. Such assessments have been utilized throughout the health care setting with varying degrees of success.

More recently, a number of professional risk assessment tools have been created, and research has found that these, more structured tools, are more predictive of patient violence than the use of either clinical judgment or intuition.

One of these structured tools is the Broset Violence Checklist (BVC) (Almvik & Woods, 1999). The BVC is one of the only violence assessment tools available to aid in the prediction of violence potential in the inpatient psychiatric setting. More reliable than either clinical judgment or intuition, the BVC predicts the probability that a patient will turn violent during the first 72 hours post admission and throughout the entire length of a patient's stay on the unit.

The BVC is a six-item checklist that assists the nurse in determining a patient's potential for violence within the subsequent 24 hours. The BVC takes less than one minute to complete. It also helps standardize the observations among nurses, regardless of the nurse's clinical experience.

The BVC specifically assesses the presence of ***three patient characteristics:***

1. **Confusion.**
2. **Irritability.**
3. **Boisterousness.**

AND ***three patient behaviors:***

1. **Verbal threats.**
2. **Physical threats.**
3. **Attacks on objects.**

The creators of the BVC hypothesized that a patient who displays *two or more of these behaviors* is more likely to become violent within the subsequent 24 hour period than a patient who does not display such behaviors.

Scoring

The BVC assesses the presence or absence of the above-mentioned patient characteristics and behaviors. A short definition of each of the six categories is included in the assessment tool.

Each of the six items is scored for its presence "1" or its absence "0." The scores are then totaled and interpreted in the following way. A score of "0" signifies a very low risk for violence. Scores of "1" or "2" suggest a moderate risk, requiring preventive measures. Scores of "3" and higher (maximum = 6) indicate that the risk of violence is very high and immediate preventive measures should be activated, including a plan for how staff will handle any violence that occurs.

The BVC should be completed during each shift. If the patients' behavior is escalating the RN can complete a BVC through "Adhoc" section in Powerchart. It is important to reevaluate the patients' BVC, if they received medication due to an elevated BVC, to measure effectiveness.

References:

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Yassi, A., Tate, R., Cooper, J., et al. (1998). Causes of staff abuse in health care facilities: implications for prevention. *American Association of Occupational Health Nursing Journal* 46, 486-491

Broset Violence Checklist

<u>Intervention & Scoring Guidelines</u>

- **ALL** D6 MENTAL HEALTH patients will receive a BVC score:
  - **Upon admission to the unit;**
  - **Each shift (see time requirements below);**
  - **Any time a patient exhibits positive BVC behaviors &/or characteristics; &**
  - **One hour after medication has been administered based on a BVC score**

- BVC Scoring Parameters: *(make sure to change the time in the Powerchart if you don't enter the score right away).*

    - ♣ **7a-3:30p:** complete BVC by **10:00am**
    - ♣ **3:00p-11:30p:** complete BVC by **6:00pm**
    - ♣ **11:00p-7:30a:** complete BVC by **2:00am**

  <u>If a patient is sleeping,</u> complete the BVC by the scheduled time, & document "sleeping" in your Powerchart form.

Note: If you have already documented your BVC score for the shift, you will need to ad hoc a new form to record a positive BVC score if the patient's status changes.

<u>INTERVENTIONS BASED ON BVC SCORE:</u>

- **<u>For a score of 1,</u>** provide support to the patient and encourage use of individualized calming measures.
- **<u>For a score of 2</u>**, the patient will be offered a PRN medication and individualized calming measures will be encouraged
- **<u>For a score of 3+,</u>** a PRN medication <u>may be</u> administered. Security may need to be summoned for support.
  - The patient will have a repeat BVC one hour after medication administration. Nurses should assess the patient and document the effects of the medication in the PowerChart (focus note). Per the medication orders, a determination should be made regarding necessity for additional pharmacological interventions.

Unit Guidelines

The Michigan Mental Health Code requires that patients are informed of the guidelines for the unit on admission. This ensures that all patients are treated equally and expectations for behavior are clearly communicated. The unit guidelines primary focus is safety. Patients are not allowed certain items to provide a safe treatment environment. Additionally, the unit guidelines provide information re: behavior, access to certain items on the unit, visitor guidelines and what is considered contraband. Below are the unit guidelines that are given to the patient on admission and posted across from the nurses' station. Please take time to carefully review to ensure you are prepared when a patient asks you a question. Talk with your preceptor if you have any questions or want to understand the reason for the guideline.

MUNSON HEALTHCARE

D6 MENTAL HEALTH UNIT GUIDELINES

We wish you to have a good treatment stay. The following guidelines are for the safety and well-being of all patients and their families. Thank you for your cooperation. If you have questions, please feel free to contact your nurse, unit manager or Recipient Rights Officer - **231-935-2335**.

VISITING HOURS

Monday - Friday: 6 pm - 7 pm / Saturday - Sunday: 1 pm - 2 pm and 6 pm - 7 pm

*****Holidays may affect the hours listed above, please confirm visiting hours with staff*****

- Only 2 people may visit a patient at one time.
- Children under the age of 16 years are not allowed on the unit. Minors ages 16-17 must be accompanied by a responsible adult. Proof of age is required (Drivers License, School ID)
- Visitors suspected by D6 staff to be intoxicated and/or impaired due to substance misuse will not be allowed on the unit. Future visits for this individual may be denied.
- For privacy reasons, recently discharged patients are not allowed to visit other patients on the unit for 6 months.
- Visitors must leave all belongings in an assigned locker upon entering the unit, including cell phones, jackets, hats, purses, wallets, and keys.
- Any items brought to patients will be searched by staff.
- Visitation will take place only in common areas designated by D6 staff.
- No visitors are allowed in patient rooms or unit hallways.
- For the safety of the patients and the unit, visitors and patients are not allowed to have physical contact e.g. kissing, hugging, sitting on laps, etc. Failure to follow this guideline may result in loss of visiting privileges and visitor being escorted off the unit.

TELEPHONE

- No calls are allowed during scheduled group/activity times to prevent interference with your treatment groups.
- Telephones are available from 7:30 AM to 10:00 PM.
- Phone calls are allowed once per hour, with a maximum 10 minutes per call, whether it is an incoming or outgoing call.
- No cell phones are allowed on the unit.
- Messages will be taken for any incoming calls for patients. The caller will be asked to leave a name and number and your presence on this unit will not be revealed to the caller. The caller will be told that if you are here and wish to, you will return the call.

PROHIBITED ITEMS

- All sharp items including razor blades, knives or weapons of any type *(Illegal items will be turned over to security as outlined by hospital policy)*.
- Non-prescribed drugs, recreational drugs including Medical Marijuana *(Illegal items will be turned over to security as outlined by hospital policy)*.
- Prescription medications will be placed in a valuables envelope and kept in the hospital safe.
- Glass or breakable items.
- Lighters or matches.
- Tobacco or smoking items *(chew, snuff, and dip, snus, water vapor cigs, e-cigs, or any other smoking/tobacco product)*.
- Personal electronic or electrical devices *(computers, cellphones, tablets, IPODs, curling irons, hair dryers, heating pads, radios, etc.)*
- Perfume or other scented products.
- D6 staff may prohibit any item that has the potential to cause harm.

*** If a patient accepts any prohibited items from visitors, the visitor may be prohibited from visiting in the future and/or patient's visiting privileges may be restricted, in accordance with the "Restricting Patient Rights" section of Michigan Mental Health code.**

BEHAVIOR

- We promote a safe and calm environment. We do not tolerate any form of violence. Aggressive, disruptive, or violent behaviors will not be tolerated by patients or visitors. Hospital Security and/or Law Enforcement will be called for any form of violence or aggression.
- Patients are not allowed in other patients' rooms. Please tell staff immediately if any patient enters or attempts to enter your room. Your room is your own personal space.

PATIENT ID LABEL
HERE

CONTINUE TO NEXT PAGE ➔

BEHAVIOR CONTINUED...

- For safety and therapeutic reasons physical contact (hugging, kissing, hitting, etc.) is not allowed between patients. If a patient touches you or attempts to touch you, please tell staff immediately.
- If your behavior is disruptive during a therapy group you may be asked to leave.
- The following behaviors are not allowed: illegal activities, vulgarities, obscenities, profanity, sexually explicit language, ethnic, race, religious, or gender intimidation or any other behavior that interferes with the therapeutic milieu.

*** D6 staff maintains the right to determine if behaviors are disruptive, aggressive or otherwise inappropriate.**

CLOTHING/BELONGINGS

Patient dress on D6 is casual street clothes and footwear. Shoes are allowed only with a doctor's order. Clothing should be comfortable, safe, and must not disrupt the therapeutic environment of the unit. All belongings will be searched during admission to D6 and stored. You may elect to be present during this search. Patients may keep a maximum of 3 changes of clothing in their room.

- The hospital is not responsible for lost, stolen or damaged property kept in your possession. Please identify all valuable items to staff. You may choose to send home the valuables, request they be securely stored in the hospital safe or documented on the waiver of responsibility form and kept in your possession.
- Not Permitted: Mini-skirts, short shorts, hats, hoods, sunglasses, or bandanas. Clothing that promotes or encourages the use of drugs, alcohol or tobacco, exhibits illegal activities, vulgarities, obscenities, profanity, sexually explicit language, or ethnic or gender intimidation.

FOOD/DRINK

- Meals and snacks should be consumed in the community dining room. Unless staff directs otherwise.
- All drinks must have lids on them.
- No outside food may be brought onto the unit except a limited amount of individually wrapped hard candy. Meals and snacks will be provided on the unit.
- Please keep food and drinks in your room while attending groups.
- No food can be saved from meal trays or kept in the room. Please order only what you plan to eat for each meal.
- Meals cannot be shared. Other patients may be on a special diet.
- Two cups of caffeinated coffee and/or soda may be ordered on breakfast and lunch trays from the dietary department. No caffeine is allowed **after 2:00 pm** due to possible reactions with medications and impact on mood and sleep.

COMMON AREAS

- Common areas for socializing include dining and multipurpose room or patient lounge.
- To protect everyone's confidentiality and privacy please do not loiter at nurses station or in front of patient rooms.
- Dining and activity room and patient lounge will be open daily from 6 am to Midnight.
- The doors to the dining and activity room and patient lounge will remain open with the lights on at all times. The doors may be closed for group sessions with the therapist present.
- For sanitary reasons, no pillows or blankets are allowed in common areas. They must be kept in your room.
- Do not lie on the floors or on the furniture in the common areas.
- Yoga mats must remain in the exercise equipment area.

SECURITY CAMERAS

For patient and staff safety, the common areas of this unit are monitored by video surveillance cameras. To ensure patient privacy, video cameras are not permitted in patient rooms or bathrooms.

PATIENT SIGNATURE ____________ DATE ____________ TIME ____________

PATIENT NAME *(PRINTED)* ____________

PATIENT ID LABEL
HERE

D6 MENTAL HEALTH Precautions Procedures

Various types of unit precautions are in place to ensure the safety of D6 MENTAL HEALTH patients and staff. Depending on symptoms, behaviors or reported thoughts (suicidal/homicidal, command hallucinations), specific precautions will be ordered for the patient on admission. The precautions provide another layer of safety and assist staff in monitoring the patient providing a specific focus e.g. staff monitors a patient on elopement precaution for walking close to exit doors. Each patients' precautions will be listed on the large patient white board in the report room. Precautions can be ordered or discontinued after the patient has been admitted to the unit based on changes in their symptoms or behavior. Below is a review of the precautions that are utilized on D6.

General Procedures

- Each patient will be rounded on no less than every 30 minutes.
- Patient location is documented on the Patient Observations (form #3929).
- Each patient will be assessed individually and a physician will order the necessary precautions.
- Only a physician may discontinue a precaution.

Specific Precautions

A patient may be placed on one or more of the following precautions during their treatment on D6 MENTAL HEALTH:

GENERAL PRECAUTIONS (GP):

The patient requires a moderate level of observation and is considered to not need more restrictive monitoring.

- The intent: to provide routine assessment of patient behaviors and to maintain patient safety.
- Frequency of observation: every 30 minutes.
- Patient location is documented on the Patient Observations (form #3929).
- The patient must be supervised if off unit for procedure.

CLOSE OBSERVATIONS (CO):

The patient requires frequent monitoring but not necessarily constant observation by the staff to prevent unintentional harm to self or others and destruction of property.

- Patient may have:
    - Unpredictable behavior that requires frequent redirection
    - Bizarre behavior that may lead to destruction of property or unintentional harm to self or others
    - Sexually inappropriate behaviors
    - A risk to respond to command auditory hallucinations

- Frequency of observation: every 5, 10, or a minimum of 15 minutes (Order must be written for a specific interval).
- Patient location is documented on the Patient Observations Form (form #3929).
- Assessment of patient behaviors or verbalizations that demonstrate the need for this level of observation will be documented in the patient record by the RN no less than once per shift.

SUICIDE PRECAUTIONS (SP):

The patient requires frequent monitoring to prevent intentional harm to self.

- The patient has:
  - Directly or indirectly expressed suicidal ideation, and/or
  - Plan or intent, and/or
  - Has attempted suicide in the immediate past, and/or
  - Experiences command auditory hallucinations to harm self
- Frequency of observation: every 15 minutes.
- Patient location is documented on the Patient Observations Form (form #3929).
- The patient is not allowed to have any belongings and/or items that staff may determine to be potentially dangerous, which may include clothing, sheets, etc.
- The patient's suicidality is assessed every shift and PRN to determine the patient's risk and intent and need to continue precaution restrictions. This assessment is documented in each shift's Behavioral Health Assessment (completed by RN).

ELOPEMENT PRECAUTIONS (EP):

The patient requires frequent monitoring to prevent unauthorized leave from the unit that may lead to harm to self or others.

- The patient has:
  - Behaviorally demonstrated and/or verbalized a desire to leave the unit against medical advice
  - Is at risk to plan and institute an **elopement** from the unit
- Frequency of observation: every 15 minutes.
- The patient cannot have access to their shoes without a provider order.
- Patient location is documented on the Patient Observations Form (form #3929).
- **Elopement precaution signs** will be posted on the main entry door and back door leading into the break room. Purpose: to alert hospital staff.
- **The patient may not leave the unit for tests** unless provider assesses patient is at low risk for elopement and documents same.
- The patient's elopement risk is assessed every shift and PRN and assessment is documented in the nursing documentation.

D6 MENTAL HEALTH Precautions Procedures

<u>1:1 PRECAUTIONS (1:1)</u>

The patient requires continuous observation by a staff in close proximity to the patient to prevent intentional or unintentional harm to self or others.

- Patients requiring this level of observation may be:
  - Suicidal with intent to harm self
  - High risk for pulling out tubes (feeding tubes, urinary catheter, IV)
  - High risk for falls
  - Confusion
  - Wandering due to confusion
  - Impulsive
  - Inappropriate Behavior (sexual, aggressive, etc.)
- <u>Frequency of observation: continuous visual observation.</u>
- Patient location is documented on the Patient Observations Form (form #3929).
- If the patient has a high risk for violence the staff person can monitor the patient using line of site to keep out of striking distance of patient (provider order required).
- The RN will document patient behaviors or verbalizations demonstrating the need for this level of care. Documentation will take place no less than once per shift.

<u>ASSAULTIVE PRECAUTIONS (AP)</u>

The patient requires frequent monitoring to prevent harm to others.

- Patients requiring this level of monitoring may be:
  - Verbally or physically threatening
  - High risk to act on those threats
  - Poor impulse control
  - History of violent behaviors in the recent past
- <u>Frequency of observation: every 15 minutes.</u>
- Patient location is documented on the Patient Observations Form (form #3929).
- The High Acuity Protocol will be implemented to include a behavioral plan
- Security will be notified of the presence of a potentially violent patient and the possibility of an emergency call.
- Staff will frequently assess the patient for signs of escalating behavior and use de-escalation techniques early.
- Staff will use caution when in close proximity to the patient and remain out of striking distance when the patient is demonstrating threatening behaviors.
- The PCC or charge nurse will assess the need for additional staff in consultation with the unit manager.
- Assess the risk of potential harm to others every shift and PRN. The RN will document this information in the patient's medical record.
- **The patient may not leave the unit for tests** unless provider assesses patient is at low risk for aggressively acting out and documents same.

D6 MENTAL HEALTH Precautions Procedures

SEXUALLY ACTING OUT PRECAUTIONS (SAOP):

The patient requires frequent monitoring to prevent inappropriate sexual behavior e.g. actions, comments etc., and/or to acknowledge allegations of a sexual nature that have potential to traumatize other patients and/or place patient or staff at risk.

- The Patient:
  - Has made allegations of a sexual nature toward a peer or staff
  - Displayed sexually inappropriate behavior toward peers or staff
  - Verbalized sexually inappropriate remarks toward a peer or staff
- Frequency of observation: every 15 minutes.
- Patient location is documented on the Patient Observations Form (form #3929).
- **Recipient Rights officer will be notified of behaviors prompting order for SAO precautions.**
- If allegations of a sexual nature are made toward staff, **all** staff will interact with the patient in a common area monitored by video. If this is not possible, 2 staff will be present with patient interactions. If allegations are toward a specific staff person modification of patient assignment will be reviewed.
- When SAO precautions are ordered due to interactions with a peer or staff, boundaries will be established and reviewed with the patient and behavioral plan developed as appropriate.
- Staff witnessing or experiencing behavior(s) by the patient will document the event(s) in detail (fact based) in the patient's chart.
- Patient may need to be continually observed (1:1) if they are unable to control behavior due to disease process.
- Assessment of patient behaviors, verbalizations and mental status demonstrating the need for this level of observation will be documented in the shift summary no less than once per shift.

Policy: "Precautions - Inpatient Behavioral Health Unit." View it at:

https://pstat-live-media.s3.amazonaws.com/pdf_cache/policy/19584312/c984d53c-72b5-4d18-b540-09d4fc6bdc57/Precautions%20-%20Inpatient%20Behavioral%20Health%20Unit.pdf

Master Treatment Plan

Making it Meaningful

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Behavioral Health

February 2024

Goal and Objective

Goal

This course provides information for staff on how to develop and complete an individualized Master Treatment Plan for a patient receiving care on the mental health unit as outlined in the Michgan Mental Health Code (MMHC).

Objective

By the end of this course, you will be able to develop a Master Treatment Plan that is:

- Individualized
- SMART (acronym)
- In compliance with regulatory requirements (CMS, MMHC, and TJC)

Master Treatment Plan (MTP)

- Guides the course of the patient's treatment while on D6.
- Identifies the patient's goals and objectives (realistic/achievable).
- Assists in evaluating the patient's progress.
- Facilitates discharge planning.
- Developed by multi-disciplinary team (includes patient and patient-identified supports.)

MTP *(cont.)*

Initial Treatment Plan

- The Joint Commission (TJC) requires an initial treatment plan be completed by an RN ***within the first 8 hours*** of admission.

Master Treatment Plan Meeting

- The Michigan Mental Health Code (MMHC) requires the multidisciplinary team to meet and develop an MTP ***within the first 72 hours*** of admission (does not include Sunday or holidays).

MTP Development

- There are several areas on the MTP that staff are expected to complete upon admission.
- Click the image below to see the blue highlighted areas indicating the areas needing to be completed. Examples have been included.

1 of 2 Automatic Zoom

MUNSON HEALTHCARE
Behavioral Health Services

Form #1415 (10/16) Page 1 of 2

1415

All areas checked are completed on admission ✓

DATE OF ADMISSION	DATE OF MEETING	ADMITTING DIAGNOSIS	PRIMARY NURSE	PSYCHIATRIST
✓	✓	✓	✓	✓

TEAM MEMBERS PARTICIPATING IN PLAN DEVELOPMENT:

STAFF INITIATING TREATMENT PLAN: ✓ DATE: ✓

PSYCHIATRIST: ______ SOCIAL WORKER: ______ NURSE: ______

MENTAL HEALTH THERAPIST: ______ CNS / NP: ______ CMH: ______

OCCUPATIONAL THERAPIST: ______ OTHER: ______ OTHER: ______

✓ PRESENTING PROBLEM:
A brief summary of why they came to the hospital - "Pt was brought to the ED by the police for suicidal thoughts and a plan to hang themself

✓ PATIENT STATED GOAL:
This can be completed on admission or in team rounding - "I want to get stable on my medications", "I want to feel better"

✓ MENTAL STATUS:
Describe the patient mental status on admission, additional information can be added during team rounds - "Alert & oriented" does not provide a complete description. Examples: depressed mood, hopeless, auditory hallucinations, tearful, flat affect, paranoid, anxious, presssured speech, flight of ideas

IDENTIFIED STRENGTHS: Intelligent, strong support system, treatment compliance, good work history, talents (artistic, musical), past accomplishment (10 years of sobriety)

IDENTIFIED BARRIERS / LIMITATIONS OF BEHAVIOR / MOVEMENT / ENVIRONMENT: Legal issue, homeless, unemployed, relationship stressors, financial issues, limited support system, substance use disorder,

LEGAL STATUS: ☐ FORMAL VOLUNTARY ☐ INVOLUNTARY

PSYCHOTROPIC MEDICATIONS: INITIAL TREATMENT & CLINICAL OBSERVATION

DATE	NAME	DOSE/FREQ	CHANGES/COMMENTS
✓ Write out all	information without abbreviations	Only include psychotropic medications - medications that treat the illness/symptoms	
2.23.21	Cymbalta	one capsule twice day	

MTP Goals and Objectives

Goals and objectives should reflect the patient's stated goals, which are documented on the front of the MTP.

	OCCUPATIONAL THERAPIST: ______	OTHER: ______	OTHER: ______
✓	PRESENTING PROBLEM: A brief summary of why they came to the hospital - "Pt was brought to the ED by the police for suicidal thoughts and a plan to hang themself		
✓	PATIENT STATED GOAL: This can be completed on admission or in team rounding - "I want to get stable on my medications", "I want to feel better"		
✓	MENTAL STATUS: Describe the patient mental status on admission, additional information can be added during team rounds - "Alert & oriented" does not provide a complete		
	description. Examples: depressed mood, hopeless, auditory hallucinations, tearful, flat affect, paranoid, anxious, presssured speech, flight of ideas		
	IDENTIFIED STRENGTHS: Intelligent, strong support system, treatment compliance, good work history, talents (artistic, musical), past accomplishment (10 years of sobriety)		

MTP Goals and Objectives *(cont.)*

Goals and objectives should reflect the patient's stated goals, which are documented on the front of the MTP.

1 of 1 Automatic Zoom

PROBLEM # 1	GOAL: Measurable & related to the pt's goal & dx: " Patient identified goal is to "feel better" and is dx'd with depression: Patient will report 50% improvement in mood absence of suicidal thoughts for 3 consecutive days				
PATIENT AGREES TO:		TARGET DATE	STAFF INTERVENTION / FREQUENCY	DATE ACCOMP.	STAFF RESPONSIBLE
Objective is related to pt. goal	write a date for each objective			write date obj. is completed	
1. Attending at least 2 groups per day to learn coping skills to manage depression symptoms for 3 days		3.2.21	Staff will encourage group participation and provide education on coping skills to reduce symptoms of depression		write discipline responsible for staff intervention (RN, BHT, MD MSW, LPC)
2. List three things they are grateful daily for five day & review with staff		3.5.21	Staff will provide support & resources for completion of gratefuls and provide time to review gratefuls daily		
3. Develop a sleep routine that will help increase sleep to 6-7 hours a night for 2 nights		3.6.21	Staff will provide information and education on good sleep habits provide feedback, to patient and record sleep		

MTP Goals

- As mentioned previously, the patient is expected to meet the set goals before discharge, “Patient Agrees To:”
- Staff interventions identify what staff will do to support the patient in accomplishing their goal and objectives, “Staff Intervention/Frequency:”

1 of 1 Automatic Zoom

PROBLEM # 1	GOAL: Measurable & related to the pt's goal & dx: Patient identified goal is to "feel better" and is dx'd with depression: " Patient will report 50% improvement in mood absence of suicidal thoughts for 3 consecutive days			
PATIENT AGREES TO:	**TARGET DATE**	**STAFF INTERVENTION / FREQUENCY**	**DATE ACCOMP.**	**STAFF RESPONSIBLE**
Objective is related to pt. goal	write a date for each objective		write date obj. is completed	
1. Attending at least 2 groups per day to learn coping skills to manage depression symptoms for 3 days	3.2.21	Staff will encourage group participation and provide education on coping skills to reduce symptoms of depression		write discipline responsible for staff intervention (RN, BHT, MD MSW, LPC)
2. List three things they are grateful daily for five day & review with staff	3.5.21	Staff will provide support & resources for completion of gratefuls and provide time to review gratefuls daily		
3. Develop a sleep routine that will help increase sleep to 6-7 hours a night for 2 nights	3.6.21	Staff will provide information and education on good sleep habits provide feedback, to patient and record sleep		

MTP Goals and Objectives

Staff initiating the MTP are expected to identify at least one goal and one objective, keeping in mind the goal must be…

- ❖ Realistic for the patient to accomplish during their inpatient stay.
- ❖ Aligned to the patient’s capabilities, level of symptoms, limitations, and willingness to cooperate.
- ❖ SMART (specific, measurable, attainable, realistic, and time-specific)

Measurable Goals and Objectives

What does measurable mean?

- ❖ Behavior, Frequency, and Duration
  - (what's expected, how much, and how often)
- ❖ SMART goals

Why is it important for goals/objectives to be measurable?

- ❖ Gives clear direction to the patient.
- ❖ Supports staff and patient to evaluate progress.

Format to Support Development of a Measurable Goal/Objective

Pt will + active verb	Expected Behavior (measurable/observable)	Frequency (How often)	Duration (How long)
Identify & use	3 coping skills to decrease anxiety	Daily	X 3 days

Active Measurable Verbs

- Demonstrate
- Identify
- Practice
- Verbalize
- Learn
- Seek out
- Participate
- Recognize
- Report
- Express
- Avoid
- Discuss
- Attend
- Take
- Journal/Write
- List
- Complete
- Explore
- Interact

Expected Behavior (Click each word)

Interact in a socially appropriate manner.
Utilize coping skills to reduce symptoms of depression.
Seek out staff, if having thoughts of suicide.
Discuss feelings of grief in process group.
Complete ADLs independently.
Use the treadmill to reduce anxiety.
Demonstrate thoughts that are goal-oriented and logical.

Duration (How long does the behavior need to be sustained?)

Interact in a socially appropriate manner for 3 consecutive days.
Utilize coping skills to reduce symptoms of depression for 1 week.
Seek out staff each time, if having thoughts of suicide for 5 consecutive days.
Complete ADLs independently for 2 weeks.
Will perform ADLs with minimal support daily for 3 days.

Frequency (How often should the behavior be completed?)

Interact in a socially appropriate manner at least twice a shift.
Utilize coping skills to reduce symptoms of depression 2-3 times a day.
Seek out staff each time, if having thoughts of suicide.
Complete ADLs independently 3 times a week.
Will perform ADLs with minimal support daily.

SMART Acronym = Measurability

Specific: What needs to be accomplished? Relate this to the presenting problem/issue and diagnosis.

Measurable: How will the nurse, patient, and/or family know the goal has been met?

Attainable: Can the goal be met with the resources available?

Realistic: Does the patient and/or family have the physical, emotional, and mental capacity to meet the goal?

Time-Specific: When will the goal be achieved?

SMART Goal Activity

Drag and drop the items to make the following goal SMART:

Identify 3-5 positive coping skills

reasons
daily
10
name
each shift
to decrease boredom
identify
every day
for three days
relate to
think of
1-3

Patient Agrees To:

Identify and practice | at least one | positive coping skill(s) | to decrease anxiety | for 3 consecutive days

Staff Interventions

Interventions need to be appropriate in order to:

- ❖ Help resolve the identified problem/issue.
- ❖ Support the patient to achieve the goal.

Staff Interventions Format:

Pt will… (Active Verb)	**Expected Behavior (Measureable)**	**Frequency (How Often)**	**Duration (How Long)**
Patient will identify and demonstrate	1 positive coping skill to decrease depression	daily	X 3 consecutive days

Staff will… (Active Verb)	**Modality (Measurable)**	**Frequency (How Often)**	**Duration (How Long)**
RN will meet with the patient	to discuss progress and identify learned coping skill	daily	for 10 minutes

Knowledge Check

Instructions: Select the most appropriate ***response*** that addresses the patient goal.

Patient Goal: The patient will identify and demonstrate one positive coping skill to decrease depression each day for 3 consecutive days.

STAFF INTERVENTION:

- (selected) A. The RN will meet with the patient each shift, while the patient is awake, to review documentation about their depression before discharge.
- B. The RN will document the patient's attendance in therapy group(s) each shift.
- C. The Therapist will let the RN know and/or document if the patient attended and participated in group each shift.
- A and C
- All of the above

Knowledge Check

Instructions: Select the most appropriate ***response*** that addresses the patient goal.

Patient Goal: The patient will identify and demonstrate at least one positive coping skill to decrease anxiety each day for three consecutive days.

STAFF INTERVENTION:

- A. The RN will discuss positive coping skills with the patient to determine if effective.
- B. The psychiatrist will meet with the RN and the patient to identify positive coping skills.
- (selected) C. The RN will meet with the patient each shift, while the patient is awake, to discuss effectiveness and document evidence whether or not the patient met the goal.
- All of the above
- None of the above

MTP Meeting

After reviewing the goals and staff interventions with the patient, the

- *Patient will be given the option to "agree", "partially agree", or "disagree" with the MTP.*
- *Patient signs/dates the MTP.*
- *Psychiatrist/Provider signs/dates the MTP.*
- *RN signs/dates the MTP.*
- *Therapist signs/dates the MTP.*

A copy of the MTP is given to the patient. The original is placed in the MTP folder/binder in the staff report room.

Conclusions

Master Treatment Plans (MTP):

- Are individualized and SMART.
- Provide patient with goals and objectives to achieve during hospitalization.
- Facilitate discharge planning.
- Include team members: clinical staff, the patient and any person that the patient designates to participate in the planning.
- Are in compliance with regulatory requirements (CMS, MMHC, and TJC).

MTP

Questions?

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Last Revised	1/9/2026	Tags	Guideline
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Patient Property Handling, Search, and Prohibited Items

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Purpose

To preserve the safety and security of patients, employees and visitors, all patients and their belongings will be subject to search at admission or return to D6 Inpatient Behavioral Health - a service of Munson Healthcare Cadillac (D6) or for reasonable cause. Items brought in by visitors will also be searched.

Definitions

1. **Contraband:** means prohibited items that are not allowed at any Munson Healthcare (MHC) facilities, per the Munson Healthcare Weapons and Contraband, Including Search Procedure policy.
2. **D6:** means the Inpatient Behavioral Health Unit - a service of Munson Healthcare Cadillac, which is a psychiatric unit licensed under Section 1137 of the Michigan Mental Health Code.
3. **Hospital:** means MHC Cadillac.
4. **Limitation:** means the modification of a right that is applied on an individual, case-by-case basis.
5. **Master Treatment Plan:** means the patient's individualized plan of services (IPOS), as defined by Section 330.1712 of the Michigan Mental Health Code.
6. **Patient:** means an inpatient who receives behavioral health services from D6, and who is also referred to as a "Recipient" under the Michigan Mental Health Code.
7. **Provider:** means the psychiatrist or psychiatric mid-level professional involved in the patient's care during their admission to D6.
8. **Security:** means the MHC Security Department.
9. **Receipt:** means a printed document containing a list of the patient's personal property brought with them, or dropped off for them, on D6 that was processed and documented by staff via the

unit search and inventory process. On D6, a printed copy of the PowerChart form "Belongings – BH" serves as the patient's receipt.

10. **Restriction:** means the modification of a right that applies to all patients equally, and is written down and posted on the unit. Restrictions are more commonly referred to as the unit's rules, which on D6, are known as the "Unit Guidelines".
11. **Valuables**: means any item of property belonging to the patient that they identify as having value, e.g. monetary or sentimental value.

Guidelines

Access, Storage, and Documentation

A. A patient admitted to D6 has the right to receive, possess, and use all personal property, including clothing, except in the circumstances and under the conditions set forth in this policy.

B. D6 shall provide a reasonable amount of storage space to each patient for his or her clothing and other personal property.

C. Prohibited, restricted, or limited items of personal property and/or items determined to be unsafe shall be securely stored in the patient's assigned belongings locker and/or sent home with the patient's family/friends, if requested or agreed to by the patient.

D. Storage on D6 is not provided for contraband. Security must be notified immediately to pick up any items that are considered by MHC to be contraband, which includes, but is not limited to, weapons of any kind, illegal drugs or illegal items, alcohol, medical or recreational marijuana, controlled substances or drugs, etc. (Refer to the Munson Healthcare Weapons and Contraband, Including Search Procedure policy).

E. Storage of a patient's own medication (including prescription, over-the-counter, herbal, or alternative products) brought from home shall follow the process set by MHC. (Refer to the Medications Brought in by Patients (Brown and White Bagging) – Patient Own Medications for Inpatients and Outpatients policy).

F. Patients are encouraged to send valuable items home with family members/friends, which may include, are not limited to, personal electronic devices, computers, wallets, money, jewelry, important papers, etc. When this is not possible, the MHC valuables process shall be followed. (Refer to the Patient Belongings and Valuables Policy).

G. If a patient requests to keep valuable items in their possession while they are on D6, then a "Waiver of Responsibility" shall be utilized in order to document:

   1. An inventory of the valuable items in the patient's possession,
   2. The patient's assumption of full responsibility for the valuable items, and
   3. Notification that the hospital will not be responsible for the replacement or reimbursement if the valuable items are lost or stolen.

H. Personal property that is brought onto D6 by the patient upon admission and/or is subsequently delivered to the patient during the course of their admission, after being searched and inventoried, shall be documented in the patient's medical record.

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I. A receipt, which contains a list of the patient's personal property taken into possession by D6, shall be given to the patient and any individual designated by the patient. This refers to all of the items searched and inventoried per subsection H above.

J. Any personal property stored will be returned to the patient to whom the property belongs at the time the patient is released from the facility

K. Patients shall be permitted to inspect personal property stored by D6 on their behalf at reasonable times.

    1. Reasonable time may be understood as the amount of time that is fairly required to do what is needed to be done, conveniently under the permitted circumstances.
    2. Factors to consider in determining reasonable time may include, but are not limited to, the frequency of recipient(s) requests, type of request, staff availability, acuity of the D6 milieu, time of day (i.e. during group time, shift change), etc.

L. Any personal property taken into possession and stored by D6 and/or the hospital shall be returned to the patient at the time of their discharge.

Prohibited Items and Limitations

A. Any restrictions or prohibitions of personal property shall be in writing and posted on D6.

B. Prohibited items that are not allowed on D6 include, but are not limited to, the following:

    1. Sharp objects,
    2. Weapons or explosives of any kind,
    3. Alcohol or recreational drugs (including mood-altering substances and marijuana),
    4. Personal/home or otherwise unauthorized medications,
    5. Glass or breakable items,
    6. Lighters or matches,
    7. Tobacco or smoking items (including chew, snuff, dip, water vapor cigarettes or vape pens, e-cigarettes, or any other smoking/tobacco product),
    8. Personal electronic or electrical devices (including computers, cell phones, tablets, cameras, curling irons, hair dryers, heating pads, radios, etc.),
    9. Perfume or other scented item, or
    10. Any item that that has the potential to cause harm, as determined by D6 staff member.

C. A provider's order shall be obtained for any individual exceptions that allow a patient access to, or possession of, excluded or prohibited items, and may include considerations such as time/frequency of use, terms of use, monitoring use, noncompliance and revocation of use, etc.

D. A limitation of an individual patient's possession, access to, or use of non-prohibited items shall be utilized to limit property in order to:

    1. Prevent the patient from physically harming himself, herself, or others, or
    2. Prevent theft, loss, or destruction of the property, unless a "Waiver of Responsibility"

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is signed by the patient. (Refer to Section II (G) above).

E. Limitations of an individual patient's property shall be justified, documented on the Limitation of Rights Master Treatment Plan Form# 12133 and documented in the patient's medical record.

F. The limitation will be removed when the circumstance that justified its adoption ceases to exist

Search and Seizure

A. Personal belongings of patients admitted to D6 are searched upon admission for prohibited and/or contraband items.

B. All searches of personal belongings upon admission shall:
   1. Be completed by two staff members - one to perform the search and one to witness the search,
   2. Allow the patient to be present during the search.

C. If the patient is unable or unwilling to participate in the search of their belongings upon admission, then two staff members will perform the search and document in the patient's medical record the reason for their non-attendance.

D. Subsequent searches of a patient's personal property or assigned room shall not occur, nor personal items seized by staff, unless:
   1. A room search is authorized in the patient's Master Treatment Plan (for example, a search is performed once per shift in order to look for unsafe items that could be used for self-harm), or
   2. There is reasonable cause to believe the patient is in possession of prohibited, contraband, or unsafe items and/or is in possession of items excluded under a limitation in their Master Treatment Plan.

E. The search of a patient's room shall consist of the following:
   1. Authorization to conduct a room search from the Behavioral Health and/or D6 Leadership staff, the patient's Provider, or lead therapeutic staff,
   2. The involvement of two staff members - one to perform the search and one to witness the search, and
   3. The presence of the patient during the search of their room, unless he or she declines to be present.

F. If any prohibited, contraband, unsafe, and/or specifically limited items are found during the room search, they shall be seized and removed from the possession of the patient. If the seized items belong to the patient, they must either be securely stored in the patient's assigned locker, sent home with the patient's family members/friends, or handled via the hospital's valuables, medication, and/or contraband handling processes as described in MHC policies. (Refer respectively to the following Munson Healthcare Weapons and Contraband, Including Search Procedure, Medications Brought in by Patients (Brown and White Bagging) – Patient Own Medications for Inpatients and Outpatients, and Patient Belongings and Valuables

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policies).

G. After the room search is completed, staff shall:
    1. Document in the patient's medical record the circumstances surrounding the search, which includes, but is not limited to, the following information:
        a. The reason and/or justification for initiating the search,
        b. The names of the staff members performing and witnessing the search,
        c. Whether the patient was/was not present for the search, and if not present, then confirmation the patient was asked to be present for search but subsequently declined this offer, and
        d. The results of the search, including a description of any property seized.
    2. Discuss the results of the search with the patient.

H. All searches will be conducted with respect for the patient's dignity and within the guidelines of the patient's rights (Refer to the Dignity and Respect policy).

I. All visitors to D6 shall:
    1. Store their personal belongings in designated lockers prior to entering D6,
    2. Be responsible for all personal belongings stored in the designated lockers for visitors,
    3. Not bring any contraband or prohibited items onto D6,
    4. Inform staff of all property brought to a patient

J. The following shall occur every time property is brought to, dropped off for, or received on behalf of a patent:
    1. The items shall be searched by a staff member in the presence of:
        a. The individual who brought/dropped of the property for the patient, and/or
        b. Two staff members in the presence of the patient (unless the patient declines to be present),
    2. Any prohibited items or contraband shall be removed and taken home by the visitor, or if this is not possible, handled according to the hospital policies and/or D6 processes referred to under Access, Storage, & Documentation.
    3. Items being given to the patient and/or stored on their behalf in the patient's designated locker shall be documented in the patient's medical record and an updated receipt given to the patient.

References

1. Michigan Mental Health Code, Section 330.1742 AR 7009
2. Michigan Department of Health and Human Services Administrative Rule 330.7009
3. Limitation of Rights Master Treatment Plan Form #12133
4. PolicyStat:

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a. Munson Healthcare Weapons and Contraband, Including Search Procedure
b. Medications Brought in by Patients (Brown and White Bagging) – Patient Own Medications for Inpatients and Outpatients
c. Patient Belongings and Valuables Policy
d. Dignity and Respect

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Attachments

Limitation of Rights Master Treatment Plan - 12133 (1).pdf

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	1/9/2026
Dir Behav Health	Terri Lacroix-Kelty: Exec Dir Service Line - Behavioral Health	1/7/2026
Document Owner	Lori Barrett: Mgr Nursing Services	1/6/2026

Applicability

Cadillac Hospital, Munson Medical Center

Standards

No standards are associated with this document

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Precautions - Inpatient Behavioral Health Unit

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Purpose

To provide a process for precautions on D6 Inpatient behavioral health - a service of Munson Healthcare Cadillac (D6)

Procedure

A. Precautions are in place to ensure the safety of the patient(s). It is recognized that the precautions may reduce the privacy and/or freedom of movement of the patient. The physician, in consultation with the treatment team, determines the needed precaution and removes the precaution as soon as possible to restore patient privacy and/or freedom of movement.

   1. It is the practice of D6 to round on each patient no less than every 30 minutes.
   2. Individual patients are clinically assessed and a physician order is entered in the electronic health record (EHR) placing the patient on the appropriate precaution(s).
   3. A registered nurse (RN) may institute a precaution before obtaining an order.
   4. Only a physician may discontinue a precaution.
   5. A physician order must be obtained for off-unit privileges.

General Procedures

A. Each patient will be rounded on no less than every 30 minutes.

B. Patient location is documented on the Patient Observations Form #3929.

C. Each patient will be assessed individually and a physician will order the necessary precautions.

D. Only a physician may discontinue a precaution.

Specific Precautions

A. A patient may be placed on one or more of the following precautions during their treatment on D6.

General Precautions (GP)

A. The patient requires a moderate level of observation, but more restrictive monitoring is not needed.

B. The intent: to provide routine assessment of patient behaviors and to maintain patient safety.

C. Frequency of observation: every 30 minutes.

D. Patient location is documented on the Patient Observations Form #3929.

E. The patient must be supervised if off the unit for a procedure.

Close Observations (CO)

A. The patient requires frequent monitoring but not necessarily constant observation by the staff to prevent unintentional harm to self or others and destruction of property.

B. Patient may have:

   1. Unpredictable behavior that requires frequent redirection
   2. Bizarre behavior that may lead to destruction of property or unintentional harm to self or others
   3. Sexually inappropriate behaviors
   4. A risk to respond to command auditory hallucinations

C. Frequency of observation: every 5, 10, or a minimum of 15 minutes (order must be written for a specific interval).

D. Patient location is documented on the Patient Observations Form #3929.

E. Assessment of patient behaviors or verbalizations that demonstrate the need for this level of observation will be documented in the patient record by the RN no less than once per shift.

Suicide Precautions (SP)

A. The patient requires frequent monitoring to prevent intentional harm to self.

B. The patient has:

   1. Directly or indirectly expressed suicidal ideation, and/or
   2. Plan or intent, and/or
   3. Has attempted suicide in the immediate past, and/or

C. Experiences command auditory hallucinations to harm self

D. Frequency of observation: every 15 minutes.

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E. Patient location is documented on the Patient Observations Form #3929.

F. The patient is not allowed to have any belongings and/or items that staff may determine as potentially dangerous, including clothing, sheets, etc.

G. The patient's suicidality is assessed every shift and as needed (PRN) to determine the patient's risk and intent and the need to continue precaution restrictions. This assessment is documented in each shift's Behavioral Health Assessment (completed by RN).

Elopement Precautions (EP)

A. The patient requires frequent monitoring to prevent unauthorized leave from the unit that may lead to harm to self or others.

B. The patient has:

1. Behaviorally demonstrated and/or verbalized a desire to leave the unit against medical advice
2. Is at risk of planning and instituting an **elopement** from the unit

C. Frequency of observation: every 15 minutes.

D. The patient cannot access their shoes without a provider order.

E. Patient location is documented on the Patient Observations Form #3929.

F. **EP signs** will be posted on the main entry and back door leading to the break room. Purpose: to alert hospital staff.

G. **The patient may not leave the unit for tests** unless the provider assesses the patient is at low risk for elopement and documents the same.

H. The patient's elopement risk is assessed every shift and PRN and assessment is documented in the nursing documentation.

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Precautions (1:1)

A. The patient requires continuous observation by staff near the patient to prevent intentional or unintentional harm to self or others.

B. Patients requiring this level of observation may be:

1. Suicidal with intent to harm self
2. High risk for pulling out tubes (feeding tubes, urinary catheter, intravenous [IV])
3. High risk for falls
4. Confusion
5. Wandering due to confusion
6. Impulsive
7. Inappropriate Behavior (sexual, aggressive, etc.)

C. Frequency of observation: continuous visual observation.

D. Patient location is documented on the Patient Observations Form #3929.

E. If the patient has a high risk for violence the staff person can monitor the patient using a line of site to keep out of striking distance of the patient (provider order required).

F. The RN will document patient behaviors or verbalizations demonstrating the need for this level of care. Documentation will take place no less than once per shift.

Assaultive Precautions (AP)

A. The patient requires frequent monitoring to prevent harm to others.

B. Patients requiring this level of monitoring may be:

    1. Verbally or physically threatening
    2. High risk to act on those threats
    3. Poor impulse control
    4. History of violent behaviors in the recent past

C. Frequency of observation: every 15 minutes.

D. Patient location is documented on the Patient Observations Form #3929.

E. The High Acuity Protocol will be implemented to include a behavioral plan

F. Security will be notified of the presence of a potentially violent patient and the possibility of an emergency call.

G. Staff will frequently assess the patient for signs of escalating behavior and use de-escalation techniques early.

H. Staff will use caution when near the patient and remain out of striking distance when the patient demonstrates threatening behaviors.

I. The Patient Care Coordinator or charge nurse will assess the need for additional staff in consultation with the unit manager.

J. Assess the risk of potential harm to others every shift and PRN. The RN will document this information in the patient's medical record.

K. **The patient may not leave the unit for tests** unless the provider assesses and documents them to be at low risk for aggressively acting out.

Sexually Acting Out Precautions (SAOP)

A. The patient requires frequent monitoring to prevent inappropriate sexual behavior e.g. actions, comments, etc., and/or to acknowledge allegations of a sexual nature that have the potential to traumatize other patients and/or place patient or staff at risk.

B. The Patient:

    1. Has made allegations of a sexual nature toward a peer or staff
    2. Displayed sexually inappropriate behavior toward peers or staff
    3. Verbalized sexually inappropriate remarks toward a peer or staff

C. Frequency of observation: every 15 minutes.

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D. Patient location is documented on the Patient Observations Form #3929.

E. **The Recipient Rights officer will be notified of behaviors prompting an order for SAOP.**

F. If allegations of a sexual nature are made toward staff, **all** staff will interact with the patient in a common area monitored by video. If this is not possible, 2 staff will be present with patient interactions. If allegations are toward a specific staff person modification of patient assignment will be reviewed.

G. When SAOPs are ordered due to interactions with a peer or staff, boundaries will be established and reviewed with the patient, and a behavioral plan will be developed as appropriate.

H. Staff witnessing or experiencing behavior(s) by the patient will document the event(s) in detail (fact-based) in the patient's chart.

I. Patients may need to be continually observed (1:1) if they cannot control their behavior due to the disease process.

J. Assessment of patient behaviors, verbalizations, and mental status demonstrating the need for this level of observation will be documented in the shift summary no less than once per shift.

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Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	1/8/2026
Dir Behav Health	Terri Lacroix-Kelty: Exec Dir Service Line - Behavioral Health	1/7/2026
Document Owner	Lori Barrett: Mgr Nursing Services	1/6/2026

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Standards

No standards are associated with this document

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Recipient Rights Complaint, Investigation, and Appeal

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Purpose

To provide a policy for Recipient Rights complaints, investigations, and appeals.

Scope

Policy applies to all D6 inpatient behavioral health - a service of Munson Healthcare Cadillac (D6) activities, operations, and sites and to all staff members, contract agents (including physicians) and volunteers.

Definitions

1. **Abuse:** means non-accidental physical or emotional harm to a recipient, or sexual contact with or without sexual penetration of a recipient that is committee by an employee, contract agent, or volunteer of MMC as those terms are defined by Section 502a of the Michigan Penal Code, 1931 PA 328, MCL 750.520a, Michigan Mental Health Code, Administrative Rules of the Michigan Department of Community Health, and the Abuse & Neglect policy.
2. **Advisor:** means the Recipient Rights Advisor(s) and Back-up Recipient Rights Advisor(s).
3. **Allegation:** means an assertion of fact made by an individual that has not yet been proved or supported with evidence.
4. **Appeals Committee:** means a committee appointed or designated by the Hospital Director or appointed designee under Section 1774 of the Michigan Mental Health Code.
5. **Appellant:** means the recipient, complainant, parent, or guardian who appeals a recipient rights finding or a respondent's action to an appeals committee.

6. **Code Protected Right:** means a right that is guaranteed in the Michigan Mental Health Code, the Administrative Rules of the Michigan Department of Community Health, or other applicable law.
7. **Complainant:** means an individual who files a rights complaint.
8. **D6:** means the inpatient Behavioral Health Unit - a service of Munson Healthcare Cadillac, which is a psychiatric unit licensed under Section 1137 of the Michigan Mental Health Code.
9. **Hospital Director:** means the MHC Cadillac Chief Executive Officer or appointed designee.
10. **Intervention:** means to act on behalf of a recipient to resolve a complaint alleging a violation of a code protected right.
11. **Investigation:** means a detailed inquiry into and systematic examination of an allegation raised in a rights complaint.
12. **MHC:** means Munson Healthcare
13. **Neglect:** means an act or failure to act committed by an employee, contract agent, or volunteer of MMC that denies a recipient the standard of care or treatment to which he or she is entitled under the Michigan Mental Health Code, Administrative Rules of the Michigan Department of Community Health, and the Abuse & Neglect policy.
14. **Office:** means the Office of Recipient Rights created by MMC under section 1755 of the Michigan Mental Health Code.
15. **Preponderance of Evidence:** means a determination that it is more likely that a right was violated than it was not, based upon the greater weight of the evidence not as to quantity, but as to quality.
16. **Recipient:** means an individual who receives behavioral health services from D6.
17. **Respondent:** means the service provider that had responsibility at the time of an alleged rights violation for the services with respect to which a rights complaint has been filed.
18. **Report of Investigative Findings (RIF)**: means a written investigative report completed by the Office of Recipient Rights
19. **Rights complaint:** means a written or oral statement that meets the requirements of section 1776 of the Michigan Mental Health Code.
20. **Rights Protection System:** means those elements including but not limited to complaint investigation and resolution, prevention, and monitoring required in the establishment of the Office of Recipient Rights by the Michigan Mental Health Code.

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Policy

D6 shall provide a uniformly fair, objective, and timely dispute resolution process for recipients and others acting on their behalf that protects the rights guaranteed by Chapter 7 and 7a of the Michigan Mental Health Code (PA 258 of 1974) and acting in compliance with certification standards established by the Michigan Department of Health and Human Services (MDHHS) Office of Recipient Rights.

Rights Complaints

A. A recipient, or another individual on behalf of a recipient, may file a rights complaint with the

office alleging a violation of the Michigan Mental Health Code or rules promulgated under the Michigan Mental Health Code.

B. Munson Healthcare and D6 employees, contract agents, and volunteers shall assist the recipient or other individuals to file a complaint or otherwise access the rights protection system. Refer also to the Duty to Report-Recipient Rights Violations policy.

C. The Office assures that individual representatives and others had ready access to complaint forms.

D. Rights complaints filed by recipients, or anyone on their behalf, are placed in a secure receptacle accessed only by the office.

E. Each rights complaint shall be recorded upon receipt by the Office, and acknowledgment of the receipt/recording of the complaint shall be sent along with a copy of the complaint to the complainant within five (5) business days.

F. The Office will notify the complainant within five (5) business days after it received/recorded the complaint if it determined that no investigation of the rights complaint is warranted.

G. The Office shall assist the recipient or other individual with the complaint process as necessary.

H. The Office shall advise the recipient or other individual that there are advocacy organizations available to assist in preparation of a written rights complaint and offer to make the referral. In the absence of assistance from an advocacy organization, the office shall assist in preparing a written rights complaint.

I. If a rights complaint has been filed regarding the conduct of the Hospital Director, the rights investigation shall be conducted by the Office of Recipient Rights of a Community Mental Health (CMH) services program or by the State of Michigan (MDHHS) Office of Recipient Rights, as decided by the MMC Board of Directors.

J. If the complainant communicates an allegation, but does not want to file a complaint, and if the allegation constitutes an apparent or suspected violation of a protected right under the Michigan Mental Health Code, then the Office will act as the complainant.

K. Complainants who communicate allegations that are outside the jurisdiction of the Office or that do not involve a protected right under the Michigan Mental Health Code shall, when possible, be provided referral information to complaint/grievance mechanisms available through internal procedures, other agencies, or to advocacy groups who may be of assistance. The Office may advocate on behalf of the recipient in response to those complaints.

L. If Munson Healthcare and D6 employees, contract agents, or volunteers fail to report apparent or suspected violations of rights, appropriate administrative action will be taken. Refer also to the Duty to Report-Recipient Rights Violations policy.

M. Upon receipt of a complaint, the Office will follow the investigation and Intervention procedures listed herein.

N. Munson Healthcare and D6 must ensure complainants, staff of the Office of Recipient Rights, and any staff acting on behalf of a recipient will be protected from harassment or retaliation resulting from recipient rights activities and that appropriate disciplinary action will be taken if there is evidence of harassment or retaliation.

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Investigations

A. The office shall initiate an investigation of apparent or suspected rights violations in a timely and efficient manner.

B. In cases involving alleged abuse, neglect, serious injury, or death when a rights violation is apparent or suspected, an investigation must be immediately initiated by the office.

C. Investigations will be conducted in a manner that does not violate employee rights.

D. Investigation activities for each rights complaint shall be accurately recorded by the office.

E. The office shall determine whether a right was violated by using the preponderance of the evidence as its standard of proof.

F. The office shall issue a written status report every 30 calendar days during the course of the investigation. The status report shall be submitted to the complainant, the respondent, and the responsible Hospital Director. The status report shall include all of the following:

    1. Statement of the allegation(s),
    2. Statement of the issues involved,
    3. Citations to relevant provisions of the Michigan Mental Health Code, rules, policies, guidelines, and other laws,
    4. Investigative progress to date,
    5. Expected date for completion of the investigation.

G. Investigations will be completed within 90 calendar days after receipt of the complaint, unless awaiting action by external agencies. Issuance of the written investigative report may be delayed pending completion of investigations that involve external agencies, including law enforcement agencies, the Department of Human Services (Adult Protective Services, Child Protective Services, the Office of Child and Adult Licensing, etc.), or others.

H. Upon completion of the investigation, the office shall submit a written investigative report (RIF) to the Hospital Director. The report shall include all of the following:

    1. Statement of the allegations.
    2. Statement of the issues involved.
    3. Citations to relevant provisions of the Michigan Mental Health Code, rules, policies, guidelines, and other laws.
    4. Investigative findings.
    5. Conclusions.
    6. Recommendations, if any.

I. The Hospital Director, shall submit a written summary report to the complainant and recipient, if different than the complainant, and, if applicable, to the recipient's legal guardian within 10 business days after the Hospital Director receives a copy of the investigative report from the office.

J. The summary report shall include all the following:

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1. Statement of the allegations.
2. Statement of the issues involved.
3. Citations to relevant provisions of the Michigan Mental Health Code, rules, policies, guidelines, and other laws.
4. Summary of investigative findings.
5. Conclusions.
6. Recommendations, if any.
7. Action taken, or plan of action proposed, by the respondent.
8. 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.

K. Information in the summary report shall be provided within the constraints of Sections 1748 (Confidentiality) and 1750 (Privileged Communication) of the Michigan Mental Health Code

L. Information in the summary report shall not violate the rights of any employee (PA 397 of 1978, Bullard-Plawecki Employee Right to Know Act).

M. At the time the investigation is initiated and completed (the summary report is sent), the Rights Office will inform the recipient or other individual of the option of mediation and under what circumstances and when it may be exercised.

N. If the summary report contains a plan of action, which was not completed at the time the report was sent to the complainant, then the Hospital Director must send a letter or amended summary report indicating when the action was completed and the date the action occurred to:

    1. The Office of Recipient Rights,
    2. The complainant,
    3. The recipient (if different from the complainant), and
    4. The recipient's guardian, if applicable.

O. If the plan of action describes action that differs from that indicated in the summary report, the letter or amended summary report (referred to in section N above) must detail the action taken, the date of the action, and indicate that an appeal on this action may be made within 45 days.

P. A rights investigation may be reopened or re-investigated by the office if there is new evidence that was not presented at the time of the investigation.

Q. If an investigation is returned by an Appeals Committee for re-investigation:

    1. The Office shall complete the reinvestigation within 45 days following the standards established in Section 330.1778 of the Michigan Mental Health Code.
    2. The Hospital Director shall, upon receipt of the Report of Investigative Findings, take appropriate remedial action and shall submit a written Summary Report to the complainant, recipient (if different than the complainant), guardian, and the appeals committee within 10 business days.

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R. If an investigation is returned to the Hospital Director by an Appeals Committee with a request for additional or different action, a response shall be sent within 30 days as to the action taken or justification as to why it was not taken. The response shall be sent to the complainant, recipient (if different than the complainant), guardian, and the appeals committee.

S. If the appeal concerns the timeliness of the investigation and the Appeals Committee confirms that the investigation was not initiated or completed in a timely manner, the Appeals Committee recommends that the Hospital Director address the cause of the lack of timeliness with the Recipient Rights Advisor.

T. If the Appeals Committee notifies the Chair of the MHC Board of Directors of a recommendation to seek an external investigation from the Michigan Department of Health and Human Services Office of Recipient Rights (MDHHS-ORR), the Board shall send a letter of request to the Director of MDHHS-ORR within five (5) business days of receipt of the request from the appeals committee. The Hospital Director making the request shall be responsible for the issuance of the summary report, which will identify the grounds and advocacy information listed in the "Appeals Process" Section of this policy and MDHHS-ORR Appeals Committee as the committee for any appeal.

Interventions

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A. The office may undertake an intervention when the facts are clear and the remedy, if applicable, is clear, easily obtainable within 30 days, and does not involve statutorily required disciplinary action under Section 1722 (2) and 1755 (3) (a) of the Michigan Mental Health Code (which include alleged violations of abuse, neglect, retaliation, harassment).

B. The office shall complete the intervention not later than 30 days after it receives the rights complaint.

C. The office shall initiate interventions into apparent or suspected rights violations in a timely and efficient manner.

D. Intervention activities for each rights complaint shall be accurately recorded by the office.

E. The office shall determine whether a right was violated by using the preponderance of the evidence as its standard of proof.

F. Upon completion of the intervention, the office shall submit a written letter to the complainant. The intervention letter, at a minimum, must contain the following elements:

    1. The specific action taken by the office, on behalf of the complainant, to resolve the complaint.
    2. Identification of the protected right under the Michigan Mental Health Code.
    3. A statement indicating whether the allegation of a rights violation is substantiated or not substantiated.
    4. If the allegation is substantiated, the specific remedial action taken is identified.
    5. The right of the complainant of their right to request an investigation pursuant to the Investigation Subsection above and Section 1778 of the Michigan Mental Health Code within 30 days of receipt of the intervention letter.

G. A rights investigation may be opened by the office if there is new evidence that was not

presented at the time of the intervention, or if the complainant requests such under the Investigation Subsection above.

Substantiated Violations

A. If it has been determined through investigation or intervention that a right has been violated, the Hospital Director will take appropriate remedial action that meets all of the following requirements:
    1. Corrects or provides for a remedy for the violation.
    2. Is implemented in a timely manner.
    3. Attempts to prevent a recurrence of the violation.

B. If it has been determined through investigation that a right requiring disciplinary action under Section 1722 (2) and 1755 (3) (a) of the Michigan Mental Health Code (which are abuse, neglect, retaliation, harassment), the Hospital Director, or other service provider for contractees, shall take appropriate disciplinary action as defined by Section 7035 (1) of the Administrative Rules, which must be one of the following:
    1. Official reprimand.
    2. Demotion.
    3. Suspension.
    4. Reassignment.
    5. Dismissal.

C. The disciplinary or remedial action taken on substantiated violations shall be documented in writing and made part of the record maintained by the office.

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Appeal Process

A. Appeals must be accepted if filed within 45 days after receipt of the summary report under the Investigations Section above and Section 1782 of the Michigan Mental Health Code.

B. An appeal shall be based on one of the following grounds:
    1. The investigative findings of the office are not consistent with the facts or with the law, rules, policies, or guidelines.
    2. The action taken or plan of action proposed by the respondent does not provide an adequate remedy.
    3. An investigation was not initiated or completed on a timely basis.

C. The office shall advise the complainant that there are advocacy organizations available to assist in preparing the written appeal and shall offer to refer the complainant to those organizations. In the absence of assistance from an advocacy organization, the office shall assist the complainant in meeting the procedural requirements of a written appeal.

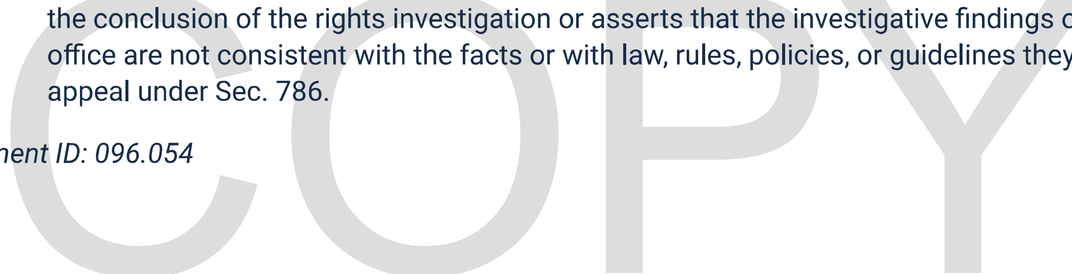
Appeals Committee

A. The Hospital Director may, by agreement with the local CMH services program, designate the appeals committee of that local CMH services program to hear an appeal of a decision on a recipient rights matter brought by or on behalf of a recipient of that CMH services program.

B. The Hospital Director shall, by agreement with the MDHHS Office of Recipient Rights, designate the appeals committee appointed by the MDHHS Office of Recipient Rights to hear appeals of rights complaints or decisions on a recipient rights matter brought against D6 by or on behalf of an individual who is not a recipient of a CMH services program.

C. If the appeals committee recommends that the governing body of the LPH request an external investigation by MDHHS rights office, the governing body must make the request to the director of MDHHS rights office in writing within 5 business days of receipt of the request from the appeals committee. An external investigation must be conducted within the timeframes outlined under Sec. 778. The MDHHS right office must submit an amended investigative report to the hospital director and governing body of the LPH. Within 10 business days of receipt of the amended report the hospital director must issue an amended summary report in compliance with Sec. 782. The amended summary report must be submitted to the appellant, recipient if different than the appellant, the recipient's legal guardian, if any, the parent of a minor recipient, rights office and the appeals committee. If the appellant still disagrees with the conclusion of the rights investigation or asserts that the investigative findings of the rights office are not consistent with the facts or with law, rules, policies, or guidelines they may file an appeal under Sec. 786.

Document ID: 096.054



Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	1/6/2026
Dir Behav Health	Terri Lacroix-Kelty: Exec Dir Service Line - Behavioral Health	1/2/2026
Document Owner	Terri Lacroix-Kelty: Exec Dir Service Line - Behavioral Health	1/2/2026

Applicability

Cadillac Hospital, Munson Medical Center

Standards

No standards are associated with this document

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Status Active PolicyStat ID 19584892

Origination	12/7/2004	Owner	Lori Barrett: Mgr Nursing Services
Last Approved	1/8/2026	Area/ Department	Behavioral Health Services
Effective	2/1/2026	Applicability	MMC, Cadillac
Last Revised	1/8/2026	Tags	Policy
Next Review	1/7/2029		

Seclusion Use - Behavioral Health Unit

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Purpose

To define the approach to the use of seclusion on D6 inpatient behavioral health - a service of Munson Healthcare Cadillac (D6) in a way that protects the patient's health and safety, and preserves his or her dignity, rights and well-being.

Scope

This policy governs the use of seclusion on D6, and applies to all healthcare team members who assess and/or provide care to patients on this unit. Behavioral health has restraint and seclusion policies that are separate from other patient care areas.

Definitions

1. **Seclusion:** Seclusion means the temporary placement of a patient in a room, alone, where egress is prevented by any means. A patient may be placed in seclusion only if it is essential in order to prevent the patient from physically harming others. Seclusion must not be imposed as a means of coercion, discipline, or retaliation by staff members. Orders for the use of seclusion must never be written as a standing order or on an as needed basis (PRN).
2. **Time Out:** Time out means a voluntary response to the therapeutic suggestion to a patient to remove themselves from a stressful situation in order to prevent a potentially hazardous outcome. The patient can leave the designated area when the patient chooses. Therefore, time out is not considered seclusion.
3. **Therapeutic De-escalation:** Therapeutic de-escalation means an intervention, the implementation of which is incorporated in the individualized plan of service, wherein the recipient is placed in an area or room accompanied by staff who shall therapeutically engage the recipient in behavioral de-escalation techniques and debriefing as to the cause and future

prevention of the target behavior.

Policy

A. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

B. The decision to use seclusion is not driven by a diagnosis, but by a comprehensive individual patient assessment. For a given patient at a particular point in time, this comprehensive individual patient assessment is used to determine whether the use of less restrictive measures poses a greater risk than the risk of using seclusion.

C. D6 strives to create an environment that minimizes circumstances that give rise to seclusion use and that maximizes safety and the preservation of the patient's rights and dignity when it is used. The decision to use seclusion will always be given serious consideration by the health care team, and be based on the understanding that secluding an individual involves an ethical dimension.

D. Seclusion will only be implemented to ensure the immediate physical safety of a staff member or others and must be discontinued at the earliest possible time.

E. Use of seclusion will be implemented in accordance with safe and appropriate techniques as determined by D6 policy and in accordance with state law. Only staff who have obtained specialized training, and are evaluated for competency, will place patients into seclusion.

F. When a patient is in seclusion, staff must assess and monitor a patient's condition on an ongoing basis to ensure that the patient is released from seclusion at the earliest possible time. However, the decision to discontinue the intervention should be based on the determination that the need for seclusion is no longer present, or that the patient's needs can be addressed using less restrictive measures. Dignity will be maintained at all times and physical care needs will be met.

G. Simultaneous use of restraint and seclusions only permitted if the patient is continually monitored, (i) Face to face by an assigned, trained staff member; or (ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.

H. The use of seclusion will be documented in the patient's plan of care or treatment plan. The use of seclusion constitutes a change in a patient's plan of care and will be reflected in the assessment and evaluation data for the patient.

I. A secluded patient will continue to receive food, be kept in sanitary conditions, be given hourly access to a toilet, have an opportunity to bathe as often as needed but at least every 24 hours, be clothed or otherwise covered unless their actions make it impractical or inadvisable, be kept in sanitary conditions, and be provided a bed or similar piece of furniture unless their actions make it impractical or inadvisable.

Authorization and Ordering of Seclusion

A. An order for seclusion can only be authorized by a physician or a psychiatric advance practice provider (APP) and must include the type of restraint.

B. A provider who orders or reorders seclusion will do so in accordance with Sec. 742.

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C. If there is a significant change in the patient's condition that requires emergent initiation of seclusion, the registered nurse (RN) competent in seclusion usage may initiate seclusion based on an appropriate assessment of patient needs. The patient may be placed in seclusion for a maximum period of 30 minutes without a physician's order. The physician, or APP will be contacted immediately after seclusion is employed. If the physician, or APP does not order or authorize continued seclusion, the patient will be removed from seclusion.

D. The patient must be seen face to face, by a physician or APP, within 1 hour of initiation of the restraint to evaluate and document. The required examination by a provider will be conducted not more than 30 minutes before the expiration of the expiring order for seclusion.

   1. Behavior(s)/symptoms necessitating restrictive measures
   2. The patient's reaction to the intervention
   3. The patient's immediate situational/behavioral condition
   4. The patient's medical and behavioral condition; and
   5. Justification to continue or terminate the physical hold, restraint or seclusion including rationale for continued use of restraint.

E. The one (1) hour face-to-face patient evaluation must be conducted in person. A telephone call or telemedicine methodology is not permitted. The face-to-face patient assessment will address the possibility that a medical condition may be the cause of behavior changes in the patient. For example, temperature elevations, hypoxia, hypoglycemia, electrolyte imbalances, drug interactions, and drug side effects may cause confusion, agitation, and combative behaviors. Addressing these medical issues may eliminate or minimize the need for the seclusion.

F. If the patient's violent behavior resolves and the seclusion intervention is no longer necessary, the physician, or APP is still required to see the patient face-to-face and conduct the evaluation within one (1) hour after the initiation of this intervention. The fact that the patient's behavior warranted the use of seclusion indicates a serious medical or psychological need for prompt evaluation of the patient's behavior that led to the intervention. The evaluation would also determine whether there is a continued need for the intervention, factors that may have contributed to the violent or self-destructive behavior and whether the intervention was appropriate to address the violent or self-destructive behavior.

G. Seclusion is a time-limited intervention and **may not be ordered as needed (PRN).** Seclusion orders may not be written in advance. Ordered seclusion must continue only for that time specified in the order, or for eight (8) hours, whichever is less. Each order for seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:

   1. Four (4) hours for adults 18 years of age or older;
   2. Two (2) hours for children and adolescents ages 9 to 17 years; or
   3. One (1) hour for children under 9 years of age.
   4. If the patient is removed from seclusion, the order is considered to be discontinued. Therefore, to allow the patient to again be secluded using the same order equals a PRN seclusion order.

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H. Each written order for seclusion is for a specified time not to exceed four (4) hours. Following the assessment of the patient by a RN for criteria to continue the seclusion a renewal of the order must be obtained from the physician for a specified time not to exceed four (4) hours.

I. The patient must be reassessed face-to-face by the physician and evaluated for the need to continue seclusion every eight (8) hours following initial assessment. After eight (8) hours, the physician must write a new order for the continued use of seclusion. The physician will document assessment findings in the medical record.

J. When the physician or APP renews an order or writes a new order authorizing the continued use of seclusion, there must be documentation in the patient's medical record that describes the findings of the physician or APP re-evaluation supporting the continued use of seclusion.

K. A patient may be secluded pursuant to an order by the provider 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.

L. If the ordering physician is not the attending physician, the attending physician must be consulted as soon as possible. The attending physician may have information regarding the patient's history that may significantly impact the use or selection of the seclusion.

M. Physician examination should be completed no more than 30 minutes prior to the expiration of the expiring seclusion order.

N. A secluded patient will be released from seclusion whenever the circumstance that justified its use ceases to exist. Seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

O. Each instance of seclusion requires full justification for its use, and the results of each periodic examination will be placed promptly in the record of the patient.

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Assessment and Documentation

A. A separate permanent record of each instance of seclusion must be kept and must include:

    1. The name of the patient
    2. The conditions of seclusion
    3. The name of the authorizing and ordering physician/provider
    4. The date and time placed in temporary, authorized, and ordered seclusion
    5. The date and time the recipient was removed from temporary, authorized, and ordered seclusion

B. Each episode of seclusion use shall be documented in the patient's medical record, and shall include but not be limited to:

    1. As soon as it is feasible in the seclusion process, the patient will not only be informed of the rational for the seclusion intervention but also the behaviors required to discontinue the seclusion.

2. A description of the patient's behavior and the intervention used.
3. The 1-hour face-to-face medical and behavioral evaluation if seclusion is used to manage violent behavior.
4. Assessment and reassessment, including:
    a. Significant changes in the patient's condition that warranted seclusion use;
    b. Patient's response to seclusion
5. Relevant orders for use of seclusion, including least restrictive intervention, time limit, clinical justification, and criteria for release from seclusion.
6. During the time that a patient is in seclusion, he or she will be continually observed and monitored (e.g. *observed without interruptions*) by qualified staff.
7. The RN or physician that have completed the training criteria specified in by hospital policy.will monitor and assess the patient's status at least every 15 minutes or more frequently if patient condition warrants.
    a. **Monitoring** determines the following:
        i. Patient's physical and emotional well-being.
        ii. Maintenance of patient's rights, dignity, and safety.
        iii. Assessment of patient's condition to determine if the current seclusion should be continued or if less restrictive methods could be used or seclusion could be discontinued.
    b. **Assessment** includes, but is not limited to, the following:
        i. Signs of injury associated with seclusion.
        ii. Mental status.
        iii. Level of distress and agitation.
        iv. Behavior.
        v. Nutrition and hydration status.
        vi. Circulation and range of motion (ROM).
        vii. Vital signs
        viii. Hygiene and elimination.
        ix. Physical and psychological status and comfort.
        x. Readiness for discontinuation of seclusion.
8. Assistance with foods and fluids, toileting, ROM or activity, and repositioning is provided every hour as appropriate while awake.
9. A secluded patient will continue to receive food, be kept in sanitary conditions, be given hourly access to a toilet, have an opportunity to bathe as often as needed but at least every 24 hours, be clothed or otherwise covered unless their actions make it impractical or inadvisable, be kept in sanitary conditions, and be provided a bed or similar piece of furniture unless their actions make it impractical or inadvisable.

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10. The RN will document the following assessment data every four hours or more as indicated by a change in behavior. This assessment will include:
    a. The actual behavior observed;
    b. A determination of the patient's behavior that continues to justify the use of seclusion;
    c. Alternative measure which may be employed to avoid seclusion and the effectiveness of those methods; and
    d. Discussion with the patient and/or family concerning the continued use of seclusion and the behavior required to discontinue the seclusion.
11. An RN can remove or direct a trained staff member to remove a patient from seclusion. This decision will be based on:
    a. Less restrictive measures are effective.
    b. A reduction in behaviors that warranted the use of seclusion.
    c. Return to a level of little or no risk for harm to self or others.
12. Use of seclusion must be addressed in the patient's plan of care.
13. Seclusion must be discontinued at the earliest possible time, regardless or the length of time identified in the order.
14. If a patient is secluded repeatedly, the patient's individual plan of services shall be reviewed and modified to facilitate the reduction of the use of seclusion.

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Key Elements of Seclusion Documentation

A. The following key elements of assessment, monitoring and care will be documented in the patient's medical record:
    1. Description of the patient's behavior and interventions used
    2. Alternatives attempted to avoid seclusion (as applicable)
    3. Face-to-face provider medical and behavioral evaluation within 1 hour
    4. Results of the RN assessment
    5. Care provided while seclusion is in use
    6. Physician order for seclusion
    7. Mental status of the patient
    8. Skin/circulation observation
    9. Assistance with elimination
    10. Range of motion
    11. Fluids offered
    12. Food/meal offered
    13. Seclusion education provided to patient and/or family

14. Ongoing assessment of least restrictive measures to seclusion
15. Ongoing assessment of appropriateness to discontinue seclusion
16. Vital signs

Staff Education

A. The foundation of all educational processes will be on a culture that encourages alternatives to seclusion and the use of least restrictive methods. In addition, education will foster a culture that respects the patient's rights and dignity.

B. All staff that apply restraints and seclusion are educated, trained and able to demonstrate competency in the implementation of seclusion, monitoring, assessment and providing care for a patient in seclusion including:

   1. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require restraint or seclusion.
   2. The use of non-physical intervention skills (de-escalation techniques).
   3. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical or behavioral status or condition.
   4. The safe application and use of violent/self-destructive restraint including training in how to recognize and respond to signs of physical and psychological distress.
   5. Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
   6. Monitoring the physical and psychological well-being of the patient who is restrained or 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.
   7. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation (CPR), including required periodic recertification.
   8. All physicians authorized to order restraints must have a working knowledge of this hospital's policy regarding the use of restraint or seclusion.

C. Initial and ongoing education, training, and competency assessment is mandatory for staff that applies or monitors patients in restraints and seclusion.

D. Trainer requirements – individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patient's behaviors.

E. Training documentation – the hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.

Patient / Family Education

A. If a patient is placed in seclusion, the following information will be provided to the patient/ family as soon as possible during waking hours:

   1. The reason why seclusion is needed

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2. The negative aspects of seclusion
3. Alternatives to seclusion
4. Behavior required to discontinue seclusion

Performance Improvement

Unit-based continuous performance improvement opportunities will be conducted to understand the cause of seclusion use and incorporate this understanding into patient care planning.

Reporting Occurrences and the Michigan Department of Health and Human Services (MDHHS) & Centers for Medicare & Medicaid Services (CMS) Requirements

A. An occurrence report should be entered in VOICE whenever there are systems, processes, or patient injury issues with seclusion or lack of compliance with the policies and procedures. Refer to the Occurrence Reporting-General policy for details on reporting and documenting actual and near-miss, patient events. A patient injury and subsequent treatment should also be documented in the medical record as a Focus Note.

B. The Michigan Mental Health Code requires the hospital to report all deaths of patients that occur on the inpatient behavioral health unit to the MDHHS - Office of Recipient Rights via email (MDHHS-recipientrights@michigan.gov with "Report of Death" in the subject line) on the Notification of Patient Death" Form #MDHHS-5949 within 72 hours of the unit becoming aware of the patient's death. Please refer to Death Reporting of Mental Health Patients policy.

C. The hospital must report deaths associated with the use of seclusion to the Department of Licensing and Regulatory Affair (LARA).

D. CMS Conditions of Participation require the hospital to report deaths associated with the use of restraint or seclusion. In order to do so, Risk management must be notified of patient deaths within the following criteria:
   1. Each death that occurs while a patient is in restraint or seclusion.
   2. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
   3. Each death known to the hospital that occurs within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient's death.

E. "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.

F. Risk Management submits required data about each death to CMS no later than the close of business on the next business day following knowledge of the patient's death. Risk management is responsible for documentation in the patient's medical record of the date and time the death was reported to CMS.

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G. Risk Management enters a report into VOICE for each death reported to CMS for tracking/trending compliance with this regulation and for follow up on any process or documentation issues identified when compiling data for the CMS Worksheet.

References

1. State Operations Manual, Appendix A
2. /§482.13(e)/Restraint or Seclusion
3. Guidelines for Hospitals
4. 482.13(e) Standard: Restraint or Seclusion
5. 482.13(f) Standard: Restraint or Seclusion: Staff Training Requirements
6. 482.13 (g) Standard: Death Reporting Requirements
7. Michigan Mental Health Code 330.1740: Section 740

Document ID: 099.027

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Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	1/8/2026
Dir Behav Health	Terri Lacroix-Kelty: Exec Dir Service Line - Behavioral Health	1/7/2026
Document Owner	Lori Barrett: Mgr Nursing Services	1/6/2026

Applicability

Cadillac Hospital, Munson Medical Center

Standards

No standards are associated with this document

SoftGuard® Safety Restraint Chair (Munson)

SoftGuard® Safety Restraint Chair (Munson)
Introduction

03/04/2024

Warning - Use of the SoftGuard® Safety Restraint Chair without first reading and thoroughly understanding the instructions could cause injury or death.

Please be aware that the SoftGuard® Safety Restraint Chair is designed for maximum protection and safety when all available restraints are used. The operator's decision to use less than every available restraint strap may increase the risk of
personal injury to the restrained individual.

The SoftGuard® Safety Restraint Chair is intended for the psychiatric, behavioral, and medical environments to protect patients that need to be restrained because they are at risk of hurting themselves or the medical staff. If used properly it can reduce the risk of physical harm to both.

Violent behavior may mask dangerous medical conditions therefore patients must be monitored for and provided with medical treatment if needed. Patients should not be left in the SoftGuard® Safety Restraint Chair for more than two hours and should be under observation during that time. This time limit was established to allow the patient to calm down, and if needed it allows for the medical staff to seek additional medical or psychological help for the patient. This two hour time limit may be extended, but only under medical supervision (Doctor/Nurse). This extended time period must not exceed eight hours and range of motion exercises should be performed regularly. Therefore it is not recommend patients be left in the SoftGuard® Safety Restraint Chair for more than ten hours total.

No belt or strap should be tight enough to restrict any blood flow. The SoftGuard® Safety Restraint Chair must always be used in the upright position.

The SoftGuard® Safety Restraint Chair should never be used as a means of punishment.

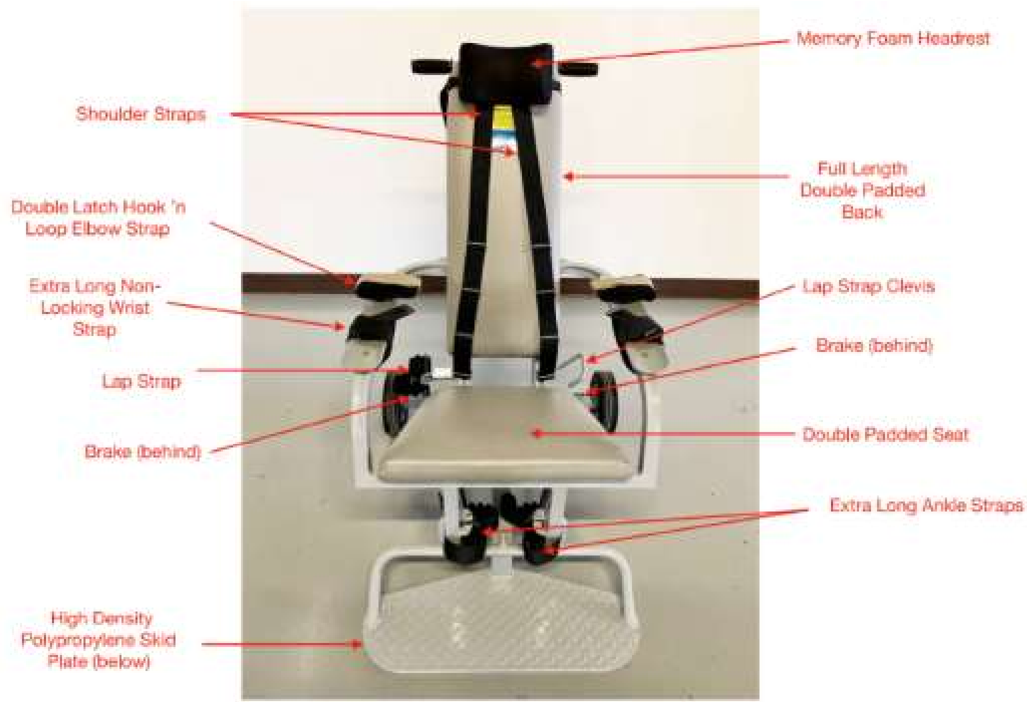
INSTRUCTIONS

Step 1.

Ensure that all of the patient's personal property has been removed include jewelry, glasses, shoes, boots, coat, hat, and belt. They should only be clothed in their shirt, pants, socks, or dress.

Note: Before restraining the patient, make sure all straps are open/loosened. This will reduce the time it takes to attach the straps and make the process safer for both the patient and the medical

Staff.



Step 2.

Set brakes by putting the head of the brake clamp piston into a slot in the wheel hub. It may be necessary to grip the wheel and roll it by hand to properly align the piston head (photo 2). Push the red handle toward the wheel to lock the brake (photo 3). Repeat on the other side.

Photo 2

Photo 3

Step 3:

Sit the patient in the chair. Secure the lap belt free looped end in the lap belt clevis (photo 4 & 5) and pull the strap until snug (photo 6).

Note: To loosen the lap belt, push on the cam and pull the strap up (photo 7).

Photo 4

Photo 5

Photo 6

Photo 7

Step 4.

Secure the ankle strap by passing the free end around the front of the ankle securing it to the ankle strap clevis (photo 8).

Photo 8

Pull the ankle strap handle until snug while **making sure the patient's heel is touching the rear of the floot plate** (photo 9).

Photo 9

Repeat on the other ankle (photo 10). Patient's feet should rest firmly on the footplate with their seat reaching the back of the chair seat.

Photo 10

Step 5.

Take one wrist and place that free arm on the arm rest of the SoftGuard® Safety Restraint Chair. Secure the arm with the left arm strap making sure the wrist is down and flat on the arm rest (photo 11). Pull the wrist strap snug.

Photo 11

Note: While tightening the wrist strap, the finger of the person restraining the patient should be placed on the outside of the patient's wrist, between the strap/arm rest slit and the patient's wrist in order to eliminate all possibility of pulling the patient's loose wrist skin ino the slit while pulling the strap tight. This also allows the patient's wrist be held firmly flat on the arm rest during this process.

Place the forearm (elbow) centered over the elbow soft strap. Double latch the hook and loop strap around the free elbow (photo 12 & 13). Repeat the above process for the other arm.

Photo 12

Photo 13

Step 6.

Install the shoulder strap by passing the free ends over the shoulders, under the armpits, and secure them to the shoulder strap clevises located on the back of the chair (photo 14).

Photo 14

Tighten by pulling down on the shoulder strap at the top back of the chair (photo 15).

Photo 15

Do not pull the shoulders back too far when tightening the shoulder straps. Straps must be even and secure on both shoulders (photo 16).

Photo 16

Note: Do not wrap the straps around the chest, head, or neck.

Step 7.

When the patient is fully restrained, retighten the lap belt (photo 17), resulting in a fully restrained patient (photo 18).

Photo 17

Photo 18

Step 8.

As soon as the patient is safely and completely restrained in the chair, the brakes should be immediately released (photo 19 and 20). Movement should not be possible with the patient completely restrained. This will ensure the wheel hubs will not break if there is a need for medical staff to quickly move the chair.

Photo 19

Photo 20

Chair Cleaning Instructions:

The SoftGuard® Safety Restraint Chair will need to be cleaned and sanitized after being used. Recommendations for cleaning all components of the chair include; mizing one cup (8 fl. oz.) of bleach with one gallon of hot water, or an appropriate bleach or non-bleach wipe. Should your organization's specific bacterial or infections control policies require other cleaning methodologies and materials it is advised that the trail be performed on the bottom of the eat to ensure it does not damage the vinyl cover of the seat.

Video Instructions

Click on the link to view open the manufacturer's instructional video page.

Enter the following password: 12nEw15Own3Rs18

Click on Submit to watch the instructional video.

https://restraintchair.com/informational-videos.php

Status **Active** PolicyStat ID **19585940**

Origination	12/10/2009	Owner	Lori Barrett: Mgr Nursing Services
Last Approved	1/8/2026	Area/ Department	Behavioral Health Services
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Use of Physical Restraints - Behavioral Health

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Purpose

The purpose of this policy is to define D6 inpatient behavioral health - a service of Munson Healthcare Cadillac (D6) approach to the application of restraint on the inpatient behavioral health unit in a way that protects the patient's health and safety, and preserves his or her dignity, rights and well-being.

Scope

This policy governs the use of physical restraint on D6 and pplies to all healthcare team members who assess and/or provide care to patients on this unit. Behavioral health has restraint and seclusion policies that are separate from other patient care areas.

Definitions

1. **Physical Restraint:** Restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
    a. If a patient refuses medically indicated treatments, which may include medications, a brief physical hold is sometimes required, but is considered a restraint and must follow applicable restraint policy elements. The use of a physical hold in these circumstances is a restraint; however, when the medication administered is within the therapeutic range for the patient's diagnosis or part of the treatment plan, it is not a restraint.
    b. A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve

the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

2. **Physical management** is defined as a technique used by staff as an emergency intervention to restrict the movement of a patient by direct physical contact to prevent the recipient from harming themselves or others. For the purposes of this policy physical management is restraint

3. **Violent/Self-Destructive Behavior Restraint:** The primary reason for violent/self-destructive behavior restraint use is in the situations where the patient's behavior is violent, aggressive, or assaultive. The behavior must present an immediate and serious danger to the safety of the patient, other patients, or staff. The least restrictive measure will be initiated to maintain the safety of the patient and staff.

4. **Physical Holding for Forced Medications:** The application of force to physically hold a patient, in order to administer a medication against the patient's wishes, is considered restraint. The patient has a right to be free of restraint, and also has a right to refuse medications, unless a court has ordered medication treatment. A court order for medication treatment only removes the patient's right to refuse the medication. Patients may be medicated against their will for the following reasons: (a) presents an immediate risk of self-harm; or (b) presents a danger to staff or others. However, in these circumstances, health care staff is expected to use the least restrictive method of administering the medication to avoid or reduce the use of force, whenever possible.

    a. The use of force in order to medicate a patient, as with other restraint, must have a physician's order prior to the application of the restraint (use of force). If physical holding for forced medication is necessary with a violent patient, the 1-hour face-to-face evaluation requirement would also apply.

    b. In certain circumstances, a patient may consent to an injection or procedure, but may not be able to hold still for an injection, or cooperate with a procedure. In such circumstances, and at the patient's request, staff may "hold" the patient in order to safely administer an injection (or obtain a blood sample, or insert an intravenous line) or to conduct a procedure. This is not considered restraint.

Policy

A. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraints, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

B. A patient will not be placed in restraint except in the circumstances and under the conditions set forth in Sec. 740 or in other law.

C. Restraint must not be imposed as a means of coercion, discipline, or retaliation by staff members.

D. Orders for the use of restraint must never be written as a standing order or on an as needed basis.

E. The decision to use a restraint is not driven by a diagnosis, but by a comprehensive individual

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patient assessment. For a given patient at a particular point in time, this comprehensive individual patient assessment is used to determine whether the use of less restrictive measures poses a greater risk than the risk of using a restraint.

F. Munson Healthcare (MHC) and D6 strive to create an environment that minimizes circumstances that give rise to restraint use and that maximizes safety and the preservation of the patient's rights and dignity when they are used. The decision to use restraints will always be given serious consideration by the healthcare team, and be based on the understanding that physically restraining an individual involves an ethical dimension.

G. A patient may be restrained only after less restrictive interventions have been considered, and only if restraint is essential in order to prevent the patient from physically harming himself, herself, or others. Consideration of less restrictive measures must be documented in the medical record. If the restraint is essential in order to prevent the patient from physically harming himself, herself, 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.

H. Use of restraint will be implemented in accordance with safe and appropriate restraint techniques as determined by MHC policy and in accordance with state law. Only staff who have obtained specialized training, and are evaluated for competency, will apply restraints.

I. When a patient is in restraints, staff must assess and monitor a patient's condition on an ongoing basis to ensure that the patient is released from restraint at the earliest possible time. Restraint will only be employed while the unsafe situation continues. Once the unsafe situation ends, restraints will be removed. However, the decision to discontinue the intervention should be based on the determination that the need for restraint is no longer present, or that the patient's needs can be addressed using less restrictive measures. Dignity will be maintained at all times and physical care needs will be met.

J. The use of restraint will be documented in the patient's plan of care or treatment plan. The use of restraint constitutes a change in a patient's plan of care and will be reflected in the assessment and evaluation data for the patient.

K. Prone immobilization of a patient for the purpose of behavior control is prohibited unless implementation of physical management techniques other than prone immobilization are medically contraindicated and documented in the patient's record.

L. Simultaneous use of restraint and seclusions only permitted if the patient is continually monitored, (i) Face to face by an assigned, trained staff member; or (ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.

M. All requirements specified in this policy are applicable to simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is monitored face-to-face by an assigned, trained staff member, or by trained staff using both video and audio equipment. This monitoring must be in close proximity to the recipient.

Authorization and Ordering of Violent Restraints

A. An order for a restraint can only be authorized by a physician or a advanced practice provider (APP) and must include the type of restraint. A patient may be restrained prior to examination pursuant to an authorization. An authorized restraint may continue only until a physician/APP can personally examine the patient or for 2 hours, whichever is less. If it is not possible for the

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physician/APP 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.

B. If there is a significant change in the patient's condition that requires emergent initiation of restraint, the registered nurse (RN) competent in restraint usage may initiate restraint use based on an appropriate assessment of patient needs. The patient may be restrained for a maximum period of 30 minutes without a physician's order. The physician or APP will be contacted immediately after emergent restraints are applied. If the physician, or APP, does not order or authorize continued restraints, the restraints must be removed.

C. The patient must seen face-to-face by a physician or APP, within 1 hour after the initiation of the restraint by a qualified staff to evaluate at a minimum: (i) the patient's immediate situation; (ii) the patient's reaction to the intervention; (iii) the patient's medical and behavioral condition; and (iv) the need to continue or terminate the restraint or seclusion.

    1. Behavior(s) necessitating restrictive measures
    2. The patient's reaction to the intervention
    3. The patient's immediate situation/behavioral condition
    4. The patient's medical condition
    5. Justification to continue or terminate the physical hold, restraint or seclusion including rationale for continued use of restraint.

D. When restraint is used, there must be documentation in the patient's medical record of the following:

    1. The 1-hour face-to-face medical and behavioral evaluation by a physician or APP including the condition and symptoms that warranted the use of the restraint.
    2. A description of the patient's behavior and the intervie ntion(s) used
    3. Alternative or other less restrictive interventions attempted (as applicable)
    4. The patient's response to the interviention(s) used, including the rationale for continued use of the intervention

E. A patient may be restrained pursuant to an order by the physician/APP 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. The attending physician may have information regarding the patient's history that may significantly impact the use or selection of the restraint.

F. The one (1) hour face-to-face patient evaluation must be conducted in person. A telephone call or telemedicine methodology is not permitted. The face-to-face patient assessment will address the possibility that a medical condition may be the cause of behavior changes in the patient. For example, temperature elevations, hypoxia, hypoglycemia, electrolyte imbalances, drug interactions, and drug side effects may cause confusion, agitation, and combative behaviors. Addressing these medical issues may eliminate or minimize the need for the restraint.

G. If the patient's violent or self-destructive behavior resolves and the restraint intervention is no longer necessary, the physician or APP is still required to see the patient face-to-face and conduct the evaluation within one (1) hour after the initiation of this intervention. The fact that

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the patient's behavior warranted the use of a restraint indicates a serious medical or psychological need for prompt evaluation of the patient's behavior that led to the intervention. The evaluation would also determine whether there is a continued need for the intervention, factors that may have contributed to the violent or self-destructive behavior and whether the intervention was appropriate to address the violent or self-destructive behavior.

H. Restraints are time-limited and **may not be ordered as needed (PRN).** Restraint orders may not be written in advance of the restraint initiation. 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

I. 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.

J. Trial release of restraints is not permitted as the release of the patient is considered to be a discontinuation of restraint order. Therefore, to allow the patient to again be restrained using the same order equals a PRN restraint order.

    1. A temporary release that occurs for the purpose of caring for a patient's needs, i.e. toileting, feeding, and range of motion, is not considered a discontinuation of the intervention.

K. Each instance of restraint requires full justification for its application, and the results of each periodic examination will be placed promptly in the record of the patient.

L. Each written order for physical restraint is for a specified time not to exceed four (4) hours. Following the assessment of the patient by a RN for criteria to continue the restraints, a renewal of the order must be obtained from the physician or APP for a specified time not to exceed four (4) hours.

M. A physician or APP, who orders or reorders a restraint for the management of violent or self-destructive behavior, must examine the patient not more than 30 minutes before the expiration of the expiring order for the restraint.

N. Before writing a new order for the use of restraint for the management of violent or self-destructive behavior, the physician or APP must complete a face-to-face assessment of the patient and document the need to continue restraint **every four (4) hours following initial assessment**. The physician or APP will document assessment findings in the medical record.

Assessment and Documentation

A. A separate, permanent chronological record specifically identifying all instances when restraint has been used on the Behavioral Health Unit. The record shall include all of the following information:

    1. The name of the patient
    2. The type of restraint
    3. The name of the authorizing and ordering physician
    4. The date and time placed in temporary, authorized, and ordered restraint

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5. The date and time the recipient was removed from temporary, authorized, and ordered restraint.

B. Each episode of restraint use shall be documented in the patient's medical record, and shall include but not be limited to:

1. As soon as it is feasible in the restraint process, the patient will not only be informed of the rational for the restraint intervention but also the behaviors required to discontinue the restraint.
2. Assessment and reassessment, including:
    a. Significant changes in the patient's condition that warranted restraint use
    b. Patient's response to restraint
3. Relevant orders for use of restraints, including least restrictive intervention, time limit, clinical justification, type of restraint to be used, and criteria for release.
4. During the time that a patient is in restraint, he or she will be continually observed and monitored (e.g. *observed without interruptions*) by qualified staff.
5. The RN will monitor and assess the patient's status at least every 15 minutes or more frequently if patient condition warrants. An assessment of the circulation status of restrained limbs is conducted and documented at each 15-minute interval or more often if medically indicated.
    a. **Monitoring** determines the following:
        i. Patient's physical and emotional well-being.
        ii. Maintenance of patient's rights, dignity, and safety.
        iii. Appraisal of patient's condition to determine if the current restraint should be continued or if less restrictive methods could be used or restraints could be discontinued.
        iv. Safety of restraint application, removal or re-application.
    b. **Assessment** includes, but is not limited to, the following:
        i. Signs of injury associated with restraint.
        ii. Mental status.
        iii. Level of distress and agitation.
        iv. Behavior.
        v. Nutrition and hydration status.
        vi. Circulation and Range of motion (ROM).
        vii. Vital signs
        viii. Hygiene and elimination.
        ix. Physical and psychological status and comfort.
        x. Readiness for discontinuation of restraint.
6. A restrained patient will:

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a. Continue to receive food
b. Be kept in sanitary conditions
c. Be clothed or otherwise covered
d. Be given hourly access to toilet facilities
e. Be bathed as often as necessary, but at least every 24 hours
f. Be given the opportunity to sit or lie down.

7. Assistance with foods and fluids, toileting, ROM or activity, and repositioning is provided every hour as appropriate while awake.
8. Restraints will be removed every two (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.
9. The RN will document the following assessment data every four hours or more as indicated by a change in behavior. This assessment will include:
   a. The actual behavior observed;
   b. A determination of the patient's behavior that continues to justify the use of a behavioral restraint;
   c. Alternative measure which may be employed to avoid restraint and the effectiveness of those methods; and
   d. Discussion with the patient and/or family concerning the continued use of restraints and the behavior required to discontinue the restraint.
10. An RN can release or direct a trained staff member to release a patient from restraints or reduce the level of restraints. This decision will be based on:
   a. Less restrictive measures are effective.
   b. A reduction in behaviors that warranted the use of restraints.
   c. Return to a level of little or no risk for harm to self or others.
11. Restraints must be discontinued at the earliest possible time, regardless of the length of time identified in the order.
12. If a patient is restrained repeatedly, the patient's Master Treatment Plan (MTP) must be reviewed and modified to facilitate the reduction of the use of restraints.

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Key Elements of Restraint Documentation

A. There must be documentation in the patient’s medical record of the following:
   1. The one-hour face to face medical and behavioral evaluation
   2. A description of the patient’s behavior and the intervention used
   3. Alternatives or other less restrictive interventions attempted (as applicable)
   4. The patient’s condition or symptom(s) that warranted the use of the restraint
   5. The patient’s response to the intervention(s) used, including rationale for continued

use of the intervention

6. Type of restraint
7. Results of the RN assessment
8. Care provided while restraints are in use
9. Physician order for restraints
10. Mental status of the patient
11. Skin/circulation observation
12. Assistance with elimination
13. Range of motion
14. Fluids offered
15. Food/meal offered
16. Restraints education provided to patient and/or family
17. Ongoing assessment of least restrictive measures to restrain
18. Ongoing assessment of appropriateness to discontinue restraints
19. Vital signs

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Staff Education

A. The foundation of all educational processes will be on a culture that encourages alternatives to restraints and the use of least restrictive methods of restraint if the alternative strategies are not effective. In addition, education will foster a culture that respects the patient's rights and dignity. Only those that have been trained and evaluated for competency can apply restraints.

B. All staff that apply restraints and seclusion are educated, trained, and demonstrate knowledge based on the specific needs of the patient population. Staff must be trained and able to demonstrate competency in the application of restraints, monitoring, assessment and providing care for a patient in restraints, including the following:

1. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require restraint or seclusion.
2. The use of non-physical intervention skills (de-escalation techniques).
3. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical or behavioral status or condition.
4. The safe application and use of violent/self-destructive restraint including training in how to recognize and respond to signs of physical and psychological distress.
5. Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
6. Monitoring the physical and psychological well-being of the patient who is restrained or 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.

7. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation (CPR), including required periodic recertification.
8. All physicians and APPs authorized to order restraints must have a working knowledge of this hospital's policy regarding the use of restraint or seclusion.

C. Initial and ongoing education, training, and competency assessment is mandatory for staff that applies or monitors patients in restraints and seclusion.

D. Trainer requirements - Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patient's behaviors.

E. Training documentation - The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.

Patient / Family Education

A. If a patient is placed in restraint, the following information will be provided to the patient/family as soon as possible during waking hours:
    1. The reason why the restraint is needed.
    2. The negative aspects of the restraint.
    3. Alternatives to the restraint.
    4. Behavior required to discontinue the restraint.

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Performance Improvement

A. Unit-based continuous performance improvement opportunities will be conducted to understand the cause of restraint use and incorporate this understanding into patient care planning.

B. Data is reviewed to ascertain that restraints are only used as emergency interventions, to identify opportunities for incrementally improving the rate and safety of restraint use, and to identify any need to redesign care processes.

C. All restraint occurrences will be audited by designated MHC staff.

Reporting Occurrences and the Michigan Department of Health and Human Services (MDHHS) & Centers for Medicare & Medicaid Services (CMS) Requirements

A. An occurrence report should be entered in VOICE whenever there are systems, processes, or patient injury issues with restraints or lack of compliance with the policies and procedures. Refer to the Occurrence Reporting-General policy for details on reporting and documenting actual and near-miss, patient events. A patient injury and subsequent treatment should also be documented in the medical record as a Focus Note.

B. The Michigan Mental Health Code requires the hospital to report all deaths of patients that occur on the inpatient behavioral health unit to the MDHHS - Office of Recipient Rights via

email (MDHHS-recipientrights@michigan.gov with "Report of Death" in the subject line) on the "Notification of Patient Death" form (Form #MDHHS-5949) within 72 hours of the unit becoming aware of the patient's death. Please refer to the Death Reporting of Mental Health Patients policy.

C. The hospital must report deaths associated with the use of restraint to LARA.

D. CMS Conditions of Participation require the hospital to report deaths associated with the use of restraint or seclusion. In order to do so, Risk management must be notified of patient deaths within the following criteria:

    1. Each death that occurs while a patient is in restraint or seclusion.
    2. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
    3. Each death known to the hospital that occurs within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient's death.

E. "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.

F. Risk Management submits required data about each death to CMS no later than the close of business on the next business day following knowledge of the patient's death. Risk management is responsible for documentation in the patient's medical record of the date and time the death was reported to CMS.

G. Risk Management enters a report into VOICE for each death reported to CMS for tracking/trending compliance with this regulation and for follow up on any process or documentation issues identified when compiling data for the CMS Worksheet.

H. For a patient who expires while in two-point soft wrist restraints in which the restraints were not suspected of contributing in any way to the patient's death, immediate reporting from Risk Management to CMS is not required. Instead, a log is maintained by the Risk Management department for these cases.

References

1. State Operations Manual, Appendix A
   /§482.13(e)/Restraint or Seclusion
   Guidelines for Hospitals

    a. 482.13(e) Standard: Restraint or Seclusion
    b. 482.13(f) Standard: Restraint or Seclusion: Staff Training Requirements
    c. 482.13 (g) Standard: Death Reporting Requirements

2. Department of Community Health Mental Health and Substance Abuse Services.
   Administrative R

Document ID: 099.047

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Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	1/8/2026
Dir Behav Health	Terri Lacroix-Kelty: Exec Dir Service Line - Behavioral Health	1/7/2026
Document Owner	Lori Barrett: Mgr Nursing Services	1/6/2026

Applicability

Cadillac Hospital, Munson Medical Center

Standards

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No standards are associated with this document

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Abuse & Neglect

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Purpose

The abuse or neglect of a recipient by a staff member, contract staff member, volunteer of D6 Inpatient Behavioral Health - a service of Munson (MHC) Cadillac (D6) or a contract provider is strictly prohibited pursuant to the Michigan Mental Health Code (MMHC) (PA 258 of 1974, MCL 330.1722) and the Michigan Department of Health and Human Services (MDHHS) Administrative Rules (R330.7001 and R330.7035), and shall subject the employee, volunteer, or agent of a provider to disciplinary action, up to and including termination.

Definitions

1. **Administrative Rules:** means the MDHHS Administrative Rules.
2. **Complaint:** means a written or oral statement that meets the requirements of section 1776 of the MMHC.
3. **D6:** means the inpatient Behavioral Health Unit - a service of MHC Cadillac, which is a psychiatric unit licensed under Section 1137 of the MMHC.
4. **Hospital:** means MHC Cadillac.
5. **Hospital Director:** means the hospital's President and Chief Executive Officer (CEO), or their appointed designee.
6. **Investigation:** means a detailed inquiry into and systematic examination of an allegation raised in a Recipient Rights complaint.
7. **Michigan Mental Health Code** (**MMHC**): means the MMHC (PA 258 of 1974).
8. **Office of Recipient Rights** (**ORR**): means the office created by the hospital under section 1755 of the MMHC for D6.
9. **Recipient (also referred to in this policy as "patient"):** means an individual who is admitted to

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and receives mental health services from D6.

10. **Recipient Rights Advisor:** means the staff members working in the hospital's ORR, and includes both the Advisor and the Back-Up Advisor.

Policy

Right to Freedom from Abuse and Neglect

A. A recipient shall not be subjected to abuse or neglect.

B. All employees, contract employees, and volunteers are responsible for protecting recipients from abuse or neglect and for understanding the definitions and adhering to reporting requirements established by this policy and procedure.

Recognizing Abuse and Neglect

A. The terms Abuse and Neglect have specific legal meaning depending on the context in which they occur. This policy addresses the following types of Abuse and Neglect:

   1. Recipient Abuse or Neglect as defined by the Mental Health Code and the MDHHS Administrative Rules, specific definitions of which are outlined in EXHIBIT A.
   2. Criminal Abuse of a Recipient as defined by the Michigan Penal Code, specific definitions of which are outlined in EXHIBIT B.
   3. Vulnerable Adult Abuse or Neglect, as defined by the Michigan Social Welfare Act, and the Michigan Penal Code, specific definitions of which are outlined in EXHIBIT C.

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Reporting Abuse and Neglect

Refer also to the Duty to Report - Recipient Rights Violations document.

A. The Recipient Rights Officer may direct that any of the required reports listed in this section be made.

B. Reporting all abuse and neglect:

   1. All incidents of recipient abuse or neglect, as defined by this policy (refer to EXHIBIT A), that are apparent to or suspected by the employee, contract employee, or volunteer shall be **immediately reported**, orally or in writing, directly to a) the D6 rights office, b) administration, and c) other agencies as required by law in a timely manner and in accordance with the procedures section of this policy.
   2. The terms "apparent" or "suspected" shall be construed to mean any and all incidents that the employee, contract employee, or volunteer has either witnessed or received reports of that constitute, or may constitute, abuse or neglect as defined by this policy, whether or not the person believes the allegation to be true.
   3. Failure to report patient abuse and neglect in accordance with this policy and procedure shall subject the staff member to administrative and potentially disciplinary action.
   4. Employees, contract employees, and volunteers are also required to make an

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immediate oral report in person or by phone, followed by a written report within 24 hours, directly to the D6 ORR in the event of the criminal or sexual assault of a recipient by any person, or of the accidental or unexplained death or serious injury of a recipient.

C. Reporting Criminal Abuse to Law Enforcement:
    1. When there is reasonable cause to suspect the criminal abuse of a recipient by any person (refer to EXHIBIT B), employees, contract employees, and volunteers must complete the following reports before the end of their shift:
        a. An Oral Report must be made to the appropriate law enforcement agency. The Oral Report to law enforcement is the responsibility of the individual who suspects criminal abuse.
        b. A Written Report must be provided to the Unit Manager. The Written Report must include the following information:
            i. Name of the Recipient,
            ii. Description of the criminal abuse, and
            iii. Manner in which the criminal abuse occurred.
    2. The Unit Manager must ensure the Written Report is submitted to law enforcement within 72 hours of the Oral Report.
    3. The Written Report must become a part of the Recipient's clinical record; however, before this occurs, the name(s) of the reporting individuals and the individual accused of committing the criminal abuse (if contained in the report) shall be deleted.

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D. Reporting abuse or neglect of a vulnerable adult to MDHHS:
    1. As also mandated by law, employees, contract employees, and volunteers are required to make an oral or written report to the Michigan Department of Health Human Services when there is reasonable cause to suspect the abuse or neglect of a vulnerable adult by any person (refer to EXHIBIT C).

E. Procedures for the prompt reporting, review, investigation, and resolution of apparent or suspected violations of the rights guaranteed by Chapter 7 of the MMHC are included in the Recipient Rights Complaint, Investigation, and Appeal Policy (Refer also to the Recipient Rights Complaint, Investigation, and Appeal document.)

Investigation of Abuse and Neglect

Refer also to the Recipient Rights Complaint, Investigation, and Appeal document.

A. The ORR shall initiate and take primary responsibility for the immediate investigation of reports of recipient abuse or neglect through a prompt and thorough review of the allegations and in a manner that is fair to both the recipient alleged to have been abused and the charged employee, volunteer, or agent of the provider.

B. Staff of the ORR shall be given unimpeded access to all employees, all recipients, all program sites, and any evidence determined as necessary by the ORR to carry out a thorough and

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independent investigation of allegations of abuse or neglect or allegations of other of rights violations. employees, contract employees, and volunteers are required to be available, cooperate, and respond as requested, both orally and in writing, to questions put forth by investigators from the ORR and other authorized investigative agencies.

Remediation of Abuse and Neglect Violations

Refer also to the Recipient Rights Complaint, Investigation, and Appeal document.

A. Appropriate disciplinary action shall be taken against those who have engaged in abuse or neglect.
    1. As defined by Section 7035 (1) of the Administrative Rules, disciplinary action must be one of the following: official reprimand, demotion, suspension, reassignment, or dismissal.
    2. An official reprimand may be categorized as either written or verbal.

B. If an allegation of abuse or neglect is found to be substantiated, appropriate remedial action will be taken as soon as is administratively possible, but no later than within the time frame recommended by the ORR with documentation submitted to the office.

C. The Hospital Director will assure, and the ORR will monitor the remediation of all substantiated violations of abuse or neglect.

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Training

A. All employees, contract employees, and volunteers of the hospital shall receive annual training in abuse and neglect definitions, prevention, identification, reporting, and investigation procedures.

Following the Identification of Recipient Abuse and Neglect

Refer also to the Duty to Report - Recipient Rights Violations document.

A. An employee, contract employee, volunteer, or agent of D6, or of a contracted provider, who witnesses or receives a report of the abuse or neglect of a recipient shall do all of the following:
    1. Whenever possible, safeguard the recipient from continuing abuse and/or neglect by providing appropriate medical care, comfort, and support to the patient; and
    2. Immediately report the incident to the employee or volunteer's supervisor unless either the supervisor is unavailable or the employee has reason to believe that the supervisor has abused or neglected the recipient, in which case the employee or volunteer shall, if possible, report to another administrator; and
    3. Immediately report to the appropriate investigative offices or agencies as follows (*Note: reports may be required to be made simultaneously. (Refer to Section IX below)

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Reporting Different Types of Recipient Abuse and Neglect

A. **RECIPIENT ABUSE OR NEGLECT - REPORT TO THE ORR** (Refer to EXHIBIT A for definitions):

1. When an employee, contract employee, or volunteer witnesses, discovers, or otherwise becomes aware of, the apparent or suspected abuse or neglect of a recipient by another employee, contract employee, or volunteer as defined by this policy, the staff member or volunteer shall immediately make an oral report to the ORR in person or by phone. The Recipient Rights Advisor should be paged 231-318-1257 and a message left on voice mail 231-935-5051 if the incident occurred after regular business hours. This must be followed by a written report submitted directly to the ORR within 24 hours.
2. An employee, contract employee, or volunteer must also immediately make an oral report to the ORR in person or by phone, followed by a written report within 24 hours, when the employee, contract employee, or volunteer witnesses, discovers, or otherwise becomes aware of the criminal abuse, accidental or unexplained death, or the serious injury of a patient.
   a. The oral report shall include all, or as much is known, of the following:
      i. The name of the recipient,
      ii. The name of the alleged perpetrator,
      iii. The date, time, and location the alleged abuse or neglect occurred,
      iv. The date, time, and location the abuse or neglect was discovered,
      v. The specific nature of the abuse or neglect,
      vi. What actions were taken to protect the patient from further harm, and
      vii. Any other information related to the incident.
   b. The written report shall be made via the incident reporting system designated by the hospital and also include the above listed information.
3. The employee, contract employee, or volunteer may, but is not required to, file a formal recipient rights complaint in addition to the incident report. The reporting individual is, as required by other policy, to forward complaints made by patients or other individuals on behalf of patients immediately to the ORR (Refer also to the Recipient Rights Complaint, Investigation, and Appeal document.

B. **CRIMINAL ABUSE OF A RECIPIENT - REPORT TO LAW ENFORCEMENT AND THE ORR** (Refer to EXHIBIT B for definitions)

1. Pursuant to Section 330.1723 of the MMHC, if an employee or volunteer has reasonable cause to suspect the criminal abuse of a recipient that individual shall immediately make an oral report, by telephone or otherwise, of the suspected

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criminal abuse to the law enforcement agency for the county or city in which the criminal abuse is suspected to have occurred or to the state police.

2. Within 72 hours after making the oral report, the reporting individual shall file a written report with the law enforcement agency to which the oral report was made, with the chief administrator of the facility responsible for the recipient, and to the ORR.
3. The written report shall contain the name of the recipient and a description of the criminal abuse and other information available to the reporting individual that might establish the cause of the criminal abuse and the manner in which it occurred. The report shall become a part of the recipient's clinical record. Before the report becomes part of the recipient's clinical record, the names of the reporting individual and the individual accused of committing the criminal abuse, if contained in the report, shall be deleted.
4. The identity of an individual who makes a report under this section is confidential and is not subject to disclosure without the consent of that individual or by order or subpoena of a court of record. An individual acting in good faith who makes a report of criminal abuse against a recipient is immune from civil or criminal liability that might otherwise be incurred. The immunity from civil or criminal liability granted by this subsection extends only to acts done under this section and does not extend to a negligent act that causes personal injury or death.
5. An individual who makes a report to law enforcement in good faith shall not be dismissed or otherwise penalized by an employer or contractor for making the report.
6. Employees and volunteers shall cooperate in the prosecution of appropriate criminal charges against those who have engaged in criminal abuse.
7. The report does not preclude from investigating reported claims of criminal abuse of a recipient by its employees or contracted employees, and from taking or ensuring appropriate disciplinary action against its employees or contracted employees based upon that investigation.
8. Employees, contracted employees, or volunteers are not required to report suspected criminal abuse to law enforcement if either of the following applies:
    a. The individual has knowledge that the incident of suspected criminal abuse has been reported to the appropriate law enforcement agency as provided in this section.
    b. The suspected criminal abuse occurred more than 1 year (for adults), and 2 years (for children) before the date on which it first became known to an individual who would otherwise be required to make a report.
9. These procedures do not require an individual required to report suspected criminal abuse to disclose confidential information or a privileged communication except under one or both of the following circumstances:
    a. If the suspected criminal abuse is alleged to have been committed or caused by a mental health professional, an individual employed by or under contract to the department, a licensed facility, or a community

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mental health services program, or an individual employed by a service provider under contract to the department, a licensed facility, or a community mental health services program.

b. If the suspected criminal abuse is alleged to have been committed in one of the following:

   i. A state facility or a licensed facility.

   ii. A county community mental health services program site.

   iii. The work site of an individual employed by or under contract to the department, a licensed facility, or a community mental health services program or a provider under contract to the department, a licensed facility, or a community mental health services program.

   iv. A place where a recipient is under the supervision of an individual employed by or under contract to the department, a licensed facility, a community mental health services program, or a provider under contract to the department, a licensed facility, or a community mental health services program.

C. **VULNERABLE ADULT ABUSE AND NEGLECT - REPORT TO THE MDHHS** (Refer to EXHIBIT C for definitions)

1. An employee, contract employee, or volunteer who has reasonable cause to suspect the abuse or neglect of a vulnerable adult by any person, as defined by applicable statutes, shall immediately make an oral report to the appropriate Department of Human Services (FIA) Adult Protective Services office. FIA 24 Hour Hotline: 231-946-3220

2. Any formal written reports of Vulnerable Abuse or Neglect to FIA shall not be placed in the recipient's clinical record, but forwarded to the MMC CEO and kept in a secure location.

3. If the abuse or neglect is of a vulnerable recipient who is a resident of a licensed facility, immediately make a report to the appropriate licensing consultant, as required by the Michigan Public Health Code (PA 368 of 1978) and the applicable licensing rules.

Exhibits

EXHIBIT A: Recipient Abuse and Neglect

As defined by the MMHC and MDHHS Administrative Rules, Section 7001.

Abuse

A. **ABUSE, CLASS I** means a non-accidental act, or provocation of another to act, by an employee, volunteer, or agent of a provider that caused or contributed to the death, serious physical harm, or sexual abuse to a recipient.

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B. **ABUSE, CLASS II** means any of the following:

1. A non-accidental act or provocation of another to act by an employee, volunteer, or agent of a provider that caused or contributed to non-serious physical harm to a recipient.
2. The use of unreasonable force on a recipient by an employee, volunteer, or agent of a provider with or without apparent harm.
3. Any action or provocation of another to act by an employee, volunteer, or agent of a provider that causes or contributes to emotional harm to a recipient.
4. An action taken on behalf of a patient by a provider who assumes the recipient is incompetent, despite the fact that a guardian has not been appointed, that results in substantial economic, material, or emotional harm to the recipient.

C. **ABUSE, CLASS III** means the use of language, or other means of communication, by an employee or volunteer to degrade, threaten, or sexually harass a recipient.

Neglect

A. **NEGLECT, CLASS I** means either of the following:

1. Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by law and/or rules, policies, guidelines, written directives, procedures, or individual plan of service and and ***causes or contributes to death or sexual abuse, or serious physical harm to a recipient.***
2. The failure to report apparent or suspected Abuse, Class I or Neglect, Class I of a recipient.

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B. **NEGLECT, CLASS II** means either of the following:

1. Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by law and/or rules, policies, guidelines, written directives, procedures, or individual plan of service and and ***causes or contributes to non-serious physical harm or emotional harm to a recipient***.
2. The failure to report apparent or suspected Abuse, Class II or Neglect, Class II of a recipient.

C. **NEGLECT, CLASS III** means either of the following:

1. Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by law and/or rules, policies, guidelines, written directives, procedures, or individual plan of service and that either ***placed or could have placed a recipient at risk of physical harm or sexual abuse***.
2. The failure to report apparent or suspected Abuse, Class III or Neglect, Class III of a recipient.

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Definition of Specific Terms

A. **BODILY FUNCTION** means the usual action of any region or organ of the body.

B. **DEGRADE** means any of the following:

   1. Treat humiliatingly, to cause somebody or something a humiliating loss of status or reputation, or to cause somebody a humiliating loss of self-esteem.
   2. To make worthless, to cause people to feel they or other people are worthless and do not have the respect or good opinion of others.
   3. Use of any language or epithets that insult a person's heritage, mental status, race, sexual orientation, gender, intelligence, etc.
   4. Actions such as swearing at recipients, using foul language at recipients, using racial or ethnic slurs toward or about recipients, making emotionally harmful remarks toward recipients, or causing/prompting others to commit any of these listed actions.

C. **EMOTIONAL HARM** means impaired psychological functioning, growth, or development of a significant nature, as evidenced by observable physical symptomatology or as determined by a mental health professional.

D. **EXPLOITATION** means an action by an employee, volunteer, or agent of a provider that involves the misappropriation or misuse of a recipient's property or funds for the benefit of an individual or individuals other than the recipient.

E. **NON-SERIOUS PHYSICAL HARM** means physical damage or what could reasonably be construed as pain suffered by a recipient that a physician or registered nurse determines could not have caused, or contributed to, the death of a recipient, the permanent disfigurement of a recipient, or an impairment of their bodily functions.

F. **PHYSICAL MANAGEMENT** means 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 themselves or others.

G. **PROTECTIVE DEVICE** means a device or physical barrier to prevent the recipient from causing serious self-injury associated with documented and frequent incidents of the behavior. Such a protective device incorporated in the written individual plan of service shall not be considered a restraint as defined in this section.

H. **PROVIDER** means the hospital, their employees, volunteers, and contracted agents.

I. **RESTRAINT** means the use of a physical device to restrict an individual's movement, and does not include the use of a device primarily intended to provide anatomical support.

J. **SERIOUS PHYSICAL HARM** means physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.

K. **SEXUAL ABUSE** means any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and a recipient.

L. **SEXUAL CONTACT** means the intentional touching of the recipient's or employee's intimate

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parts or the touching of the clothing covering the immediate area of the recipient's or employee's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or gratification, done for a sexual purpose, or in a sexual manner for any of the following: revenge, to inflict humiliation, or out of anger.

M. **SEXUAL PENETRATION** means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required.

N. **SEXUAL HARASSMENT** means sexual advances to a recipient, requests for sexual favors from a recipient, or other conduct or communication of a sexual nature toward a recipient.

O. **THERAPEUTIC DE-ESCALATION** means an intervention, the implementation of which is incorporated in the individualized written plan of service, wherein the recipient is placed in an area or room, accompanied by staff who shall therapeutically engage the recipient in behavioral de-escalation techniques and debriefing as to the cause and future prevention of the target behavior.

P. **THREATEN** means any of the following:

   1. To utter intentions of injury or punishment against a recipient.
   2. To express a deliberate intention to deny the well-being, safety, or happiness of a recipient unless they do what is being demanded.

Q. **TIME OUT** means a voluntary response to the therapeutic suggestion to a recipient to remove themselves from a stressful situation in order to prevent a potentially hazardous outcome.

R. **UNREASONABLE FORCE** means physical management or force that is applied by an employee, volunteer, or agent of a provider to a recipient in one or more of the following circumstances:

   1. There is no imminent risk of serious or non-serious physical harm to the recipient, staff or others.
   2. The physical management used is not in compliance with techniques approved by the hospital for use on D6.
   3. The physical management used is not in compliance with the emergency interventions authorized in the recipient's individual plan of service.
   4. The physical management or force is used when other less restrictive measures were possible but not attempted immediately before the use of physical management or force.

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EXHIBIT B: Criminal Abuse

As defined by the MMHC, Section 7000 (a)

A. An assault that is a violation or an attempt or conspiracy to commit a violation of sections 81 to 90 of the Michigan Penal Code, Act No. 328 of the Public Acts of 1931, being sections 750.81 to 750.90 of the Michigan Compiled Laws. Criminal abuse does not include an assault or an assault and battery that is a violation of section 81 of Act No. 328 of the Public Acts of 1939, being section 750.81 of the Michigan Compiled Laws, and that is committed by a recipient against another recipient.

B. A criminal homicide that is a violation or an attempt or conspiracy to commit a violation of

section 316, 317, or 321 of Act No. 328 of the Public Acts of 1931, being sections 750.316, 750.317, and 750.321 of the Michigan Compiled Laws.

C. Criminal sexual conduct that is a violation or an attempt or conspiracy to commit a violation of sections 520b to 520e or 520g of Act No. 328 of the Public Acts of 1931, being sections 750.520b to 750.520e and 750.520g of the Michigan Compiled Laws.

D. Vulnerable adult abuse that is a violation or an attempt or conspiracy to commit a violation of section 145n of the Michigan penal code, Act No. 328 of the Public Acts of 1931, being section 750.145n of the Michigan Compiled Laws.

E. Child abuse that is a violation or an attempt or conspiracy to commit a violation of section 136b of Act No. 328 of the Public Acts of 1931, being section 750.136b of the Michigan Compiled Laws. *NOTE: D6 does not treat minors, therefore, reporting requirements are per hospital wide policy.*

As defined by the Michigan Penal Code

A. Violations of Sections 81 to 90 of the Michigan Penal Code; including an attempt or a conspiracy to commit a violation of Sections 81 to 90.
    1. Note: Abuse does not include an assault which is a violation of Section 81 of the Michigan Penal Code committed by a patient or resident against another patient or resident unless the battery results in serious physical injury.
    2. Note: A brief explanation of the violation follows each section where necessary for the sake of understanding. These explanations are not exact definitions from the Penal Code.

B. Sec. 750.81 Assault/Assault and Battery
    1. Assault – Any willful attempt or threat to inflict injury upon the person of another when coupled with an apparent present ability to do so and any intentional display of force such as would give the victim reason to fear or expect immediate bodily harm.
    2. Assault and battery – Any unlawful touching of another which is without justification or excuse. Battery requires physical contact of some sort (bodily injury or offensive touching).

C. Sec. 750.81A Aggravated Assault
    1. An assault committed with the intention of committing some additional crime or one attended with circumstances of peculiar outrage or atrocity. A person is guilty of aggravated assault if he/she: (a) attempts to cause serious bodily injury to another, or causes such injury purposely, knowingly or recklessly under circumstances manifesting extreme indifference to the value of human life; or (b) attempts to cause or purposely or knowingly causes bodily injury to another with a dangerous or deadly weapon.

D. Sec. 750.82 Felonious Assault (Deadly Weapon)
    1. An unlawful attempt or offer to do bodily harm without justification or excuse by use of an instrument calculated to do harm or cause death. An aggravated form of assault as distinguished from a simple assault, e.g., pointing a loaded gun at another is an assault with a dangerous/deadly weapon.

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E. Sec. 750.83 Assault With Intent to Murder
    1. To constitute this assault, specific intent to kill, actuated by malice aforethought must occur.
F. Sec. 750.84 Assault With Intent to Do Great Bodily Harm Less Than Murder
G. Sec. 750.86 Assault With Intent to Maim
    1. An assault which inflicts upon another any injury which deprives that person of the use of any limb or member of the body; or to seriously disfigure or disable.
H. Sec. 750.87 Assault With Intent to Commit (A Felony)
    1. An example would be inflicting bodily injury with an accompanying intent to kidnap or rape the victim.
I. Sec. 750.88 Assault With Intent to Rob While Unarmed
J. Sec. 750.89 Assault With Intent to Rob While Armed
    1. Criminal homicide in violation of Sections 316, 317, or 321 of the Michigan Penal Code, including an attempt or a conspiracy to commit a violation of Sections 316, 317, or 321.
K. Sec. 750.316 First Degree Murder
    1. All murder which shall be perpetrated by means of poison, or by lying in wait, or by any other kind of willful, deliberate and premeditated killing, or which shall be committed in the perpetration of, or attempt to perpetrate any arson, rape, robbing or burglary are commonly deemed murder of the first degree.
L. Sec. 750.317 Second Degree Murder
    1. All other kinds of murder not deemed in the first degree.
M. Sec. 750.321 Manslaughter
    1. The unlawful killing of a human without malice and without premeditation and deliberation. Criminal sexual conduct in violation of Sections 520b to 520e, or assault with intent to commit criminal sexual conduct in violation of Section 520g of the Michigan Penal Code, including an attempt or conspiracy to commit a violation of Sections 520b though 520e or Section 520g.

Criminal Sexual Conduct (CSC)

***As defined by the Michigan Penal Code* (PA 328 of 1931)**

1st Degree CSC

A. **MCLA 750.520b**
    1. A person is guilty of criminal sexual conduct in the first degree if he or she engages in sexual penetration with another person and if any of the following circumstances exist:
        a. That other person is under 13 years of age.

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b. That other person is at least 13 but less than 16 years of age and any of the following:
    i. The actor is a member of the same household of the victim.
    ii. The actor is related to the victim by blood or affinity to the fourth degree.
    iii. The actor is in a position of authority over the victim and used this authority to coerce the victim to submit.
c. Sexual penetration occurs under circumstances involving the commission of any other felony.
d. The actor is aided or abetted by 1 or more other persons and either of the following circumstances exists:
    i. The actor knows or has reason to know that the victim is mentally incapable, mentally incapacitated, or physically helpless.
    ii. The actor uses force or coercion to accomplish the sexual penetration. Force or coercion includes but is not limited to any of the circumstances listed in subdivision (f) (I) to (v).
e. The actor is armed with a weapon or any article used or fashioned in a manner to lead the victim to reasonably believe it to be a weapon.
f. The actor causes personal injury to the victim and force or coercion is used to accomplish sexual penetration. Force or coercion includes but is not limited to any of the following circumstances:
    i. When the actor overcomes the victim through the actual application of physical force or physical violence.
    ii. When the actor coerces the victim to submit by threatening to use force or violence on the victim, and the victim believes that the actor has the present ability to execute these threats.
    iii. When the actor coerces the victim to submit by threatening to retaliate in the future against the victim, or any other person, and the victim believes that the actor has the ability to execute this threat. As used in this subdivision, "to retaliate" includes threats of physical punishment, kidnapping, or extortion.
    iv. When the actor engages in the medical treatment or examination of the victim in a manner or for the purposes which are medically recognized as unethical or unacceptable.
    v. When the actor, through concealment or by the element of surprise, is able to overcome the victim.
g. The actor causes personal injury to the victim, and the actor knows or has reason to know that the victim is mentally incapable, mentally incapacitated, or physically helpless.
h. That other person is mentally incapable, mentally disabled, mentally

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incapacitated, or physically helpless, and any of the following:

    i. The actor is related to the victim by blood or affinity to the fourth degree.
    ii. The actor is in a position of authority over the victim and used this authority to coerce the victim to submit.

2. Criminal sexual conduct in the first degree is a felony punishable by imprisonment in t he state prison for life or f or any term of years.

2nd Degree CSC

A. MCLA 750.520c

1. A person is guilty of criminal sexual conduct in the second degree if the person engages in sexual contact with another person and if any of the following circumstances exist:
    a. That other person is under 13 years of age.
    b. That other person is at least 13 but less than 16 years of age and any of the following:
        i. The actor is a member of the same household as the victim.
        ii. The actor is related by blood or affinity to the fourth degree to the victim.
        iii. The actor is in a position of authority over the victim and the actor used this authority to coerce the victim to submit.
    c. Sexual contact occurs under circumstances involving the commission of any other felony.
    d. The actor is aided or abetted by 1 or more other persons and either of the following circumstances exists:
        i. The actor knows or has reason to know that the victim is mental incapable, mentally incapacitated, or physically helpless.
        ii. The actor uses force or coercion to accomplish the sexual contact. Force or coercion includes but is not limited to any of the circumstances listed in sections 520b (1) (f) (i) to (v).
    e. The actor is armed with a weapon, or any article used or fashioned in a manner to lead a person to reasonably believe it to be a weapon.
    f. The actor causes personal injury to the victim and force or coercion is used to accomplish the sexual contact. Force or coercion includes but is not limited to any of the circumstances listed in section 520b (1) (f) (i) to (v).
    g. The actor causes personal injury to the victim and the actor knows or has reason to know that the victim is mentally incapable, mentally incapacitated, or physically helpless.
    h. That other person is mentally incapable, mentally disabled, mentally

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incapacitated, or physically helpless, and any of the following:

i. The actor is related to the victim by blood or affinity to the fourth degree.

ii. The actor is in a position of authority over the victim and used this authority to coerce the victim to submit.

2. Criminal sexual conduct in the second degree is a felony punishable by imprisonment for not more than 15 years.

3rd Degree CSC

A. MCLA 750.520d

1. A person is guilty of criminal sexual conduct in the third degree if the person engages in sexual penetration with another person and any of the following circumstances exist:

   a. That other person is at least 13 years of age and under 16 years of age.

   b. Force or coercion is used to accomplish the sexual penetration. Force or coercion includes but is not limited to any of the circumstances listed in section 520b (1) (f) (i) to (v).

   c. The actor knows or has reason to know that the victim is mentally incapable, mentally incapacitated, or physically helpless.

2. Criminal sexual conduct in the third degree is a felony punishable by imprisonment for not more than 15 years.

4th Degree CSC

A. MCLA 750.520e

1. A person is guilty of criminal sexual conduct in the fourth degree if he or she engages in sexual contact with another person and any of the following circumstances exists:

   a. Force or coercion is used to accomplish the sexual contact. Force or coercion includes but is not limited to any of the circumstances listed in section (1) (f) (i) to (v).

   b. The actor knows or has reason to know that the victim is incapable, mentally incapacitated, or physically helpless.

   c. That other person is under the jurisdiction of the department of corrections, and the actor is an employee or a contractual employee or volunteer with, the department of corrections who has knowledge that the other person is under the jurisdiction of the department of corrections.

   d. That other person is related to the actor by blood or affinity to the third degree and the sexual contact occurs under circumstances not otherwise prohibited by this chapter.

   e. The actor is a mental health professional and the sexual contact occurs during or within 2 years after the period in which the victim is his or her

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client or patient and not his or her spouse. The consent of the victim is not a defense to a prosecution under this subdivision; this does not indicate that the victim is mentally incompetent.

2. Criminal sexual conduct in the fourth degree is a misdemeanor punishable by imprisonment for not more than 2 years, or by a fine of not more than $500.00 or both.

Criminal Abuse

As defined by the Michigan Penal Code

A. **MCLA 750.520a (as amended)**
   1. "Actor" means a person accused of criminal sexual conduct.
   2. "Developmental disability" means an impairment of general intellectual functioning or adaptive behavior which meets the following criteria:
      a. It originated before the person became 18 years of age.
      b. It has continued since its origination or can be expected to continue indefinitely.
      c. It constitutes a substantial burden to the impaired person's ability to perform in society.
      d. It is attributable to one or more of the following:
         i. Mental retardation, cerebral palsy, epilepsy, or autism.
         ii. Any other condition of a person found to be closely related to mental retardation because it produces a similar impairment or requires treatment and services similar to those required for a person who is mentally retarded.
   3. "Intimate parts" includes the primary genital area, groin, inner thigh, buttock, or breast of a human being.
   4. "Mental illness" means a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality or ability to cope with the ordinary demands of life.
   5. "Mentally disabled" means that a person has a mental illness, is mentally retarded, or has a developmental disability.
   6. "Mentally incapable" means that a person suffers from a mental disease or defect which renders that person temporarily or permanently incapable of appraising the nature of his or her conduct.
   7. "Mentally incapacitated" means that a person is rendered temporarily incapable of appraising or controlling his or her conduct due to the influence of a narcotic, anesthetic, or other substance administered to that person without his or her consent, or due to any other act committed upon that person without his or her consent.
   8. "Mentally retarded" means significantly subaverage general intellectual functioning

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which originates during the developmental period and is associated with impairment in adaptive behavior.

9. "Physically helpless" means that a person is unconscious, asleep, or for any other reason is physically unable to communicate unwillingness to an act.
10. "Personal injury" means bodily injury, disfigurement, mental anguish, chronic pain, pregnancy, disease, or loss or impairment of a sexual or reproductive organ.
11. "Sexual contact" includes the intentional touching of the victim's or actor's intimate parts or the intentional touching of the clothing covering the immediate area of the victim's or actor's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or gratification.
12. "Sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required.
13. "Victim" means the person alleging to have been subjected to criminal sexual conduct.

EXHIBIT C: Vulnerable Adult Abuse and Neglect Definitions

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Vulnerable Adult Abuse

As defined by the Michigan Penal Code (PA 328 of 1931): Sec. 144n

A. A caregiver is guilty of vulnerable adult abuse in the first degree if the caregiver intentionally causes serious physical harm or serious mental harm to a vulnerable adult. Vulnerable adult abuse in the first degree is a felony punishable by imprisonment for not more than 15 years or a fine of not more than $10,000.00, or both.

B. A caregiver or other person with authority over the vulnerable adult is guilty of vulnerable adult abuse in the second degree if the reckless act or reckless failure to act of the caregiver or other person with authority over the vulnerable adult causes serious physical harm or serious mental harm to a vulnerable adult. Vulnerable adult abuse in the second degree is a felony punishable by imprisonment for not more than 4 years or a fine of not more than $5,000.00, or both.

C. A caregiver is guilty of vulnerable adult abuse in the third degree if the caregiver intentionally causes physical harm to a vulnerable adult. Vulnerable adult abuse in the third degree is a misdemeanor punishable by imprisonment for not more than 2 years or a fine of not more than $2,500.00, or both.

D. A caregiver or other person with authority over the vulnerable adult is guilty of vulnerable adult abuse in the fourth degree if the reckless act or reckless failure to act of the caregiver or other person with authority over a vulnerable adult causes physical harm to a vulnerable adult. Vulnerable adult abuse in the fourth degree is a misdemeanor punishable by imprisonment for not more than 1 year or a fine of not more than $1,000.00, or both.

E. This section does not prohibit a caregiver or other person with authority over a vulnerable adult from taking reasonable action to prevent a vulnerable adult from being harmed or from harming others.

F. This section does not apply to an act or failure to act that is carried out as directed by a patient advocate under a patient advocate designation executed in accordance with sections 5506 to 5515 of the estates and protected individuals code, 1998 PA 386, MCL 700.5506 to 700.5515.

As defined by the Michigan Social Welfare Act (PA 280 of 1938, MCL 400.11)

A. **VULNERABLE ADULT**

   1. An adult whose condition is such that he or she is unable to protect himself or herself from abuse, neglect, or exploitation because of a mental or physical impairment or because of advanced age.

B. **VULNERABLE ADULT ABUSE OR NEGLECT**

   1. Harm or threatened harm to an adult's health or welfare caused by another person. Abuse includes, but is not limited to, nonaccidental physical or mental injury, sexual abuse, or maltreatment.

C. **VULNERABLE ADULT EXPLOITATION**

   1. "Exploitation" means; by employee, volunteer, or agent of provider, any action that involves the misuse of a recipients funds, property, or personal dignity for the benefit of an individual or individuals other than the recipient.

D. **VULNERABLE ADULT NEGLECT**

   1. Harm to an adult's health or welfare caused by the inability of the adult to respond to a harmful situation or by the conduct of a person who assumes responsibility for a significant aspect of the adult's health or welfare. Neglect includes the failure to provide adequate food, clothing, shelter, or medical care. A person shall not be considered to be abused, neglected, or in need of emergency or protective service s for the sole reason that the person is receiving or relying upon treatment by spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination, and this act shall not require any medical care or treatment in contravention of the stated or implied objection of that person.

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Applicability

Cadillac Hospital, Munson Medical Center

Standards

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Next Review	12/3/2028		

Dignity and Respect

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Purpose

To provide a definition of and guidelines for ensuring patients and their families are treated in a dignified and respectful manner.

Policy

A. All patients receiving behavioral health services and their family members shall be treated with dignity and respect, the definitions of which include, but are not limited to the following:
   1. Dignity means:
      a. To be treated with esteem, honor, politeness
      b. To be addressed in a manner that is not patronizing or condescending
      c. To be treated as an equal
      d. To be treated the way any individual would like to be treated
   2. Respect means:
      a. To show deferential regard for an individual
      b. To be treated with esteem, concern, consideration or appreciation
      c. To use patient's preferred pronoun
      d. To be sensitive to cultural differences
      e. To allow an individual to make choices.

B. All Munson Healthcare (MHC) employees, volunteers, contractual service providers, and employees of contractual service providers shall treat patients and their family members with dignity and respect. Refer to the Employee Code of Conduct policy.

C. Treatment with dignity and respect shall be further clarified by the patient or family member and considered in light of the specific incident, treatment goals, safety concerns, laws and standards, and what a reasonable person would expect under similar circumstances.

D. Treatment with dignity and respect may also include being sensitive to conduct that is, or may be deemed, offensive to the other person. Staff shall refrain from coarse or vulgar language in the presence of patients or their family members.

E. Respectful communication shall be used when interacting with patients, family members, legal representatives, and other patient designated support persons. Respectful communication with patients is:

    1. Communication that is courteous and professional at all times
    2. Communication that is humane and is designed to assist all persons to achieve self-esteem, independence, and quality of life
    3. Communication that considers and is responsive to the nature of a patient's disorder or disability, especially considering the phenomenon of institutionalization and/or degree of dependency that the patient may have experienced
    4. Communication that considers and does not reinforce the realities of stigma, inequality, and discrimination that the person may have encountered or may encounter in community life as a result of his or her disability
    5. Communication that accommodates the patient's need for privacy during all therapeutic interventions
    6. Communication that prioritized the use of positive approaches in addressing treatment or supports goals and overcoming barriers to the achievement of full inclusion in the community.

F. In addition to the provisions listed above, showing respect for family members of patients shall also include, but is not limited to, the following:

    1. Giving family members an opportunity to provide information to the treating professionals or unit staff,
    2. Providing family members an opportunity to request and receive educational information about a patient's diagnosed mental illness, medications and their side effects, available support services, advocacy and support groups, financial assistance and coping strategies.
    3. Information shall be received from or provided to family members within the confidentiality constraints of Section 1748 of the Michigan Mental Health Code. Refer to the Confidentiality of Patients Receiving Behavioral Health Services policy.

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Applicability

Cadillac Hospital, Munson Medical Center

Standards

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Next Review	12/3/2028		

Duty to Report-Recipient Rights Violations

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Purpose

To provide a policy explaining the duties and reporting recipient rights violations.

Scope

Policy applies to all Munson Medical Center (MMC) Behavioral Health Unit activities, operations, and sites and to all staff members, contract agents (including physicians) and volunteers.

Definitions

1. **Abuse:** means nonaccidental physical or emotional harm to a recipient, or sexual contact with or sexual penetration of a recipient that is committee by an employee, contract agent, or volunteer of MMC as those terms are defined by Section 502a of the Michigan Penal Code, 1931 PA 328, MCL 750.520a, Michigan Mental Health Code, Administrative Rules of the Michigan Department of Community Health, and MMC Abuse and Neglect Policy.
2. **Advisor:** means the Recipient Rights Advisor(s) and Back-up Recipient Rights Advisor(s).
3. **Allegation**: means an assertion of fact made by an individual that has not yet been proved or supported with evidence.
4. **Code Protected Right:** means a right that is guaranteed in the Michigan Mental Health Code, the Administrative Rules of the Michigan Department of Community Health, or other applicable law.
5. **Complainant:** means an individual who files a recipient rights complaint.
6. **Complaint:** means a written or oral statement that meets the requirements of section 1776 of the Michigan Mental Health Code for a recipient rights complaint.
7. **D6:** means the inpatient Behavioral Health Unit - a service of Munson Healthcare Cadillac

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Hospital (CAD), which is a psychiatric unit licensed under Section 1137 of the Michigan Mental Health Code.

8. **Employee:** means any MHC staff member, contract agent, or volunteer.
9. **MHC:** means Munson Healthcare.
10. **Neglect:** means an act or failure to act committed by an employee, contract agent, or volunteer of MMC that denies a recipient the standard of care or treatment to which he or she is entitled under the Michigan Mental Health Code, Administrative Rules of the Michigan Department of Community Health, and MMC Abuse and Neglect Policy.
11. **Office:** means the Office of Recipient Rights created by MMC under section 1755 of the Michigan Mental Health Code.
12. **Recipient:** means an individual who receives behavioral health services from D6.
13. **Rights Complaint:** means a written or oral statement that meets the requirements of section 1776 of the Michigan Mental Health Code.
14. **Rights Violation:** means any incident involving an apparent or suspected violation of a right guaranteed by Chapter 7 and 7a of the Michigan Mental Health Code or as further devised by Munson policy and procedures.
15. **Rights Protection System:** means those elements including but not limited to complaint investigation and resolution, prevention, and monitoring required in the establishment of the Office of Recipient Rights by the Michigan Mental Health Code.
16. **Serious Injury:** means physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of the recipient's bodily functions, or caused the permanent disfigurement of a recipient.

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Policy

All staff members, contract agents, and volunteers of MHC shall report any alleged, apparent, or suspected violation of the rights of a recipient directly to the Office of Recipient Rights as required by the Michigan Mental Health Code (PA 258 of 1974, Section 330.1752).

Abuse, Neglect, Serious Injury, or Death

A. MHC employees have a duty to report any and all apparent or suspected instances of abuse, neglect, serious injury, unexplained injury, or death of a recipient to the Office or Advisor.

B. When an employee witnesses, receives report of, or otherwise has knowledge of an apparent or suspected instance of abuse, neglect, serious or unexplained injury, or death of a recipient, they shall do the following in as immediate a manner as is possible and reasonable:

    1. Contact the Office or Advisor and notify them of the above instance.
    2. Communicate all relevant details of the aforementioned instance verbally or in writing to the Office or Advisor.

C. Failure of an employee to report apparent or suspected instances of abuse, neglect, serious or unexplained injury, or death of a recipient may result in the following:

1. Administrative and/or disciplinary action up to and including termination.
2. Investigation of the employee under a violation of Neglect, Failure to Report, Class I, II, or III as defined in the Michigan Mental Health Code, Administrative Rules of the Michigan Department of Community Health, and Munson Abuse and Neglect Policy, and as set forth in Munson Recipient Rights Complaint, Investigation, and Appeal Policy.

Communication of a Rights Violation to an Employee

A. MHC employees have a duty to report any alleged rights violations communicated verbally or in writing by a recipient, or other party on behalf of the recipient, to the Office or Advisor.

B. Recipient communication of abuse or neglect are to be communicated in as immediate a manner as possible to the Office or Advisor. See Abuse, Neglect, Serious Injury, or Death Section above.

C. Should the complainant choose to not contact the Office or Advisor, this does not alleviate the duty of the employee to report the matter directly and in a timely manner to the Office or Advisor, as set forth below.

D. When a rights violation is communicated verbally to an employee, they shall do one of the following in a timely manner:
   1. Assist the complainant to fill out a recipient rights complaint form, or otherwise put their complaint in writing.
   2. Direct the complainant to contact the Office or Advisor and provide such contact details to enable them to do so.
   3. Contact the Office or Advisor on behalf of the complainant to notify them of the complaint.

E. When a rights violation is communicated in writing to an employee, they shall do one of the following in a timely manner:
   1. Direct and/or assist the complainant to place complaint in the Recipient Rights box located on D6.
   2. Deliver the complaint to the Office or Advisor on behalf of the complainant.
   3. Contact the Office or Advisor on behalf of the complainant to notify them of the complaint.

F. Failure of an employee to report an alleged rights violation communicated to them will result in an investigation of the employee for a potential rights violation in and of itself under the provisions set forth in the Munson Recipient Rights Complaint, Investigation, and Appeal Policy.

Employee Witnessed, Suspected, or Apparent Violations

A. MHC employees have a duty to report any apparent or suspected rights violations they witnessed, received report of, or have knowledge of to the Office or Advisor.

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B. Any instances of abuse or neglect that an employee witnessed, received report of, or has knowledge of are to be communicated in as immediate a manner as possible to the Office or Advisor. See Abuse, Neglect, Serious Injury, or Death Section above.

C. When an employee directly witnesses, received reports of, or has knowledge of an apparent or suspected rights violation, they shall do the following in a timely manner:

   1. Contact the Office or Advisor directly.
   2. Communicate the possible violation verbally or in writing to the Office or Advisor.

D. An employee may choose, but is not required, to file a recipient rights complaint on behalf of the recipient, provided that a report has been made to the Office or Advisor as required by this policy.

E. Failure of an employee to report an apparent or suspected rights violation communicated to them will result in an investigation of the employee for a potential rights violation in and of itself under the provisions set forth in the MHC Recipient Rights Complaint, Investigation, and Appeal Policy.

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Applicability

Cadillac Hospital, Munson Medical Center

Standards

No standards are associated with this document

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Emergency Removal of Patients in Restraint or Seclusion

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Purpose

To provide a process for emergently removing a patient that is restrained or secluded.

Procedure

A. The nurse assigned to the patient will be responsible for removal of restraints or from seclusion in case of an emergency. All nurses have badge entry to seclusion room. Keys to lock-type restraints must be kept on the staff members' key ring.

B. When the fire, severe weather, or internal disaster procedures (drill or active) are initiated, the nurse (with assistance from additional staff as indicated) shall immediately release the patient from restraints or unlock the seclusion room. The nurse shall remain there with the patient, with support as deemed necessary, unless transport to another area is necessary for the preservation of life. If assistance is necessary, see below.

C. If transport to another area is necessary, additional staff trained in AEGIS shall be called to assist. The need for additional staff will be determined by the unit manager, charge registered nurse (RN) or resource clinician.

   1. The following guidelines will be used in requesting additional staff to assist with patient transport for *fire, severe weather* procedures (call in order listed):

      a. 7-3 (Monday - Friday)

         i. Unit manager

         ii. Resource clinician

         iii. Behavioral Health Therapist

         iv. Behavioral Health Technician

         v. RN

vi. Security

b. 7-3 (Weekends) Security

c. 3-11 (All days) Security

d. 11-7 (All days) Security

2. The following guidelines should be followed in requesting additional staff to assist with patient transport or management during *disaster* procedures. All staff are to be notified in the order listed and requested to report to the unit if off duty.

   a. Unit Manager

   b. Resource Clinician

   c. Behavioral Health Therapist

   d. Nursing

   e. Behavioral Health Technician

D. When the emergency has passed, the patient will again be evaluated to determine the need for restraint or seclusion.

E. For other specific duties related to fire, severe weather and disaster procedures please refer to the Munson Healthcare Disaster Response Plan: Code Triage and Fire Plan Response policies.

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Applicability

Cadillac Hospital, Munson Medical Center

Standards

No standards are associated with this document

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Last Revised	1/6/2026	Tags	Policy
Next Review	1/5/2029		

Informed Consent for Psychotropic Medication

Purpose

To provide a policy for obtaining informed consent for psychotropic medications.

Definition

1. **Consent:** A written agreement executed by a patient. If the patient is a minor, the consent should be signed by the patient's parent. If the patient has a guardian or other legal representative with authority to execute a consent, the consent should be signed by the legal representative. If it is not possible to obtain the patient's written consent, then the patient's verbal agreement should be documented in the medical record by a provider who witnessed the patient's verbal agreement other than the provider who is providing treatment.

Policy

A. In keeping with the standards of the Michigan Mental Health Code, it is the policy of the Behavioral Health Unit and to obtain the written informed consent of the patient when psychotropic medication is to be administered.

B. **Psychotropic Medication** means any medication administered for the treatment or amelioration of disorders of thought, mood or behavior.

C. Psychotropic Medication shall not be administered to a patient unless:

   1. Patient gives informed consent
   2. Administration is necessary to prevent physical injury to person or to another
   3. Court order is signed by judge

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Consent

A. **All of the following are elements of informed consent:**
    1. **Legal competency.** A patient shall be presumed to be legally competent. This presumption may be rebutted only by a court appointment of a guardian or exercised by a court of guardianship powers and only to the extent of the scope and duration of the guardianship. A patient shall be presumed legally competent regarding matters that are not within the scope and authority of the guardianship.
    2. **Knowledge.** To consent, a patient or legal representative must have basic information about the procedure, risks, other related consequences, and other relevant information. The standard governing required disclosure by a doctor is what a reasonable patient needs to know in order to make an informed decision. Other relevant information includes all of the following:
        a. The purpose of the procedures.
        b. A description of the attendant discomforts, risks, and benefits that can reasonably be expected.
        c. A disclosure of appropriate alternatives advantageous to the patient.
        d. An offer to answer further inquiries.
    3. **Comprehension.** A patient must be able to understand what the personal implications of providing consent will be based upon the information provided under subdivision (b) of this subrule.
    4. **Voluntariness.** There shall be free power of choice without the intervention of an element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion, including promises or assurances of privileges or freedom. There shall be an instruction that a patient is free to withdraw consent and to discontinue participation or activity at any time without prejudice to the patient.

B. Prior to obtaining consent, the individual shall be evaluated for capacity to grant informed consent or his/her refusal to provide informed consent and for assuring disclosure and voluntarism. This procedure shall precede an evaluation of consent for the purpose of determining whether guardianship proceedings are necessary.

C. D6 Inpatient Behavioral Health - a service of Munson Healthcare Cadillac (D6) shall establish written policies that include procedures for evaluation comprehension and for assuring disclosure of relevant information and measure to ensure voluntariness before obtaining consent. The policies and procedures shall specify for specific circumstances the types of information that shall be disclosed and steps that may be taken to protect voluntariness. The procedures shall include a mechanism for determining whether guardianship proceedings should be considered.

D. Informed consent shall be **re-obtained** if changes in circumstances substantially change the risks, other consequences or benefits that were previously expected.

E. A written agreement documenting an informed consent shall not include any exculpatory language through which the patient, or a person consenting on the patient's behalf, waives or appears to waive, a legal right, including a release of D6 or its agents from liability for

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negligence. The agreement shall embody the basic elements of informed consent in the particular context. The patient, guardian, or parent consenting shall be given an adequate opportunity to read the document before signing it. The requirement of a written consent shall not eliminate, where essential to the patient's understanding or otherwise deemed advisable, a reading of the document to the patient or an oral explanation in a language the patient understands. A note of the explanation and by whom made shall be placed in the record along with the written consent.

F. A consent is executed when it is signed by the appropriate patient.

G. Written informed consent must be obtained when any medication of the following categories is prescribed or when changes in prescription substantially affect the benefits, risks, or consequences to the patient:

    1. Antianxiety agents
    2. Anticholinergic agents
    3. Antidepressants
    4. Antiparkinsonian agents
    5. Antipsychotic agents
    6. Mood stabilizers
    7. Sedatives/hypnotics

H. Each time consent is obtained, it is documented in the record.

I. Medications shall be administered:

    1. Only at the order of a physician
    2. Must conform to federal standards
    3. Must conform to Mental Health Code/Administrative Rules
    4. Those standards as adopted by the Psychiatry Department.

J. Medication shall not be used as punishment, for the convenience of the staff or as a substitute for other appropriate treatment.

K. Psychotropic medication shall **not** be administered to a patient who has been admitted involuntarily until after the patient has been to their court hearing (adjudicated).

L. D6 may administer medication to prevent physical harm or injury after signed documentation of the physician is placed in the resident's clinical record and when the actions of a resident or other objective criteria clearly demonstrate to a physician that the resident poses a risk of harm to himself, herself or others.

M. The initial period of treatment shall be as short as possible and not extend beyond 48 hours unless there is consent. The duration of psychotropic medication shall be as short as possible and at the lowest possible dosage that is therapeutically effective and shall be terminated as soon as there is little likelihood that the resident will quickly return to an actively dangerous state and shall be the smallest possible dosage needed.

    1. The psychiatrist is responsible for informing the patient about psychotropic medication ordered and other information relevant to obtaining informed consent.

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The psychiatrist must document in History and Physical or progress notes that patient has been informed regarding medication, effects, and side effects. Patient signature may be obtained at this time or may be obtained by nursing personnel *prior* to the administration of the first dosage of the prescribed medication. A note shall be placed in the record of the explanation and by whom it was made. A written summary of the most common adverse effects shall be provided to the patient.

2. Nursing personnel may participate with the psychiatrist to review medication information with the patient in an effort to obtain the signature for informed consent and provide education regarding adverse side effects.
3. The signed *Informed Consent For Psychotropic Medication* form shall be placed in the patient record.
4. The psychiatrist and registered nurse (RN) noting newly prescribed medication orders are responsible to institute this informed consent procedure. This is to be done at the earliest point possible so that medication can be started in a timely manner.
5. Administration of all medications shall be recorded in the patient's clinical record.
6. The patient is to be informed to the right to obtain further information, to not be pressured to decide, and to withdraw consent without prejudice. Documentation in progress notes of each occurrence of teaching and the patient's response is required.

N. Only psychotropic medications that have been authorized in writing by a physician shall be given to patients upon discharge and shall be in compliance to state and federal regulations pertaining to labeling and packaging. Enough medication is made available to the patient and a prescription is given to insure that he/she has an adequate supply until he/she can become established with another provider.

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Applicability

Cadillac Hospital, Munson Medical Center

Standards

No standards are associated with this document

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MUNSON HEALTHCARE

Inpatient Mental Health Patients' Belongings and Valuables:

Protecting Patient Rights

Valerie Harpel MS, APRN-BC
November 2023

Goal and Objectives

Goal:

To familiarize staff with the management of patient belongings and valuables for inpatient mental health patients according to the Michigan Mental Health Code (MMHC) & Michigan Department of Health and Human Services Administrative Rules (MDHHS-AR).

Objectives:

1. Review the MMHC and MDHHS-AR as they relate to patient belongings and valuables.
2. Differentiate between belongings and valuables.
3. Explain documentation and management of patient belongings/valuables upon and during admission to the inpatient mental health unit.
4. Describe the proper procedure for returning valuables upon patient discharge.

Definitions

Belongings – Anything a patient brings onto the mental health unit.

Valuables – The patient defines what is valuable. Some examples are:

- Watch
- Cellphone
- Picture of a loved one
- Lucky key chain

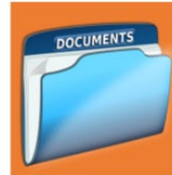
Basics of Michigan Mental Health Code & MDHHS Administrative Rules

The State of Michigan developed a group of laws that protect the rights of patients receiving care on a mental health unit.

These rights are located in the MMHC & MDHHS-AR documents.

Basics of Michigan Mental Health Code & MDHHS Administrative Rules *(cont.)*

The MMHC & MDHHS-AR were created to ensure the rights of the individual are protected and their safety is maintained during their stay on a mental health unit.



Certain rights listed on the MMHC & MDHHS-AR are based on civil rights (rights guaranteed and protected by the US Constitution and federal laws such as voting, privacy, etc.).

Basics of Michigan Mental Health Code & MDHHS Administrative Rules *(cont.)*

The rules related to patient belongings are based on the civil right from unreasonable search and seizure.

The justification for searching a patients' property is based on reasonable cause that the property may include items that could cause harm to self or others.

The MMHC-AR have specific rules that must be followed to ensure the patients' rights are not violated with searching and storing of their belongings.

Knowledge Check #1 of 4

The Michigan Mental Health Code was created to

- ○ Prevent a patient's belongings from being searched
- ○ Protect staff from legal action
- ◉ Ensure a patient's rights are not violated
- ○ Keep family informed of the patient's care

What does this mean for patients' belongings and valuables when they are admitted to an inpatient mental health unit?

What does this mean? *(cont.)*

All patient belongings are carefully searched and inventoried on admission ***and*** any time belongings are brought to the patient.

Search of the belongings are:

- Done with two (2) staff (one to search and one to witness)
- In view of a security camera
- **AND** with the patient present, unless they decline

If the patient declines to participate, the search can be done with two (2) staff as described above.

What does this mean? *(cont.)*

Inventory of a patient's belongings is entered into the patient's electronic record on admission **and** every time a patient receives belongings during their admission.

Two copies of the belongings inventory are printed (one is signed and placed in the chart and the second copy is given to the patient).

Focus note is entered in the chart listing who was present for the search and reason if the patient declined to be present.

What is the process for taking possession of the patient’s belongings?

When the patient arrives on the unit, their belongings are labeled with a belongings label and a patient ID label.

The belongings are placed in the laundry room or workshop.

Unsearched belongings **are not** placed in the patient’s locker (in the laundry room).

Admission Belongings Documentation

1 of 1 Automatic Zoom

BH - Belongings - CERNCHARGE, MOLLY

*Performed on: 11/02/2023 12:32 EDT

BH - Belongings

Belongings

Belongings Policy Discussed
- (●) Pt/family informed hospital not responsible for belongings
- ( ) Pt/Family unavailable for belongings discussion

Valuables To/From Safe Status
- ( ) Patient valuables sent to safe
- ( ) Patient valuables returned from safe

Patient's Home Medications
- ( ) Unit lock-up
- ( ) sent home
- ( ) in safe
- ( ) With patient at discharge
- ( ) Other

Instruct patient/family that the hospital is not responsible for items left at bedside.

	With patient	With patient at discharge	Comment
Glasses	X		
Contacts			
Hearing aid, right	X		
Hearing aid, left	X		
Dentures, upper			
Dentures, lower			
Partial/Retainer, upper			
Partial/Retainer, lower			
Cane			
Crutches			
Prosthesis			
Walker	X		
Wheelchair			
Other equipment			

Necessary items that may be kept at bedside:
glasses
contacts
dentures
wig
hearing aid
brace
prosthesis
ambulatory aide

Clothing

Discharge Belongings Documentation

BH - Belongings - CERNCHARGE, MOLLY

*Performed on: 11/02/2023 12:37 EDT

BH - Belongings

Belongings

Belongings Policy Discussed
- (selected) Pt/family informed hospital not responsible for belongings
- Pt/Family unavailable for belongings discussion

Valuables To/From Safe Status
- Patient valuables sent to safe
- Patient valuables returned from safe

Patient's Home Medications
- Unit lock-up
- sent home
- in safe
- With patient at discharge
- Other:

Instruct patient/family that the hospital is not responsible for items left at bedside.

	With patient	With patient at discharge	Comment
Glasses	X	X	
Contacts			
Hearing aid, right	X	X	
Hearing aid, left	X	X	
Dentures, upper			
Dentures, lower			
Partial/Retainer, upper			
Partial/Retainer, lower			
Cane			
Crutches			
Prosthesis			
Walker	X	X	
Wheelchair			
Other equipment			cell phone sent home with spouse

Necessary items that may be kept at bedside:
glasses
contacts
dentures
wig
hearing aid
brace
prosthesis
ambulatory aide

Clothing

	With patient	Unit lock-up	sent home	in safe	With patient at discharge	Comment

Knowledge Check #2 of 4

Click the dropdown arrows and view the tasks to place in the correct order.

1. Label the belongings with a patient ID and Belongings sticker and place in the workshop
2. Ask the patient if they want to be present during the search
3. Print 2 copies of the inventory form
4. Place a Focus Note in the chart on who was present for the belongings search

What is the process for taking possession of the patient's belongings? *(cont.)*

The only exception to placing unsearched patient belongings in their locker (in the laundry room) is when there is an item with multiple pieces, e.g., purse, large suitcase, etc.

The item(s) is/are labeled with a belongings label and patient ID label, marked as "unsearched", and entered on the belongings inventory form (i.e., one blue suitcase unsearched).

A patient has the right to access these items only with staff supervision.

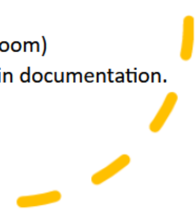
Valuables

On arrival to the unit, the patient is asked if they have valuables (jewelry, money, sentimental items, etc.).

Remember, the patient defines what is valuable!

If valuables are present, the patient has three (3) options:

- Item(s) are sent to Nursing Administration per the valuables policy.
- Valuables are sent home.
- Valuables are kept with them.
  - Stored in their locker (in the laundry room)
  - Kept with them on the unit, as noted in documentation.



Valuables *(cont.)*

The patient is asked to sign a personal property waiver of responsibility form:

- To indicate they do not have valuables.

OR

- To indicate and document they do have valuables and they take responsibility of the valuables if they keep them on the unit (if appropriate).

Medications

Home medications are not kept on the unit.

The only exception is if a patient's home medication is not available at the hospital.

The patient's belongings will be searched to confirm presence or absence of medications.

Home medications, if present, will be placed in a valuables envelope following the same process for patient valuables.

Searching

Safety is the primary reason belongings are searched.

Patients knowingly or unknowingly may have items that could be used to harm themselves or others.

This also include items brought in by visitors.

Searching *(cont.)*

It is important that each item is thoroughly searched:

- Turn clothes inside out, check seams, pockets, collars, etc.
- Remove strings in hoods or pants.
  (with patient permission)
- Turn pages in a book or journal.
- Open glasses case.
- Check under insoles of shoes.

Permitted Items

Three (3) changes of clothing

Any personal item that is appropriate and does not pose a risk for harm to the patient or others

When in doubt if a patient should receive an item, ask the charge nurse

Knowledge Check #3 of 4

Items permitted on the unit include:

- ○ Personal cellphone
- ○ 3 changes of clothing
- ○ Patient's home medication
- ○ Laptop

Items NOT Permitted

- Any item that could pose a safety risk to the patient or others:
  - Tobacco or smoking items
  - Lighters/matches
  - Personal electronic or electronic devices (e.g., cellphones, computers, iPods, hair dryer, etc.)
  - Glass or breakable items
- Any contraband per hospital policy (e.g., illegal or non-prescribed drugs, weapons, etc.).
  - Security should be contacted for management of contraband.
  - Contraband is never stored in the patient's locker.

Accessing Belongings

Patients are allowed to access their belongings at reasonable times.

Determining if it is a reasonable time includes what the situation is at the time of the request.

If it is not a good time, problem-solve with the patient regarding an alternative time.

Items marked as "unsearched" require close staff supervision and may require staff to review the item(s) for prohibited objects prior to the patient accessing them.

Visitors and Belongings

Visitors are required to leave all their belongings in provided lockers (e.g., cellphone, hats, coats, keys, purse, etc.). **No Exceptions!**

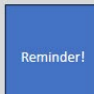
This requirement is to prevent prohibited items being brought on the unit and given to a patient.

Visitors are allowed to bring items to patients that follow unit guidelines.

Wrapped hard candy is the only food allowed to be brought to a patient.

Discharge

All belongings will be returned to the patient on discharge.



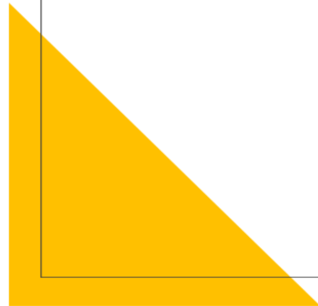
A discharge sticker will be placed on the most recent belongings form as a reminder to check all areas where a patient's belongings may be stored, e.g., bathroom, nursing administration, etc.

Before the patient is discharged, they will be given the opportunity to review the belongings list and their belongings.

Knowledge Check #4 of 4

Items marked "unsearched" don't require staff to be present when a patient is reviewing them.

- True
- False



Visitors and Belongings *(cont.)*

The process for searching and inventorying belongings on admission is used for items brought in by a visitor.

Each time there is a change with the patient's belongings (new items, items sent home, items taken out of the patient locker), a new belongings form should be opened to update the list.

Discharge *(cont.)*

If a patient reports any missing items, recheck all locations where belongings are stored.

Reminder!

If the reported missing item(s) are not found:

- Inform the charge nurse.
- Document the reported missing item(s) in a Focus note.
- Provide the patient the Recipient Rights Officer's telephone number.

After review by the patient, the belongings are kept in a secure location until the patient is discharged from the unit.

References

Department of Community Health. (2007). Mental Health and Substance Abuse Services, Administrative Rules, §330.7009 (7).

Michigan Mental Health Code. (1996). Personal Property §330.1728.

Munson Medical Center Policies and Procedures. (2022, May 19). Patient Property Handling, Search, and Prohibited Items. PolicyStat.