

# SHIAWASSEE COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

## POLICY AND PROCEDURE MANUAL

Section: Recipient Rights  
Policy Number: 16  
Subject: **Restraint, Seclusion, and Physical Management**

Effective Date: 10/9/95  
Last Revision Date: 7/27/09  
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### **Policy**

It is the policy of Shiawassee County Community Mental Health Authority (SCCMHA) that the use of seclusion and/or restraint to manage a recipient's behavior will be prohibited at all service sites except for those contract facilities providing inpatient care for persons with mental illness and/or for persons with development disabilities. [MHC 740(1)]

It also is the policy of SCCMHA that contract agencies providing inpatient care to recipients of the SCCMHA will document that such interventions are clinically justified, that less restrictive interventions were attempted prior to the use of seclusion or restraint and that the individual's condition was considered when using these interventions.

It also is the policy of SCCMHA that all inpatient and child caring institution policies must be submitted to SCCMHA Office of Recipient Rights to ensure they comply with all applicable state and federal (CMSHCFA) standards [MHC 755(5)(a)(g)].

It also is the policy of SCCMHA that the Office of Recipient Rights will review the seclusion and restraint policies of contracted inpatient settings and child caring institutions for compliance with applicable state and federal rules and regulations [MHC 755 (5) (a) (g)].

### **Purpose**

To ensure that the use of special treatment procedures which limit an individual's movement and ability to tend to personal needs are clinically justified.

To ensure that the application of these special treatment procedures are carried out according to best standard of practice.

To ensure compliance with the Michigan Mental Health Code, the Department of Community Health Administrative Rules and requirements of accrediting bodies.

## **Application**

This policy applies to all employees, independent contractors, and contract agencies of SCCMHA.

## **Definitions**

Physical Management: A technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from harming himself, herself, or others.

Restraint: The use of a physical device to restrict an individual's movement. Restraint does not include the use of a device primarily intended to provide anatomical support. [MHC 700 (i); 42 CFR 482; 42 CFR 483]

Seclusion: Temporary placement of an individual alone in a room where egress is prevented by any means. [MHC 700(i)]

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. [AR 7001(w)]

Time Out: A voluntary response to the therapeutic suggestion to a recipient to remove himself/herself from a stressful situation in order to prevent a potentially hazardous outcome. [AR 7001(x)]

## **Standards**

1. Contract facilities providing inpatient care to recipients of SCCMHA will have written policies and procedures which establish control over the use of seclusion or restraint. These written policies and procedures address the range, scope, indications, contraindications, documentation requirements, reporting, review and other essential requirements governing the use of seclusion or restraint.
2. Contract facilities providing inpatient care to SCCMHA recipients will use seclusion if it is essential to prevent the resident from physically harming others or in order to prevent the resident from causing substantial property damage.
3. Contract facilities will use physical restraint only after less restrictive interventions have been considered and only if restraint is essential in order to prevent the individual from physically harming himself/herself or others, or in order to prevent causing substantial property damage.

4. Physical management as defined in R 330.7001 (m) may only be used in situations where a recipient is presenting an imminent risk of serious or non-serious physical harm to himself, herself or others and lesser restrictive interventions have been unsuccessful in reducing or eliminating the imminent risk of serious or non-serious physical harm. Both of the following shall apply:
  - a. Physical management shall not be included as a component in a behavior treatment plan.
  - b. Prone immobilization of a recipient for the purpose of behavior control is prohibited unless implementation of physical management techniques other than prone immobilization is medically contraindicated and documented in the recipient's record. [AR 330.7243 (11)].
5. The policies and procedures of contract inpatient facilities which provide care to SCCMHA recipients will ensure the following:
  - a. Seclusion, restraint and physical management is not used as punishment or for staff convenience.
  - b. The documented rationale for using seclusion or restraint addresses the inadequacy of less restrictive intervention techniques.
  - c. To justify the use of seclusion or restraint an individual permitted by law and by the contract inpatient facility conducts a clinical assessment of the recipient before authorizing the use of either procedure.
  - d. The following conditions apply to physical restraint:
    - i. A resident may be restrained only after less restrictive interventions have been considered [MHC 749 (2)]. Orders for the use of restraint must never be written as a standing order or on an as needed basis (PRN).
    - ii. Restraint is essential in order to:
      1. Prevent the resident from physically harming self.
      2. Prevent the resident from physically harming others.
      3. Prevent the resident from causing substantial property damage [MHC 740 (2)].
      4. The use of restraint 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 restraint techniques as determined by hospital policy in accordance with state law; and
  - c. If the resident is restrained repeatedly, the resident's individual plan of service shall be reviewed and modified to facilitate the reduction of the use of restraints. (MHC 330.1740(9))
- iii. Consideration of less restrictive measures is documented in the resident's medical record [MHC 740 (3)].
  - iv. The use of restraint must be in accordance with the order of a physician. In an emergency a resident may be temporary restrained for a maximum of 30 minutes without an order or authorization [MHC 1740 (3)].
  - v. Immediately after imposition of a temporary restraint a physician will be contacted. If after being contacted the physician does not authorize the restraint, the restraint will be removed [MHC 740 (3)].
  - vi. A resident may be restrained prior to examination pursuant to an authorization by a physician. An authorized restraint may continue only until a physician can personally examine the resident or for 2 hours, whichever is less. If it is not possible for the physician to examine the resident within 2 hours, a physician may reauthorize the restraint for another 2 hours [MHC 740 (4)].
  - vii. Authorized restraint may not continue for more than 4 hours [MHC 740 (4)].
  - viii. A resident may be restrained pursuant to an order by a physician made after personal examination of the resident. An ordered restraint will continue only for that period of time specified in the order or for 8 hours, whichever is less [MHC 740 (5)].
  - ix. Orders and renewal orders:
    1. Each order used for restraint 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:
- a. 4 hours for adults 18 years or older
  - b. 2 hours for children and adolescents 9 to 17 years of age; or
  - c. 1 hour for children under 9 years of age; and
2. After 8 hours before writing a new order for the use of restraint for the management of violent or self-destructive behavior a physician must see and assess the patient.
  3. The required examination by a physician shall be conducted not more than 30 minutes before the expiration of the expiring order. (AR 330.7243 6b).
- x. Restraint will be discontinued at the earliest possible time, regardless of the length of time identified in the order.
  - xi. A restrained resident will:
    1. Continue to receive food.
    2. Be given hourly access to toilet facilities.
    3. Be bathed as often as needed, but at least every 24 hours.
    4. Be clothed or otherwise covered.
    5. Be given the opportunity to sit or lie down [MHC 330.1740 (6)], [AR 330.7243].
  - xii. Restraints will be removed every 2 hours for not less than 15 minutes unless medically contraindicated [MHC 330.1740 (7)].
  - xiii. Restraints will be removed whenever they are no longer essential in order to achieve the objective which justified their initial application [MHC 740 (7)].
  - xiv. A separate permanent chronological record of each specific instance identifying all instances when restraint has been used and will be kept and will comply with applicable standards [AR 7243 (1)]. The record shall include all of the following:
    1. The name of the recipient

2. The type of restraint or conditions of seclusion
  3. The name of the authorizing and ordering physician
  4. The date and time placed in temporary, authorized, and ordered restraint
- xv. A recipient in restraint is inspected at least every 15 minutes by designated personnel and that inspection is documented in the medical record of the resident [AR 7243 (2, 3)]. An assessment of the circulation status of the restrained limbs is conducted and documented at 15 minute intervals or more often if clinically indicated [AR330.7243 (9)].
- xvi. Removal from restraint for more than 30 minutes results in termination of the order or authorization [AR 7243 (7)].
- xvii. A provider shall ensure that a restrained recipient is given an explanation of why he or she is being restrained and what he or she needs to do to have the restraint order removed. The explanation shall be provided in clear behavioral terms and documented in the record.
- xviii. The condition of the patient who is restrained must be monitored by a physician or trained staff that have completed the training criteria specified in paragraph(s) of this section at an interval determined by hospital policy. 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 restraint or seclusion.
- xix. When restraint 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:
1. By a physician
  2. 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 restraint or seclusion.
- xx. If the face-to-face evaluation specified under paragraph xviii of this section is conducted by a 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.

- xxi. All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored:
  - 1. Face-to-face by an assigned, trained staff member; or
  - 2. By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.
  
- xxii. 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 if restraint is used to manage violent or self-destructive behavior;
  - 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; and
  - 5. The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.
  - 6. A provider shall ensure that documentation of staff monitoring and observation is entered into the medical record of the resident. [AR330.7243(3)].
  
- xxiii. If an order for restraining is to expire and the continued use of restraint is clinically indicated and must be extended, then a physician's reauthorization or reordering of restraint shall comply with both of the following provisions:
  - 1. If the restraint device is a cloth vest and is used to limit the resident'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 section 740(4) and (5) of the act.
  - 2. Except as specified in subdivision (a) of this subrule, a physician who orders or reorders restraint shall do so in accordance with sections 740(5) and 742(5) of the act. The required examination by a physician shall be conducted no more than 30 minutes

before the expiration of the expiring order for restraint. [AR330.7243(6)].

- xxiv. A separate permanent chronological record specifically identifying each instance of restraint shall be kept and shall comply with the applicable standards. [AR330.7243(1)].
- xxv. Standard Restraint: Staff training requirements. The patient has the right to safe implementation of restraint by trained staff.
  - 1. Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, monitoring, assessment, and providing care for a patient in restraint--
    - a. Before performing any of the actions specified in this paragraph;
    - b. As part of orientation, and
    - c. Subsequently on a periodic basis consistent with hospital policy.
  - 2. 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 a restraint.
    - 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 or use of all types of used in the hospital including training in how to recognize and respond to signs of physical and psychological distress (e.g. positional asphyxia);
    - e. Clinical identification of specific behavioral changes that indicate that restraint is no longer necessary.
    - f. Monitoring the physical and psychological well-being of the patient who is restrained, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1 hour face-to-face evaluation.
    - g. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

3. Trainer requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patient's behaviors.
  4. Training documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.
- xxvi. Standard. Death reporting requirements. Hospitals must report deaths associated with the use of restraint.

1. The hospital must report the following information to CMS:
  - a. Each death that occurs while a patient is in restraint.
  - b. Each death that occurs within 24 hours after the patient has been removed from restraint.
  - c. Each death known to the hospital that occurs within 1 week after restraint where it is reasonable to assume that use of restraint contributed directly or indirectly to a patient's death.  
"Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time or death related to chest compression, restriction of breathing or asphyxiation.
2. Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.
3. Staff must document in the patient's medical record the date and time the death was reported to CMS.

[All citations from 42CFR482.13 unless otherwise indicated]

- e. The following conditions apply to seclusion:
- i. 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. AR330.7243(10)].
  - ii. A resident may be secluded only after less restrictive interventions have been considered [MHC 330.1742 (2)]. Orders for the use of seclusion must never be written as a standing order or on an as needed basis (PRN).
  - iii. Seclusion is essential in order to:

1. Prevent the resident from physically harming others.
2. Prevent the resident from causing substantial property damage [MHC 742 (2)].
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; and
  - c. If the resident is secluded repeatedly, the resident's individual plan of service shall be reviewed and modified to facilitate the reduction of the use of seclusion. (MHC 330.1742(7))
- iv. Justification for each use of seclusion and consideration of less restrictive measures is documented in the resident's medical record [MHC 1742 (8)].
- v. The use of seclusion must be in accordance with the order of a physician. In an emergency a resident may be temporarily secluded for a maximum of 30 minutes without authorization or an order [MHC 1742 (3)].
- vi. Immediately after the resident is placed in temporary seclusion, a physician will be contacted. If after being contacted, the physician does not authorize or order the seclusion, the resident will be removed from seclusion [MHC 742 (3)].
- vii. A resident may be placed in seclusion under an authorization by a physician. Authorized seclusion will continue only until a physician can personally examine the resident or for 1 hour, whichever is less [MHC 742 (4)].
- viii. A resident may be placed in seclusion under an order of a physician made after personal examination of the resident. Ordered seclusion will continue only for that period of time specified in the order or for 8 hours, whichever is less [MHC 742 (5)].
- ix. Ordered seclusion for a minor will continue only for that period of time specified in the order or for a maximum 4 hours, whichever is less [MHC 742 (5)].

x. Orders and renewal orders:

1. Each order used for seclusion 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:
  - a. 4 hours for adults 18 years or older
  - b. 2 hours for children and adolescents 9 to 17 years of age; or
  - c. 1 hour for children under 9 years of age; and
2. 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.
3. The required examination by a physician shall be conducted not more than 30 minutes before the expiration of the expiring order. (AR 330.7243 6b).

xi. Seclusion will be discontinued at the earliest possible time, regardless of the length of time identified in the order.

xii. A secluded resident will:

1. Continue to receive food.
2. Be given hourly access to toilet facilities.
3. Be bathed as often as needed but at least every 24 hours.
4. Remain clothed or otherwise covered.
5. Be given the opportunity to sit or lie down. [MHC 330.1742 (6), AR 330.7243].

xiii. A secluded resident will be released from seclusion whenever the circumstance that justified its use ceases to exist [MHC 742 (7)].

xiv. Periodic examinations of secluded resident are promptly placed in the resident's record [MHC 742 (8)].

xv. If a resident is secluded repeatedly the resident's individual plan of services will be reviewed and modified to facilitate the reduced use of seclusion [MHC 742 (9)].

- xvi. A separate permanent chronological record specifically identifying each instance of seclusion has been used will be kept and will comply with applicable standards [AR 7243 (1)]. The record shall include all of the following:
  - 1. The name of the recipient
  - 2. The type of restraint or conditions of seclusion
  - 3. The name of the authorizing and ordering physician
  - 4. The date and time placed in temporary, authorized, and ordered restraint
- xvii. A resident in seclusion is inspected at least once every 15 minutes by designated personnel and that inspection is documented in the medical record of the resident [AR 7243 (2) (3)].
- xviii. Removal from seclusion for more than 30 minutes results in termination of the order or authorization [AR 7243 (7)].
- xix. A provider shall ensure that a secluded recipient is given an explanation of why he or she is being secluded and what he or she needs to do to have the seclusion order removed. The explanation shall be provided in clear behavioral terms and documented in the record.
- xx. The condition of the patient who is secluded must be monitored by a physician or trained staff that have completed the training criteria specified in paragraph(s) of this section at an interval determined by hospital policy. 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 restraint or seclusion.
- xxi. 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:
  - 1. By a physician
  - 2. 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.
- xxii. If the face-to-face evaluation specified under paragraph xviii of this section 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.

- xxiii. All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored:
  - 1. Face-to-face by an assigned, trained staff member; or
  - 2. By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.
  
- xxiv. When seclusion 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 if seclusion is used to manage violent or self-destructive behavior;
  - 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 seclusion; and
  - 5. The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.
  - 6. A provider shall ensure that documentation of staff monitoring and observation is entered into the medical record of the resident. [AR330.7243(3)].
  
- xxv. If an order for seclusion is to expire and the continued use of seclusion is clinically indicated and must be extended, then a physician's reauthorization or reordering of seclusion shall comply with both of the following provisions:
  - 1. If the restraint device is a cloth vest and is used to limit the resident'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 section 740(4) and (5) of the act.
  - 2. Except as specified in subdivision (a) of this subrule, a physician who orders or reorders seclusion shall do so in accordance with

sections 740(5) and 742(5) of the act. The required examination by a physician shall be conducted no more than 30 minutes before the expiration of the expiring order for seclusion. [AR330.7243(6)].

- xxvi. A separate permanent record of each instance of seclusion shall be kept and shall comply with the applicable standards. [AR330.7243(1)].
- xxvii. Standard Seclusion: Staff training requirements. The patient has the right to safe implementation of seclusion by trained staff.
  - 1. Training intervals. Staff must be trained and able to demonstrate competency in the application of seclusion, monitoring, assessment, and providing care for a patient in seclusion--
    - a. Before performing any of the actions specified in this paragraph;
    - b. As part of orientation, and
    - c. Subsequently on a periodic basis consistent with hospital policy.
  - 2. 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 or use of all types of 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.

3. Trainer requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patient's behaviors.
  4. Training documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.
- xxviii. Standard. Death reporting requirements. Hospitals must report deaths associated with the use of seclusion.
1. The hospital must report the following information to CMS:
    - a. Each death that occurs while a patient is in seclusion.
    - b. Each death that occurs within 24 hours after the patient has been removed from seclusion.
    - c. 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.  
"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.
  2. Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.
  3. Staff must document in the patient's medical record the date and time the death was reported to CMS.

[All citations from 42CFR482.13 unless otherwise indicated]

6. The policies and procedures of contract child caring institutions under contract with or subject to the policy of SCCMHA and provide care to SCCMHA recipients will ensure the following:

Sec. 2b. (1) 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:

- i. Is administered to manage a minor child's behavior in a way that reduces the safety risk to the minor child or others.
  - ii. Has the temporary effect of restricting the minor child's freedom of movement.
  - iii. 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:
  - i. A physician licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
  - ii. 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.
  - iii. A physician's assistant licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
  - iv. A registered nurse licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
  - v. 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.
  - vi. 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.

- vii. 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:
  - i. The use of a protective or adaptive device.
  - ii. Briefly holding a minor child without undue force in order to calm or comfort him or her.
  - iii. Holding a minor child's hand, wrist, shoulder, or arm to safely escort him or her from 1 area to another.
  - iv. 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.

(2) 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 a community mental health services program or prepaid inpatient health plan for the care, treatment, maintenance, and supervision of a minor child in that child caring institution.

Sec. 2c. (1) If a child caring institution contracts with and receives payment from a community mental health services program or prepaid inpatient health plan 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.

(2) A child caring institution shall require its staff to have ongoing education, training, and demonstrated knowledge of all of the following:

(a) Techniques to identify minor children's behaviors, events, and environmental factors that may trigger emergency safety situations.

(b) 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.

(c) 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.

(3) A child caring institution's staff shall be trained in the use of personal restraint and seclusion, shall be knowledgeable of the risks inherent in the implementation of personal restraint and seclusion, and shall demonstrate competency regarding personal restraint or seclusion before participating in the implementation of personal restraint or seclusion. A child caring institution's staff shall demonstrate their competencies in these areas on a semiannual basis. The state agency 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.

Sec. 2d. (1) Personal restraint or seclusion shall not be imposed as a means of coercion, discipline, convenience, or retaliation by a child caring institution's staff.

(2) An order for personal restraint or seclusion shall not be written as a standing order or on an as-needed basis.

(3) 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.

(4) 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.

(5) Except as provided in subsection (6), at the time a minor child is admitted to a child caring institution, the child caring institution shall do all of the following:

(a) 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.

(b) 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.

(c) 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.

(d) Provide a copy of the policy to the minor child's parent or legal guardian.

(6) 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 (5) 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 XIA 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.

(7) An order for personal restraint or seclusion shall only be written by a licensed practitioner.

(8) 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.

(9) If the order for personal restraint or seclusion is verbal, it must be received by a child caring institution staff member who is 1 of the following:

(a) A licensed practitioner.

(b) A social services supervisor as described in R400.4118 of the Michigan administrative code.

(c) A supervisor of direct care workers as described in R400.4120 of the Michigan administrative code.

(d) A practical nurse licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(10) 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.

(11) An order for personal restraint or seclusion shall meet both of the following criteria:

(a) Be limited to no longer than the duration of the emergency safety situation.

(b) 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.

(12) If more than 2 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.

(13) 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 under subsection (14).

(14) 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 1 of the following:

(a) A physician licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(b) 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.

(c) A physician's assistant licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(d) A registered nurse licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(15) 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:

- (a) The minor child's physical and psychological status.
- (b) The minor child's behavior.
- (c) The appropriateness of the intervention measures.
- (d) Any complications resulting from the intervention.

Sec. 2e. (1) 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.

(2) 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.

(3) Each order for personal restraint or seclusion shall include all of the following:

- (a) The name of the licensed practitioner ordering personal restraint or seclusion.
- (b) The date and time the order was obtained.
- (c) The personal restraint or seclusion ordered, including the length of time for which the licensed practitioner ordered its use.

(4) 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:

- (a) Each order for personal restraint or seclusion.
- (b) The time the personal restraint or seclusion actually began and ended.
- (c) The time and results of the 1-hour assessment.
- (d) The emergency safety situation that required the resident to be personally restrained or secluded.
- (e) The name of the staff involved in the personal restraint or seclusion.

(5) 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.

(6) 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.

(7) The child caring institution staff shall ensure that documentation of staff monitoring and observation is entered into the minor child's record.

(8) 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.

(9) The child caring institution staff shall notify the minor child's parent or legal guardian and the appropriate state or local government agency 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. 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. 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 XIA 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.

(10) 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. 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. 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.

(11) 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.

(12) 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:

(a) Discussion of the emergency safety situation that required personal restraint or seclusion, including a discussion of precipitating factors that led up to the situation.

(b) Alternative techniques that might have prevented the use of personal restraint or seclusion.

(c) The procedures, if any, that child caring institution staff are to implement to prevent a recurrence of the use of personal restraint or seclusion.

(d) The outcome of the emergency safety intervention, including any injury that may have resulted from the use of personal restraint or seclusion.

(13) 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 who 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.

(14) Each child caring institution subject to this section and sections 2c and 2d shall report each serious occurrence to the state agency licensing the child caring institution. The state agency 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. 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. The child caring institution shall notify the minor child's parent or legal guardian and the appropriate state or local government agency 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. Staff shall document in the minor child's record that the serious occurrence was reported to both the state agency 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. 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.

(15) 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:

- (a) Whether personal restraint or seclusion was used.
- (b) The setting, unit, or location in which personal restraint or seclusion was used.
- (c) Staff who initiated the process.
- (d) The duration of each use of personal restraint or seclusion.
- (e) The date, time, and day of the week restraint or seclusion was initiated.
- (f) Whether injuries were sustained by the minor child or staff.
- (g) The age and gender of the minor child.

(16) Each child caring institution subject to this section and sections 2c and 2d shall submit a report annually to the state agency 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 agency 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.

{MCL 722.111 to 722.128}

7. The policies and procedures of settings where seclusion is permitted and governed solely by MI Mental Health Code/Administrative Rules and agency policy under contract with or subject to the policy of SCCMHA and provide care to SCCMHA recipients will ensure the following:

- a.) A resident may be secluded only after less restrictive interventions have been considered [MHC 742(2), AR 7243 (2) and;
- b.) Seclusion is essential in order to:
  - 1) prevent the resident from physically harming others.
  - 2) prevent the resident from causing substantial property damage [MHC 742 (2)]
- c.) Justification for each use of seclusion and consideration of less restrictive measures is documented in the resident's medical record [MHC 742(8), AR 7243 (8)(c)]
- d.) In an emergency, a resident may be temporarily secluded for a maximum of 30 minutes without an authorization or an order. [MHC 742 (3)]
- e.) 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. [MHC 742 (3)]
- f.) A resident may be placed in seclusion under an authorization by a physician. Authorized seclusion shall continue only until a physician can personally examine the resident, or for 1 hour, whichever is less. [MHC 742 (4)]
- g.) A resident may be placed in seclusion under an order of a physician made after personal examination of the resident. Ordered seclusion shall continue only for that period of time specified in the order or for 8 hours, whichever is less [MHC 742 (5)]
- h.) 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 [MHC 742 (5)]
- i.) A secluded resident shall:
  - 1.) Continue to receive food
  - 2.) Be given hourly access to toilet facilities
  - 3.) Be bathed as often as needed, but at least every 24 hours
  - 4.) Remain clothed, except as clinically contraindicated
  - 5.) Be provided a bed or similar piece of furniture except as clinically contraindicated [MHC 742(6), AR 7243]
- j.) A secluded resident shall be released from seclusion whenever the circumstance that justified its use ceases to exist [MHC 742 (7)]



