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## Seclusion

### POLICY

It is the policy of Detroit Wayne Mental Health Authority (DWMHA) that seclusion of a recipient of services within DWMHA's network is prohibited unless where permitted by statute **and** DWMHA policy.

### PURPOSE

The purpose of this policy is to provide policy direction to ensure that recipients of DWMHA-contracted services at all DWMHA programs or sites are not placed in seclusion unless where permitted by statute **and** DWMHA policy.

### APPLICATION

**(Instructions:** The information below is not to be removed, retyped or revised. Only remove organizations, populations, or service lines from the information below that do not apply to this policy. Please do not add any group or population, ie ICO or MHP. Delete this instructions paragraph and text in these parentheses before moving to the next section.

1. The following groups are required to implement and adhere to this policy: DWMHA Board, DWMHA Staff, Contractual Staff, Access Center, MCPN Staff, Network Providers, Crisis services vendor
2. This policy serves the following populations: Adults, Children, I/DD, SMI/SEI, SED, Autism
3. This policy impacts the following **contracts/service lines**: MI-HEALTH LINK, Medicaid, Autism, Grants, General Fund

### KEYWORDS

1. Child Caring Institution (CCI)
2. Centers for Medicare & Medicaid Services (CMS)
3. Individual Plan of Service
4. LPH/U
5. Seclusion – The temporary placement of a recipient in a room, alone, where egress is prevented by any means.
6. Therapeutic de-escalation – 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.

7. Time Out – A voluntary response to the therapeutic suggestion to a recipient to remove himself or herself from a stressful situation in order to prevent a potentially hazardous outcome.

## STANDARDS

1. DWMHA shall review the seclusion policies of contracted providers of inpatient services and child caring institutions for compliance with applicable state and federal rules and regulations
2. DWMHA expressly prohibits the use of seclusion in all programs and service sites directly operated or under contract where it is not permitted by statute **and** this policy.

### For Licensed Psychiatric Hospital/Unit

1. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.
2. The type or technique of seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.
3. The use of seclusion must be:
  - a. In accordance with a written modification to the patient's plan of care; and
  - b. Implemented in accordance with safe and appropriate seclusion techniques as determined by hospital policy in accordance with State law.
  - c. If a resident is secluded repeatedly, the resident's individual plan of services shall be reviewed and modified to facilitate the reduction of the use of seclusion.
4. The use of seclusion must be in accordance with the order of a physician.
5. Seclusion may be temporarily employed for a maximum of 30 minutes in an emergency without an authorization or an order. Immediately after the resident is placed in temporary seclusion, a physician shall be contacted. If, after being contacted, the physician does not authorize or order the seclusion, the resident shall be removed from seclusion.
6. Orders for the use of seclusion must never be written as a standing order or on an as-needed basis (PRN).
7. The attending physician must be consulted as soon as possible if the attending physician did not order the seclusion.
8. Unless superseded by State law that is more restrictive:
  - a. 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 8 hours:
    1. 4 hours for adults 18 years of age or older;
    2. 2 hours for children and adolescents 9 to 17 years of age; or

3. 1 hour for children under 9 years of age; and
  - b. After 8 hours, before writing a new order for the use of seclusion for the management of violent or self-destructive behavior, a physician must see and assess the patient.
  - c. The required examination by a physician shall be conducted not more than 30 minutes before the expiration of the expiring order.
9. Seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.
10. A secluded resident shall:
  - a. Continue to receive food;
  - b. Be given hourly access to toilet facilities;
  - c. Be bathed as often as needed, but at least every 24 hours;
  - d. Be clothed or otherwise covered;
  - e. Be given the opportunity to sit or lie down.
11. The condition of the patient who is secluded must be monitored by a physician or trained staff that have completed the training criteria specified below at an interval determined by hospital policy.
12. Physician training requirements must be specified in hospital policy. At a minimum, physicians must have a working knowledge of hospital policy regarding the use of seclusion.
13. When seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention by a physician to evaluate:
  - a. The patient's immediate situation;
  - b. The patient's reaction to the intervention;
  - c. The patient's medical and behavioral condition; and
  - d. The need to continue or terminate the seclusion.
14. If the face-to-face evaluation is conducted by a physician other than the attending physician who is responsible for the care of the patient, that physician must consult the attending physician as soon as possible after the completion of the 1-hour face-to-face evaluation.
15. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored:
  - a. Face-to-face by an assigned, trained staff member; or
  - b. By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.
16. When seclusion is used, there must be documentation in the patient's medical record of the following:
  - a. The 1-hour face-to-face medical and behavioral evaluation if seclusion is used to manage violent or self-destructive behavior;
  - b. A description of the patient's behavior and the intervention used;
  - c. Alternatives or other less restrictive interventions attempted as applicable;
  - d. The patient's condition or symptom(s) that warranted the use of the seclusion; and
  - e. The patient's response to the intervention(s) used, including the rationale for continued use of the

intervention.

17. A provider shall ensure that documentation of staff monitoring and observation is entered into the medical record of the resident.
18. A separate permanent record of each instance of seclusion shall be kept and shall comply with applicable standards.
19. Staff training requirements:
  - a. The patient has the right to safe implementation of seclusion by trained staff.
  - b. Training intervals: Staff must be trained and able to demonstrate competency in the implementation of seclusion, monitoring, assessment, and providing care for a patient in seclusion:
    1. Before performing any of the actions specified in this paragraph;
    2. As part of orientation; and
    3. Subsequently on a periodic basis consistent with hospital policy.
20. Training content: The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:
  - a. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of seclusion.
  - b. The use of nonphysical intervention skills.
  - c. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical or behavioral status or condition.
  - d. The safe application and use of all types of restraint and seclusion used in the hospital including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia);
  - e. Clinical identification of specific behavioral changes that indicate that seclusion is no longer necessary.
  - f. Monitoring the physical and psychological well-being of the patient who is secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation.
  - g. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.
21. Trainer requirements: Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.
  - a. Training documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.
22. Death reporting requirements: Hospitals must report deaths associated with the use of seclusion.
  - a. The hospital must report the following information to CMS:
    1. Each death that occurs while a patient is in seclusion.
    2. Each death that occurs within 24 hours after the patient has been removed from seclusion.
    3. Each death known to the hospital that occurs within 1 week after seclusion where it is reasonable to assume that use of seclusion contributed directly or indirectly to a patient's death.

- i. "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.
- b. Each death must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.
- c. Staff must document in the patient's medical record the date and time the death was reported to CMS.

## For Child Caring Institution

1. **Sec. 2b.** The provisions of this section and sections 2c, 2d, and 2e only apply to a child caring institution that contracts with or receives payment from DWMHA for the care, treatment, maintenance, and supervision of a minor child in that child caring institution:
2. As used in this section and sections 2c, 2d, and 2e, unless the context requires otherwise:
  - a. "Adaptive device" means a mechanical device incorporated in the individual plan of services that is intended to provide anatomical support or to assist the minor child with adaptive skills.
  - b. "Chemical restraint" means a drug that meets all of the following criteria:
    1. Is administered to manage a minor child's behavior in a way that reduces the safety risk to the minor child or others.
    2. Has the temporary effect of restricting the minor child's freedom of movement.
    3. Is not a standard treatment for the minor child's medical or psychiatric condition.
  - c. "Emergency safety intervention" means use of personal restraint or seclusion as an immediate response to an emergency safety situation.
  - d. "Emergency safety situation" means the onset of an unanticipated, severely aggressive, or destructive behavior that places the minor child or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention.
  - e. "Individual plan of services" means that term as defined in section 100b of the mental health code, 1974 PA 258, MCL 330.1100b.
  - f. "Licensed practitioner" means an individual who has been trained in the use of personal restraint and seclusion, who is knowledgeable of the risks inherent in the implementation of personal restraint and seclusion, and who is 1 of the following:
    1. A physician licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
    2. An individual who has been issued a specialty certification as a nurse practitioner under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
    3. A physician's assistant licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
    4. A registered nurse licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
    5. A psychologist and a limited licensed psychologist licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
    6. A counselor and a limited licensed counselor licensed under article 15 of the public health code,

1978 PA 368, MCL 333.16101 to 333.18838.

7. Until July 1, 2005, a certified social worker registered under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838. Beginning July 1, 2005, a licensed master's social worker licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
  - g. "Mechanical restraint" means a device attached or adjacent to the minor child's body that he or she cannot easily remove and that restricts freedom of movement or normal access to his or her body. Mechanical restraint does not include the use of a protective or adaptive device or a device primarily intended to provide anatomical support. Mechanical restraint does not include use of a mechanical device to ensure security precautions appropriate to the condition and circumstances of a minor child placed in the child caring institution as a result of an order of the family division of circuit court under section 2(a) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2.
  - h. "Personal restraint" means the application of physical force without the use of a device, for the purpose of restraining the free movement of a minor child's body. Personal restraint does not include:
    1. The use of a protective or adaptive device.
    2. Briefly holding a minor child without undue force in order to calm or comfort him or her.
    3. Holding a minor child's hand, wrist, shoulder, or arm to safely escort him or her from one area to another.
    4. The use of a protective or adaptive device or a device primarily intended to provide anatomical support.
  - i. "Protective device" means an individually fabricated mechanical device or physical barrier, the use of which is incorporated in the individualized written plan of service. The use of a protective device is intended to prevent the minor child from causing serious self-injury associated with documented, frequent, and unavoidable hazardous events.
  - j. "Seclusion" means the involuntary placement of a minor child in a room alone, where the minor child is prevented from exiting by any means, including the physical presence of a staff person if the sole purpose of that staff person's presence is to prevent the minor child from exiting the room. Seclusion does not include the use of a sleeping room during regular sleeping hours to ensure security precautions appropriate to the condition and circumstances of a minor child placed in the child caring institution as a result of an order of the family division of circuit court under section 2(a) and (b) of chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.2, if the minor child's individual case treatment plan indicates that the security precautions would be in the minor child's best interest.
  - k. "Serious injury" means any significant impairment of the physical condition of the minor child as determined by qualified medical personnel that results from an emergency safety intervention. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.
3. **Sec. 2c.** If a child caring institution contracts with and receives payment from DWMHA for the care, treatment, maintenance, and supervision of a minor child in a child caring institution, the child caring institution may place a minor child in personal restraint or seclusion only as provided in this section and sections 2d and 2e but shall not use mechanical restraint or chemical restraint
- a. A child caring institution shall require its staff to have ongoing education, training, and demonstrated knowledge of all of the following:

1. Techniques to identify minor children's behaviors, events, and environmental factors that may trigger emergency safety situations.
  2. The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods to prevent emergency safety situations.
  3. The safe use of personal restraint or seclusion, including the ability to recognize and respond to signs of physical distress in minor children who are in personal restraint or seclusion or who are being placed in personal restraint or seclusion.
- b. A child caring institution's staff shall:
1. Be trained in the use of personal restraint and seclusion,
  2. Be knowledgeable of the risks inherent in the implementation of personal restraint and seclusion, and
  3. Demonstrate competency regarding personal restraint or seclusion before participating in the implementation of personal restraint or seclusion.
  4. Demonstrate their competencies in these areas on a semiannual basis.
- c. The state Authority licensing child caring institutions shall review and determine the acceptability of the child caring institutions' staff education, training, knowledge, and competency requirements required by this subsection and the training and knowledge required of a licensed practitioner in the use of personal restraint and seclusion.
4. **Sec. 2d.** Personal restraint or seclusion shall not be imposed as a means of coercion, discipline, convenience, or retaliation by a child caring institution's staff.
- a. An order for personal restraint or seclusion shall not be written as a standing order or on an as-needed basis.
  - b. Personal restraint or seclusion must not result in harm or injury to the minor child and shall be used only to ensure the minor child's safety or the safety of others during an emergency safety situation. Personal restraint or seclusion shall only be used until the emergency safety situation has ceased and the minor child's safety and the safety of others can be ensured even if the order for personal restraint or seclusion has not expired. Personal restraint and seclusion of a minor child shall not be used simultaneously.
  - c. Personal restraint or seclusion shall be performed in a manner that is safe, appropriate, and proportionate to the severity of the minor child's behavior, chronological and developmental age, size, gender, physical condition, medical condition, psychiatric condition, and personal history, including any history of physical or sexual abuse.
  - d. Except as provided in subsection (e), at the time a minor child is admitted to a child caring institution, the child caring institution shall do all of the following:
    1. Inform the minor child and his or her parent or legal guardian of the provider's policy regarding the use of personal restraint or seclusion during an emergency safety situation that may occur while the minor child is under the care of the child caring institution.
    2. Communicate the provider's personal restraint and seclusion policy in a language that the minor child or his or her parent or legal guardian will understand, including American Sign Language, if appropriate. The provider shall procure an interpreter or translator, if necessary to fulfill the requirement of this subdivision.

3. Obtain a written acknowledgment from the minor child's parent or legal guardian that he or she has been informed of the provider's policy on the use of personal restraint and seclusion during an emergency safety situation. The child caring institution's staff shall file the acknowledgment in the minor child's records.
  4. Provide a copy of the policy to the minor child's parent or legal guardian.
- e. The child caring institution is not required to inform, communicate, and obtain the written acknowledgment from a minor child's parent or legal guardian as specified in subsection (d) if the minor child is within the care and supervision of the child caring institution as a result of an order of commitment of the family division of circuit court to a state institution, state agency, or otherwise, and has been adjudicated to be a dependent, neglected, or delinquent under chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.1 to 712A.32, if the minor child's individual case treatment plan indicates that notice would not be in the minor child's best interest.
  - f. An order for personal restraint or seclusion shall only be written by a licensed practitioner.
  - g. A licensed practitioner shall order the least restrictive emergency safety intervention measure that is most likely to be effective in resolving the emergency safety situation based on consultation with staff. Consideration of less restrictive emergency safety intervention measures shall be documented in the minor child's record.
  - h. If the order for personal restraint or seclusion is verbal, it must be received by a child caring institution staff member who is one of the following:
    1. A licensed practitioner.
    2. A social services supervisor as described in R400.4118 of the Michigan administrative code.
    3. A supervisor of direct care workers as described in R400.4120 of the Michigan administrative code.
    4. A practical nurse licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
  - i. A verbal order must be received while personal restraint or seclusion is being initiated by child caring institution staff or immediately after the emergency safety situation begins. The licensed practitioner shall be available to staff for consultation, at least by telephone, throughout the period of personal restraint or seclusion. The licensed practitioner shall verify the verbal order in signed written form in the minor child's record.
  - j. An order for personal restraint or seclusion shall meet both of the following criteria
    1. Be limited to no longer than the duration of the emergency safety situation.
    2. Not exceed 4 hours for a minor child 18 years of age or older; 2 hours for a minor child 9 to 17 years of age; or 1 hour for a minor child under 9 years of age.
  - k. If more than two orders for personal restraint or seclusion are ordered for a minor child within a 24-hour period, the director of the child caring institution or his or her designated management staff shall be notified to determine whether additional measures should be taken to facilitate discontinuation of personal restraint or seclusion.
  - l. If personal restraint continues for less than 15 minutes or seclusion continues for less than 30 minutes from the onset of the emergency safety intervention, the child caring institution staff qualified to receive a verbal order for personal restraint or seclusion, in consultation with the licensed practitioner, shall evaluate the minor child's psychological well-being immediately after the minor



child is removed from seclusion or personal restraint. Staff shall also evaluate the minor child's physical well-being or determine if an evaluation is needed by a licensed practitioner authorized to conduct a face-to-face assessment.

- m. A face-to-face assessment shall be conducted if the personal restraint continues for 15 minutes or more from the onset of the emergency safety intervention or if seclusion continues for 30 minutes or more from the onset of the emergency safety intervention. This face-to-face assessment shall be conducted by a licensed practitioner who is one of the following:
    - 1. A physician licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
    - 2. An individual who has been issued a specialty certification as a nurse practitioner under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
    - 3. A physician's assistant licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
    - 4. A registered nurse licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
  - n. The face-to-face assessment shall be conducted within 1 hour of the onset of the emergency safety intervention and immediately after the minor child is removed from personal restraint or seclusion. The face-to-face assessment of the physical and psychological well-being of the minor child shall include, but is not limited to, all of the following:
    - 1. The minor child's physical and psychological status.
    - 2. The minor child's behavior.
    - 3. The appropriateness of the intervention measures.
    - 4. Any complications resulting from the intervention.
5. **Sec. 2e.** A minor child shall be released from personal restraint or seclusion whenever the circumstance that justified the use of personal restraint or seclusion no longer exists.
- a. Each instance of personal restraint or seclusion requires full justification for its use, and the results of the evaluation immediately following the use of personal restraint or seclusion shall be placed in the minor child's record.
  - b. Each order for personal restraint or seclusion shall include all of the following:
    - 1. The name of the licensed practitioner ordering personal restraint or seclusion.
    - 2. The date and time the order was obtained.
    - 3. The personal restraint or seclusion ordered, including the length of time for which the licensed practitioner ordered its use.
  - c. The child caring institution staff shall document the use of the personal restraint or seclusion in the minor child's record. That documentation shall be completed by the end of the shift in which the personal restraint or seclusion occurred. If the personal restraint or seclusion does not end during the shift in which it began, documentation shall be completed during the shift in which the personal restraint or seclusion ends. Documentation shall include all of the following:
    - 1. Each order for personal restraint or seclusion.
    - 2. The time the personal restraint or seclusion actually began and ended.

3. The time and results of the 1-hour assessment.
  4. The emergency safety situation that required the resident to be personally restrained or secluded.
  5. The name of the staff involved in the personal restraint or seclusion.
- d. The child caring institution staff trained in the use of personal restraint shall continually assess and monitor the physical and psychological well-being of the minor child and the safe use of personal restraint throughout the duration of its implementation.
  - e. The child caring institution staff trained in the use of seclusion shall be physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the minor. Video monitoring shall not be exclusively used to meet this requirement.
  - f. The child caring institution staff shall ensure that documentation of staff monitoring and observation is entered into the minor child's record.
  - g. If the emergency safety intervention continues beyond the time limit of the order for use of personal restraint or seclusion, child caring institution staff authorized to receive verbal orders for personal restraint or seclusion shall immediately contact the licensed practitioner to receive further instructions.
  - h. The child caring institution staff shall notify the minor child's parent or legal guardian and the appropriate state or local government Authority that has responsibility for the minor child if the minor child is under the supervision of the child caring institution as a result of an order of commitment by the family division of circuit court to a state institution or otherwise as soon as possible after the initiation of personal restraint or seclusion.
  - i. This notification shall be documented in the minor child's record, including the date and time of the notification, the name of the staff person providing the notification, and the name of the person to whom notification of the incident was reported.
  - j. The child caring institution is not required to notify the parent or legal guardian as provided in this subsection if the minor child is within the care and supervision of the child caring institution as a result of an order of commitment of the family division of circuit court to a state institution, state agency, or otherwise, and has been adjudged to be dependent, neglected, or delinquent under chapter XIIA of the probate code of 1939, 1939 PA 288, MCL 712A.1 to 712A.32, if the minor child's individual case treatment plan indicates that the notice would not be in the minor child's best interest.
  - k. Within 24 hours after the use of personal restraint or seclusion, child caring institution staff involved in the emergency safety intervention and the minor child shall have a face-to-face debriefing session.
    - l. The debriefing shall include all staff involved in the seclusion or personal restraint except if the presence of a particular staff person may jeopardize the well-being of the minor child.
  - m. Other staff members and the minor child's parent or legal guardian may participate in the debriefing if it is considered appropriate by the child caring institution.
  - n. The child caring institution shall conduct a debriefing in a language that is understood by the minor child. The debriefing shall provide both the minor child and the staff opportunity to discuss the circumstances resulting in the use of personal restraint or seclusion and strategies to be used by staff, the minor child, or others that could prevent the future use of personal restraint or seclusion.
  - o. Within 24 hours after the use of personal restraint or seclusion, all child caring institution staff

involved in the emergency safety intervention, and appropriate supervisory and administrative staff, shall conduct a debriefing session that includes, at a minimum, all of the following:

1. Discussion of the emergency safety situation that required personal restraint or seclusion, including a discussion of precipitating factors that led up to the situation.
  2. Alternative techniques that might have prevented the use of personal restraint or seclusion.
  3. The procedures, if any, that child caring institution staff are to implement to prevent a recurrence of the use of personal restraint or seclusion.
  4. The outcome of the emergency safety intervention, including any injury that may have resulted from the use of personal restraint or seclusion.
- p. The child caring institution staff shall document in the minor child's record that both debriefing sessions took place and shall include the names of staff that were present for the debriefings, names of staff that were excused from the debriefings, and changes to the minor child's treatment plan that result from the debriefings.
- q. Each child caring institution subject to this section and sections 2c and 2d shall report each serious occurrence to the state Authority licensing the child caring institution. The state Authority licensing the child caring institution shall make the reports available to the designated state protection and advocacy system upon request of the designated state protection and advocacy system.
- r. Serious occurrences to be reported include a minor child's death, a serious injury to a minor child, and a minor child's suicide attempt. Staff shall report any serious occurrence involving a minor child by no later than close of business of the next business day after a serious occurrence. The report shall include the name of the minor child involved in the serious occurrence, a description of the occurrence, and the name, street address, and telephone number of the child caring institution.
- s. The child caring institution shall notify the minor child's parent or legal guardian and the appropriate state or local government Authority that has responsibility for the minor child if the minor child is under the supervision of the child caring institution as a result of an order of commitment by the family division of circuit court to a state institution or otherwise as soon as possible and not later than 24 hours after the serious occurrence.
- t. Staff shall document in the minor child's record that the serious occurrence was reported to both the state Authority licensing the child caring institution and the state-designated protection and advocacy system, including the name of the person to whom notification of the incident was reported.
- u. A copy of the report shall be maintained in the minor child's record, as well as in the incident and accident report logs kept by the child caring institution.
- v. Each child caring institution subject to this section and sections 2c and 2d shall maintain a record of the incidences in which personal restraint or seclusion was used for all minor children. The record shall include all of the following information:
1. Whether personal restraint or seclusion was used.
  2. The setting, unit, or location in which personal restraint or seclusion was used.
  3. Staff who initiated the process.
  4. The duration of each use of personal restraint or seclusion.
  5. The date, time, and day of the week restraint or seclusion was initiated.
  6. Whether injuries were sustained by the minor child or staff

7. The age and gender of the minor child.
- w. Each child caring institution subject to this section and sections 2c and 2d shall submit a report annually to the state Authority that licenses the child caring institution containing the aggregate data from the record of incidences for each 12-month period as directed by the state licensing agency. The state licensing Authority shall prepare reporting forms to be used by the child caring institution, shall aggregate the data collected from each child caring institution, and shall annually report the data to each child caring institution and the state-designated protection and advocacy system.

### **For settings where seclusion is permitted and governed solely the Mental Health Code and Administrative Rules and DWMHA policies**

1. For purposes of this rule, a time out or therapeutic de-escalation program, as defined in R 330.7001, is not a form of seclusion.
2. A recipient may be secluded only after less restrictive interventions have been considered and;
3. Seclusion is essential in order to:
  - a. Prevent the recipient from physically harming others.
  - b. Prevent the recipient from causing substantial property damage.
4. Each instance of seclusion requires full justification for its use, and the results of each periodic examination shall be placed promptly in the record of the resident.
5. Justification for each use of seclusion and consideration of less restrictive measures shall be documented in the recipient's medical record.
6. In an emergency, a recipient may be temporarily secluded for a maximum of 30 minutes without an authorization or an order.
7. Immediately after the recipient is placed in temporary seclusion, a physician shall be contacted. If after being contacted, the physician does not authorize or order the seclusion, the recipient shall be removed from seclusion.
8. A recipient may be placed in seclusion under an authorization by a physician. Authorized seclusion shall continue only until a physician can personally examine the recipient, or for 1 hour, whichever is less.
9. A recipient may be placed in seclusion under an order of a physician made after personal examination of the recipient. Ordered seclusion shall continue only for that period of time specified in the order or for 8 hours, whichever is less.
10. Ordered seclusion for a minor shall continue only for that period of time specified in the order or for a maximum 4 hours, whichever is less.
11. If an order for restraint or seclusion is to expire and the continued use of restraint or seclusion is clinically indicated and must be extended, then a physician's reauthorization or reordering of restraint or seclusion shall be in compliance with both of the following provisions:
  - a. If the restraint device is a cloth vest and is used to limit the recipient's movement at night to prevent the recipient from injuring himself or herself in bed, the physician may reauthorize or reorder the continued use of the cloth vest device pursuant to the provisions of section 740(4) and(5) of the act.
  - b. Except as specified in part (a) of this subrule, a physician who orders or reorders restraint or seclusion shall do so in accordance with the provisions of sections 740(5) and 742(5) of the act. The required examination by a physician shall be conducted not more than 30 minutes before the expiration of the expiring order for restraint or seclusion.

12. A recipient who is in restraint or seclusion shall be inspected at least once every 15 minutes by designated personnel.
13. A provider shall ensure that documentation of staff monitoring and observation is entered into the medical record of the recipient.
14. A secluded recipient shall
  - a. Continue to receive food,
  - b. Be given hourly access to toilet facilities,
  - c. Be bathed as often as needed, but at least every 24 hours,
  - d. Remain clothed, except as clinically contraindicated,
  - e. Be provided a bed or similar piece of furniture except as clinically contraindicated.
15. A secluded recipient shall be released from seclusion whenever the circumstance that justified its use ceases to exist.
16. Removal from restraint or seclusion for more than 30 minutes results in termination of the order or authorization.
17. A provider shall ensure that a secluded or restrained recipient is given an explanation of why he or she is being secluded or restrained and what he or she needs to do to have the restraint or seclusion order removed. The explanation shall be provided in clear behavioral terms and documented in the record.
18. If a recipient is secluded repeatedly, the recipient's individual plan of services shall be reviewed and modified to facilitate the reduced use of seclusion.
19. A provider shall keep a separate, permanent chronological record specifically identifying all instances when restraint or seclusion has been used. The record shall include all of the following information:
  - a. The name of the recipient.
  - b. The type of restraint or conditions of seclusion.
  - c. The name of the authorizing and ordering physician.
  - d. The date and time placed in temporary, authorized, and ordered restraint or seclusion.
  - e. The date and time the recipient was removed from temporary, authorized, and ordered restraint or seclusion.

## **QUALITY ASSURANCE/IMPROVEMENT**

DWMHA shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

The quality improvement programs of MCPNs, their subcontractors, and direct contractors must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

## **COMPLIANCE WITH ALL APPLICABLE LAWS**

DWMHA staff, MCPNs, contractors, and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

# LEGAL AUTHORITY

1. Code of Federal Regulation, 42CFR482.13,
2. Michigan Mental Health Code, P.A. 258 of 1974, as amended, MCL 330.1700, MCL 330.1742, MCL 330.1755, MCL 722.111 to 722.128.
3. Michigan Administrative Code, R330.7001, R330.7243

# RELATED POLICIES

1. Individual Plan of Service/Person Centered Plan

# RELATED DEPARTMENTS

1. Administration
2. Clinical Practice Improvement
3. Compliance
4. Customer Service
5. Integrated Health Care
6. Managed Care Operations
7. Quality Improvement
8. Recipient Rights

# CLINICAL POLICY

YES

# INTERNAL/EXTERNAL POLICY

EXTERNAL

## Attachments:

No Attachments

## Approval Signatures

Approver	Date
Dana Lasenby: Deputy Chief Operating Officer	08/2017
Allison Smith: Project Manager, PMP	08/2017
Lorraine Taylor-Muhammad: Director, Managed Care Operations	08/2017
Stacie Durant: CFO Management & Budget	08/2017
Carmen McIntyre: Chief Medical Officer	08/2017
Andrea Smith: Director	08/2017
Donna Coulter: Dir. of OPA	08/2017

<b>Approver</b>	<b>Date</b>
Eric Doeh	08/2017
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Maha Sulaiman	08/2017
Rolf Lowe: Assistant General Counsel/HIPAA Privacy Officer	08/2017
Mary Allix	08/2017
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Michele Vasconcellos: Director, Customer Service	08/2017
Bessie Tetteh: CIO	08/2017
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