### Tag Requirement

#### The following requirements apply to all designated receiving facilities, whether they be hospital-based or crisis stabilization units. There are gaps in the assignment of tag numbers to allow for addition of new requirements at a later time. Within a single tag number, certain requirements have been omitted from these survey guidelines as they do not require the surveyor’s review.

<table>
<thead>
<tr>
<th>Tag</th>
<th>Requirement</th>
<th>Guidelines</th>
</tr>
</thead>
</table>
| BA 001 | **Title:** MINIMUM STANDARDS FOR DESIGNATED RECEIVING FACILITIES  
**Cite:** 65E-5.351(1), F.A.C.                                                                                                                    | Any facility designated as a receiving facility failing to comply with this chapter may have such designation suspended or withdrawn.                                                                               |
| BA 002 | **Title:** MINIMUM STANDARDS FOR DESIGNATED RECEIVING FACILITIES  
**Cite:** 65E-5.351(2), F.A.C.                                                                                                                    | Each receiving facility shall have policies and procedures that prescribe, monitor and enforce all requirements specified in chapter 65E-5, F.A.C.                                                               |
| BA 003 | **Title:** MINIMUM STANDARDS FOR DESIGNATED RECEIVING FACILITIES  
**Cite:** 65E-5.351(3), F.A.C.                                                                                                                    | Each receiving facility shall assure that its reception, screening, and inpatient services are fully operational 24-hours-per-day, 7-days-per-week.                                                        |
| BA 004 | **Title:** MINIMUM STANDARDS FOR DESIGNATED RECEIVING FACILITIES  
**Cite:** 65E-5.351(4), F.A.C.                                                                                                                    | Each receiving facility shall have a compliance program that monitors facility and professional compliance with chapter 394, part I, F.S. and chapter 65E-5, F.A.C. Every such program shall specifically monitor the adequacy of and the timeframes involved in the facility procedures utilized to expedite obtaining informed consent for treatment. This program may be integrated with other activities. |
| BA 005 | **Title:** DELEGATION OF AUTHORITY                                                                                                                   | Review the facility’s policy and procedure manual(s) to ensure that facility and professional compliance is monitored through its internal compliance program. See Policy and Procedure Worksheet. |
### Baker Act Chapter 394, Part I, F.S. and Chapter 65E-5 F.A.C

<table>
<thead>
<tr>
<th>Cite: 65E-5.110, F.A.C.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any delegation of an administrator’s authority pursuant to the Baker Act shall be documented in writing prior to exercising the delegated authority.</td>
</tr>
<tr>
<td>Review facility policies and procedures to confirm if delegations of authority have been formalized and approved by the governing board.</td>
</tr>
</tbody>
</table>

| BA 006 | **Title:** TRAINING - ABUSE REPORTING  
Cite: 394.459(5)(f), F.S. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility staff shall be required, as a condition of employment, to become familiar with the requirements and procedures for the reporting of abuse.</td>
<td></td>
</tr>
<tr>
<td>Sample personnel files to ensure training in abuse reporting is documented. See also Rights 394.459(5)(f), F.S. See Personnel Worksheet.</td>
<td></td>
</tr>
</tbody>
</table>

| BA 007 | **Title:** BACKGROUND SCREENING  
Cite: 394.4572(1)(a), F.S. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment screening for mental health personnel using the standards for level 2 screening set forth in chapter 435 is required. “Mental health personnel” includes all program directors, professional clinicians, staff members, and volunteers working in public or private mental health programs and facilities that have direct contact with unmarried patients under the age of 18 years. Mental health personnel working in a facility licensed under chapter 395 who have less than 15 hours per week of direct contact with patients or who are health care professionals licensed by the Agency for Health Care Administration or a board thereunder are exempt from the fingerprinting and screening requirements, except for persons working in mental health facilities where the primary purpose of the facility is the treatment of minors.</td>
<td></td>
</tr>
<tr>
<td>Sample personnel files to ensure that fingerprinting requirements are met for those individuals who have direct patient contact. See Personnel Worksheet.</td>
<td></td>
</tr>
</tbody>
</table>

| BA 008 | **Title:** INTRODUCTION OR REMOVAL OF CERTAIN ARTICLES  
Cite: 394.458(1)(a), F.S. |
|---|---|
| Except as authorized by law or as specifically authorized by the person in charge of each hospital providing mental health services, it is unlawful to introduce into or upon the grounds of such hospital, or to take or attempt to take or send therefrom, any of the following articles, which are hereby declared to be contraband for the purposes of this section:  
1. Any intoxicating beverage or beverage which causes or may cause an intoxicating effect;  
2. Any controlled substance as defined in chapter 893; or  
3. Any firearms or deadly weapon. |
| Review facility policies and procedures that address contraband, weapons, intoxicating beverages or controlled substances and methods to deal with those situations when they may arise. Interview staff at admissions to determine if patients are searched for contraband prior to admission to a unit. See Policies and Procedures Worksheet. |
**BA 010**  
**CONTINUITY OF CARE MANAGEMENT SYSTEM 65E-5.130 F.A.C.**  
**Title:** CASE MANAGEMENT  
**Cite:** 65E-5.130(1) F.A.C.  

At the time of admission and continuing until successful determined, receiving facilities shall inquire of the patient or significant others as to the identity of the patient’s case manager and request authorization to notify the case manager.  

If authorized, notification to the case management agency will be made within 12 hours and documented in the clinical record.  

If the clinical record reflects that the patient has a case manager, determine if the case manager’s agency was notified of the patient’s presence in the receiving facility within 12 hours.  

---  

**BA 011**  
**Title:** ADMISSIONS TO STATE TREATMENT FACILITIES  
**Cite:** 65E-5.1302(1), F.A.C.  

Where the patient is transferred to a state treatment facility, the following documents were provided in advance of a pre-admission staffing:  

A. State Mental Health Facility Admission Form, with required attachments (CF-MH 7000)  
B. Application for Voluntary Admission (CF-MH 3040) or Order for Involuntary Placement (CF-MH 3008)  
C. Transfer Evaluation (CF-MH 3089)  

A Physician to Physician Transfer form was sent to the state treatment facility at the time of transfer (CF-MH 7002)  

For patients who have been transferred from the receiving facility to a state mental hospital, review the closed record to ensure that the three required forms were provided in advance of the pre-admission staffing conducted by state hospital staff and that the recommended Physician-to-Physician Transfer form was prepared and delivered to the state hospital on the day of the patient's admission prior to or at the time of the patient’s arrival.  

---  

**BA 012**  
**Title:** DISCHARGE FROM RECEIVING AND TREATMENT FACILITIES  
**Cite:** 65E-5.1303(2), F.A.C.  

Discharge planning shall include and document consideration of the following:  

A. Transportation resources  
B. Access to stable housing  
C. Assistance in securing housing or shelter to at-risk persons, especially for those at-risk of homelessness within the next three weeks  
D. A timely aftercare appointment  
E. Access to needed psychotropic medications for a period of up to 21 calendar days  
F. Education and written information about the illness and medications  
G. Information about and referral to community-based peer support services  
H. Information about and referral to any needed community resources  
I. Referral to substance abuse treatment programs, trauma or abuse  

Review open records of patients nearing discharge and closed records to ensure that all required elements were addressed in the patient’s discharge planning. See clinical record worksheet.  

Interview patient as to level of participation in discharge planning.  

If being discharged to a licensed facility, verify that license is in good standing.  

See BA 088
### BA 013 Title: DISCHARGE POLICIES OF RECEIVING & TREATMENT FACILITIES

CITE: 65E-5.1304, F.A.C.

Receiving and treatment facilities have written discharge policies and procedures which contain:

1. Agreements or protocols for transfer and transportation arrangements between facilities
2. Protocols for assuring that current medical and legal information, including day of discharge medication administered, is transferred before or with the patient to another facility;
3. Policy statement which reflects cooperation with local publicly-funded mental health and substance abuse providers and which will both facilitate access by publicly funded case managers, as designated by the district administrator, and enhance the continuity of services and access to necessary psychotropic medications.

Review the receiving facility’s policy and procedure manuals (see worksheet) to ensure that each of the required elements are included.

Are the protocols actually being implemented?

### RIGHTS OF PATIENTS 394.459, F.S.

### BA016 Title: PATIENT RIGHTS

Cite: 65E-5.140(1), F.A.C.

Every patient admitted to a designated receiving or treatment facility shall be provided with a written description of their rights at the time of admission. A copy of the rights statement, signed by the patient evidencing receipt of the copy, shall be placed in the patient’s clinical record and shall also be provided to the patient’s guardian, guardian advocate, representative, and health care surrogate or proxy.

Form entitled “Rights of Patients” (CF-MH 3103) is considered by the department to be sufficient.

Interview staff and patients to verify that rights have been explained and a copy provided.

### BA 017 Title: PATIENT RIGHTS

Cite: 65E-5.140(2), F.A.C.

To assure that patients have current information as to their rights as a mental health patient, a copy of the Florida Mental Health Act (chapter 394, part I, Florida Statutes) and Mental Health Act Regulations (chapter 65E-5, Florida Administrative Code) shall be available, and provided upon request, in every

Tour unit and ask to see a copy of the Baker Act law (394, F.S.) and rules (65E-5, F.A.C.)
Baker Act Chapter 394, Part I, F.S. and Chapter 65E-5 F.A.C

| BA 018 | Title: **PATIENT RIGHTS**  
|        | Cite: 65E-5.140(3), F.A.C.  
|        | Patient rights posters, including those with telephone numbers for the Florida Abuse Hotline, Human Rights Advocacy Committee, and the Advocacy Center for Persons with Disabilities, shall be legible, a minimum of 14 point font size, and shall be posted immediately next to telephones which are available for patient use.  
|        | Tour the unit to verify that phone numbers for the abuse Hotline, HRAC, and the Advocacy Center are posted near the telephones. While the font size may not be verified, it is necessary that the information be legible.  

| BA 019 | Title: **PATIENT RIGHTS**  
|        | Cite: 65E-5.140(4), F.A.C.  
|        | Each patient shall be afforded the opportunity to exercise their rights in a manner consistent with s. 394.459(1), F.S. The imposition of individual or unit restrictions and the development of unit policies and procedures shall address observance of patient’s rights in developing criteria or processes to provide for patient care and safety.  
|        | Interview patients to determine if any restrictions of rights or privileges, other than those provided for in the law and rule, have been placed on individuals or the entire unit.  

| BA 020 | Title: **PATIENT RIGHTS – RIGHT TO INDIVIDUAL DIGNITY**  
|        | Cite: 65E-5.150(1), F.A.C.  
|        | Receiving and treatment facilities shall maximize patient access to fresh air, sunshine and exercise, within the facility’s physical capabilities and management of risks. When accommodated by a suitable area immediately adjacent to the unit, each patient shall be afforded an opportunity to spend at least one half hour per day in an open, out-of-doors, fresh air activity area, unless there is a physician’s order prohibiting this activity.  
|        | Interview patients to ensure that they have the opportunity to spend at least 30 minutes a day out-of-doors if desired, unless there is a physician’s order prohibiting such activity or unless no secured area is available at the facility.  

| BA 021 | Title: **PATIENT RIGHTS - RIGHT TO INDIVIDUAL DIGNITY**  
|        | Cite: 65E-5.150(2), F.A.C.  
|        | Use of special clothing for identification purposes such as surgical scrubs or hospital gowns to identify patients who are in need of special precautions or  
|        | Observe the patients on each unit to ensure they are wearing street clothing. If any...
| BA 022 | Title: PATIENT RIGHTS - RIGHT TO TREATMENT  
Cite:   394.459(2)(a), F.S. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients are not wearing street clothing, interview the patients to determine the reason and review the clinical record to determine if orders for special clothing had been issued. A patient who has just been admitted to the facility may be placed in special clothing while the clothing worn at the time of admission is being laundered.</td>
<td></td>
</tr>
<tr>
<td>Ensure compliance with federal COBRA and State health care emergency access provisions. Interview local law enforcement agency personnel to determine if persons are denied admission or if admission is delayed while insurance is verified.</td>
<td></td>
</tr>
</tbody>
</table>
| BA 023 | Title: PATIENT RIGHTS - RIGHT TO TREATMENT  
Cite:   394.459(2)(b), F.S. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Observe vocational, social, educational and rehabilitative services to determine that every person has an opportunity to participate in meaningful activities. This can be determined from a posted schedule of activities, review of the clinical records, and interviews with patients.</td>
<td></td>
</tr>
</tbody>
</table>
| BA 024 | Title: PATIENT RIGHTS - RIGHT TO TREATMENT  
Cite:   394.459(2)(d), F.S. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>See above</td>
<td></td>
</tr>
</tbody>
</table>
| BA 025 | Title: PATIENT RIGHTS - RIGHT TO TREATMENT – PHYSICAL EXAMINATION  
Cite:   394.459(2)(c), F.S. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Review clinical records to find a physical examination performed within 24 hours of patient arrival. This may be documented on a form or dictated in narrative form.</td>
<td></td>
</tr>
</tbody>
</table>

Behavior modification restrictions is prohibited. Prison or jail attire shall not be permitted for persons admitted or retained in a receiving facility except while accompanied by a uniformed law enforcement officer, for purposes of security. Under non-psychiatric medical circumstances, use of special clothing may be ordered by the patient’s physician on an individual basis.
### BA 026

**Title:** PATIENT RIGHTS - RIGHT TO TREATMENT - INDIVIDUALIZED TREATMENT PLAN  
**Cite:** 394.459(2)(e), F.S.

Not more than 5 days after admission to a facility, each patient shall have and receive an individualized treatment plan in writing which the patient has had an opportunity to assist in preparing and to review prior to its implementation. The plan shall include a space for the patient’s comments.

Interview patients to determine that they have participated in the development of an individualized treatment plan within five days of admission. Review records to ensure the presence of the plan and that it is signed by the patient or guardian and that the form has space for the patient’s comments. Interview staff to determine how the facility affords the patient or patient’s guardian the opportunity to participate in treatment planning.

### BA 027

**Title:** PATIENT RIGHTS - RIGHT TO TREATMENT  
**Cite:** 65E-5.160(2), F.A.C.

To obtain legal consent for treatment, assessment and planning protocols shall also include the following:

- **a)** How any advance directives will be obtained and their provisions addressed and how consent for treatment will be expeditiously obtained for any person unable to provide consent.

- **b)** Completion of necessary diagnostic testing and the integration of the results and interpretations from those tests, including the individual’s strengths and weaknesses;

- **c)** The development of treatment goals specifying the factors and symptomology precipitating admission and addressing their resolution or mitigation.

- **d)** The development of a goal within an individualized treatment plan that addresses each of the following: housing, social supports, financial supports, and health, including mental health. Goals shall be inclusive of patient choices and preferences and utilize available natural social supports such as family, friends, and peer support group meetings and

- **a)** Review policies and procedures to ensure staff are directed to obtain advance directives, if any, from patients upon admission.

- **b)** Review clinical records to ensure that significant results of diagnostic testing have been included in treatment planning, when appropriate.

- **c)** Review clinical records to ensure the presence of treatment goals in the patient’s treatment plan, individualized to address the problems causing the admission.

- **d)** Review clinical records to ensure that each of the four required elements is incorporated into the individualized treatment plan and that the plan addresses the patient’s preferences and
| Objectives for implementing each goal shall list the actions needed to obtain the goal, and shall be stated in terms of outcomes that are observable, measurable, and time-limited; |
| Progress notes shall be dated and shall address each objective in relation to the goal, describing the corresponding progress, or lack of progress being made. Progress note entries and the name and title of writer must be clearly legible; |
| Periodic reviews shall be comprehensive and shall be the basis for major adjustments to goals and objectives. Frequency of periodic reviews shall be determined considering the degree to which the care provided is acute care and the projected length of stay of the patient; |
| Progress note observations, rehabilitative and social services, and medication changes shall reflect an integrated approach to treatment; |
| Facilities shall update the treatment plan, including the physician summary, at least every 30 days during the patient’s hospitalization except that patients retained for longer then 24 months shall have updates at least every 60 days. |
| The clinical record shall comprehensively document the patient’s care and treatment, including injuries sustained and all uses of emergency treatment orders. |
| BA 028 Title: CONTINUITY OF CARE – ADVANCE DIRECTIVES |
| Patients who will have a hearing for continued involuntary placement, shall be provided with comprehensive re-assessments, the results of which shall be available at the hearing. |
| e) Review clinical records to ensure each goal details actions needed to reach specified outcomes. |
| f) Review clinical records to ensure legibility so that staff and the patient can read the progress notes. Ensure the notes respond to the goals and objectives established in the individualized treatment plan. |
| g) If the patient is to be retained beyond brief stabilization, periodic reviews of the patient’s condition should be conducted and documented in order to modify the treatment plan, as needed. |
| h) Review the clinical record to ensure that all parts of the patient’s treatment are integrated toward a common outcome. |
| i) Review the clinical record to ensure the physician summarizes the patient’s plan at least monthly, except in long-term care (over 2 years) in which the update can occur every other month. |
| j) Review the seclusion/restraint logbook and ensure that entries are also incorporated in each patient’s clinical record. The clinical records should also detail any injuries mentioned by patients during interviews. |
| k) Continued involuntary placement hearings generally take place after the original six-month order has expired. This usually occurs only in state hospitals. |
At the time of admission, receiving facilities shall inquire of the patient or significant others as to the existence of any advance directives. Interview patients to determine if they have previously prepared any advance directives and, if so, were they questioned about the directives at the time of admission. If so, are copies of the advance directives in the clinical record?

Each designated receiving and treatment facility shall develop a schedule of daily activities listing the times for specific events, which shall be posted in a common area and provided to all patients. Tour each patient unit of a receiving or treatment facility to observe the posted schedule of daily activities. Determine if the activity scheduled at the time of the tour is actually occurring. Interview patients to determine if the posted activities generally occur as scheduled.

Management of the facility’s treatment environment shall use positive incentives in assisting patients to acquire and maintain socially appropriate behaviors as determined by the patient’s age and developmental level. Surveyors should be alert for any evidence of a punitive approach to patient care. Review clinical records for documentation of removal of a patient’s privileges. Interview patients to determine if privileges have been removed, with or without documentation in the clinical record.

When an individualized treatment plan requires interventions beyond the existing unit rules of conduct, the following shall be included in the patient’s treatment plan for such interventions:

- Documentation, signed by the physician that the patient’s medical
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>condition does not exclude the proposed interventions;</td>
<td>are incorporated in the individual patient’s behavior management plan.</td>
<td></td>
</tr>
<tr>
<td>(2) Consent for the treatment to be provided;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) A general description of the behaviors requiring the intervention, which may include previous emergency interventions;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4) Antecedents of that behavior;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5) The events immediately following the behavior;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(6) Objective definition of the target behaviors, such as specific acts, level of force, encroachment on others’ space, self-injurious behavior or excessive withdrawal;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(7) Arrangements for the consistent collection and recording of data;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(8) Analysis of data;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(9) Based on data analysis, development of intervention strategies, if necessary;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(10) Development of a written intervention strategy that includes criteria for starting and stopping specific staff interventions and the process by which they are to occur;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(11) Continued data collection, if interventions are implemented; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(12) Periodic review and revision of the plan based upon data collected and analyzed.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BA 032**

**Title:** PATIENT RIGHTS - RIGHT TO EXPRESS AND INFORMED PATIENT CONSENT  
**Cite:** 394.459(3)(a), F.S.  

**Express and Informed consent** means consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of
Each patient entering a facility shall be asked to give express and informed consent for admission and treatment.

If the patient has been adjudicated incapacitated or found to be incompetent to consent to treatment, express and informed consent to treatment shall be sought instead from the patient's guardian or guardian advocate.

Incompetent to Consent to Treatment means that a person's judgment is so affected by his or her mental illness that the person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment. [394.455(15), F.S.]

Review clinical records to ensure that a signed consent for treatment has been signed by an individual authorized to provide consent before any treatment has been administered.

Ensure from the progress notes and other documentation that the patient is not too confused or disoriented to provide informed consent. Use of recommended form “Certification of Patient’s Competence to Provide Express and Informed Consent” (CF-MH 3104) is considered by the department to be sufficient to document the competence of a person to give express and informed consent.

Interview several patients authorizing their own treatment to determine their ability to provide informed consent.

For patients who are incompetent to consent to treatment and have a guardian or guardian advocate, has that surrogate been asked to provide consent? If possible, telephone the guardian or guardian advocate to ensure that they were provided full disclosure of the proposed treatment prior to being asked to sign the authorization for treatment.
The facility shall determine whether a patient has been adjudicated as incapacitated and whether a guardian has been appointed by the court. If a guardian has been appointed by the court, the limits of the authority of the guardian shall be determined prior to allowing the guardian to authorize treatment. A copy of any court order delineating a guardian’s authority to consent to mental health or medical treatment shall be obtained by the facility and included in the patient’s clinical record prior to allowing the guardian to give express and informed consent to treatment for the patient.

Review the clinical record of any patients in the facility that have a court-appointed guardian. Ensure that the court order and/or letters of guardianship are in the record. Review the order/letters to determine what rights have been removed from the patient and delegated by the court to the guardian to ensure that the guardian has been given the authority to consent to mental health and/or medical treatment of the patient.

| BA 034 | Title: PATIENT RIGHTS - RIGHT TO EXPRESS AND INFORMED PATIENT CONSENT  
| Cite: 394.459(3)(a), F.S. |  
If the patient is a minor, express and informed consent for admission and treatment shall also be requested from the patient’s guardian. Express and informed consent for inpatient admission and treatment of a patient less than 18 years of age shall be required from the patient’s guardian. 

If a minor refuses or is unable to provide express and informed consent to his or her voluntary admission and treatment, the minor should be processed as an involuntary patient to ensure his or her due process rights. No treatment may be administered to the minor, except in case of imminent danger, without the express and informed consent of the minor’s guardian (usually the biological parent).

| BA 035 | Title: PATIENT RIGHTS - EXPRESS AND INFORMED CONSENT  
| Cite: 65E-5.170(1)(a), F.A.C. |  
As soon as possible, but in no event longer than 24 hours from entering a designated receiving facility on a voluntary or involuntary basis, each patient shall be examined by the admitting physician to determine the patient’s ability to provide express and informed consent to admission and treatment. 

The examination of a minor for this purpose may be limited to the documentation of the minor’s age.

The examination of a person alleged to be incapacitated for this purpose may be limited to the documentation of letters of guardianship. Documentation of this determination shall be placed in the patient’s clinical record. 

Ensure that the physician for a voluntary patient has documented the patient’s competence to provide express and informed consent to the admission and to treatment within 24 hours of admission. 

Where the patient is a minor or and adult who is adjudicated as incapacitated by a court order, such documentation is sufficient to preclude the patient’s ability to consent to his or her own treatment. In such situations, a guardian must decide whether or not to provide express and informed consent to
### BA 036

**Title:** PATIENT RIGHTS - EXPRESS AND INFORMED CONSENT – DISCLOSURE  
**Cite:** 394.459(3)(a), F.S.

Prior to giving consent, the following information shall be disclosed to the patient, or to the patient's guardian if the patient is 18 years of age or older and has been adjudicated incapacitated, or to the guardian advocate if the patient has been found to be incompetent to consent to treatment, or to both the patient and guardian if the patient is a minor:

1. The reason for admission,
2. The proposed treatment,
3. The purpose of the treatment to be provided,
4. The common side effects thereof,
5. Alternative treatment modalities,
6. The approximate length of care, and
7. That any consent given by a patient may be revoked orally or in writing prior to or during the treatment period by the patient, the guardian advocate or the guardian.

Examine the explanation in the chart of the treatment to be given to determine if the information does in fact explain the risk/benefit of the treatment and alternatives.

Review documentation of disclosure in charts and interview selected patients to determine if full disclosure had been provided prior to being asked to sign consent to treatment form.

Confirm that guardians or guardian advocates had been provided full disclosure prior to being asked to sign consent for treatment for persons adjudicated by a court to be incapacitated or incompetent to consent to treatment.

### BA 037

**Title:** PATIENT RIGHTS - CONSENT FOR MEDICAL PROCEDURES OR ELECTROCONVULSIVE TREATMENT (ECT)  
**Cite:** 394.459(3)(b), F.S.

In the case of medical procedures requiring the use of a general anesthesia or electroconvulsive treatment and prior to performing the procedure, express and informed consent shall be obtained from:

1. the patient, if the patient is legally competent, or
2. from the guardian of a minor patient,
3. from the guardian of a patient who has been adjudicated incapacitated, or
4. the guardian advocate of the patient if the guardian advocate has been given express court authority to consent to medical procedures or electroconvulsive treatment as provided under s. 394.4598.

Recommendation of ECT by two physicians is required.

### BA 038

**Title:** PATIENT RIGHTS - QUALITY OF TREATMENT  
**Cite:** 394.459(4)(a), F.S.
Each patient in a facility shall receive services suited to his or her needs, which shall be administered skillfully, safely, and humanely with full respect for the patient’s dignity and personal integrity. Each patient shall receive such medical, vocational, social, educational, and rehabilitative services, as his or her condition requires to bring about an early return to the community. In order to achieve this goal, the department is directed to coordinate its mental health programs with all programs of the department and other state agencies.

<table>
<thead>
<tr>
<th>BA 039</th>
<th>Title: PATIENT RIGHTS - QUALITY OF TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cite:</td>
<td>65E-5.180, F.A.C.</td>
</tr>
</tbody>
</table>

The following minimum standards shall be required in the provision of quality mental health treatment:

(1) Each receiving and treatment facility shall, using nationally accepted accrediting standards for guidance, develop written policies and procedures for planned program activities designed to enhance a patient’s self image, as required by s. 394.459(2)(d), F.S. These policies and procedures shall include curriculum, specific content, and performance objectives and shall be delivered by staff with content expertise. Medical, rehabilitative, and social services shall be integrated and provided in the least restrictive manner consistent with the safety of the patient or patients.

(2) Each facility, using nationally accepted accrediting standards for guidance, shall adopt written professional standards of quality, accuracy, completeness, and timeliness for all diagnostic reports, evaluations, assessments, examinations, and other procedures provided to individuals under the authority of chapter 394, part I, F.S. Facilities shall monitor the implementation of those standards to assure the quality of all diagnostic products. Standards shall include and specify provisions addressing:

   (a) The minimum qualifications to assure competence and performance of staff who administer and interpret diagnostic procedures and tests;

   (b) The inclusion and updating of pertinent information from previous reports, including admission history and key demographic, social, economic, and medical factors;

   (c) The dating, accuracy and the completeness of reports;

   (d) The timely availability of all reports to users;

   1) Program policies and procedures should be based on nationally accepted standards. Staff training shall be performed by persons who are competent by reason of training and/or experience in the subject matter.

   2) Review clinical records to determine that reports are legible, understandable, signed and dated. Issues raised by these reports should be addressed in the individualized treatment and discharge plans for each patient.
(e) Reports shall be legible and understandable;

(f) The documentation of facts supporting each conclusion or finding in a report;

(g) Requirements for the direct correlation of identified problems with problem resolutions which consider the immediacy of the problem or time frames for resolution and which include recommendations for further diagnostic work-ups;

(h) Requirement that the completed report be signed and dated by the administering staff; and

(i) Consistency of information across various reports and integration of information and approaches across reports.

### BA 040

**Title:** PATIENT RIGHTS - QUALITY OF TREATMENT – PSYCHIATRIC EXAMINATION  
**Cite:** 65E-5.180(3), F.A.C.

Psychiatric Examination. Psychiatric examinations shall include:

(a) Patient medical history, including psychiatric history, developmental abnormalities, physical or sexual abuse or trauma, and substance abuse;

(b) Examination, evaluative or laboratory results, including mental status examination;

(c) Working diagnosis, ruling out non-psychiatric causes of presenting symptoms of abnormal thought, mood or behaviors;

(d) Course of psychiatric interventions including:
   1. Medication history, trials and results;
   2. Current medications and dosages;
   3. Other psychiatric interventions in response to identified problems;

(e) Course of other non-psychiatric medical problems and interventions;

Review clinical records for the presence of a psychiatric examination for all patients within 72 hours of admission on a voluntary or involuntary basis. The examination must include essential elements (a-g) required in the rule; issues of discharge or transfer diagnosis should be incorporated in the discharge or transfer summary completed upon the patient’s departure from the facility.
(f) Identification of prominent risk factors including physical health, psychiatric and co-occurring substance abuse; and

(g) Discharge or transfer diagnoses.

| BA 041 | Title: **PATIENT RIGHTS - QUALITY OF TREATMENT**  
Cite: 65E-5.180(4), F.A.C. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedures for the transfer of the physical custody of patients shall specify and require that documentation necessary for legal custody and medical status, including the person’s medication administration record for that day, shall either precede or accompany the patient to their destination.</td>
<td></td>
</tr>
<tr>
<td>Review facility policies and procedures to ensure the specified documents are required to be transferred prior to or with the patient. Review closed clinical records to ensure that the facility is following the rule and its own policy in the transfer of records with a patient.</td>
<td></td>
</tr>
</tbody>
</table>

| BA 042 | Title: **PATIENT RIGHTS - QUALITY OF TREATMENT – PSYCHIATRIC EXAMINATION**  
Cite: 65E-5.180(5), F.A.C. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health services provided shall comply with the following minimum standards:</td>
<td></td>
</tr>
</tbody>
</table>

(a) In designated receiving facilities, the on-site provision of emergency psychiatric reception and treatment services shall be available 24-hours-a-day, seven-days a week, without regard to the individual’s financial situation.

(b) Assessment standards shall include provision for determining the presence of co-occurring mental illness and substance abuse, and clinically significant physical and sexual abuse or trauma.

(c) A clinical safety assessment shall be accomplished at admission to determine the person’s need for, and the facility’s capability to provide, an environment and treatment setting that meets the patient’s need for |

a. Ensure that the facility is open and fully staffed to provide all essential functions 24-hours per day, 7-days per week. **Each facility shall accept all persons brought to the facility by law enforcement officers for involuntary examination.**

b. Psychosocial evaluations shall address the patient’s history of physical or sexual abuse or trauma, as well as substance abuse. Treatment and discharge planning should address these issues.

c. The clinical record should include documentation of the patient’s need for a staff or facility-secure setting for the
<table>
<thead>
<tr>
<th>a secure facility or close levels of staff observation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(d) The development and implementation of protocols or procedures for conducting and documenting the following shall be accomplished by each facility:</td>
</tr>
<tr>
<td>1. Determination of a patient’s competency to consent to treatment within 24 hours after admission;</td>
</tr>
<tr>
<td>2. Prompt identification of a duly authorized decision-maker for the patient upon any patient being determined not to be competent to consent to treatment;</td>
</tr>
<tr>
<td>3. Obtaining express and informed consent for treatment and medications before administration, except in a medical emergency; and</td>
</tr>
<tr>
<td>4. Required involvement of the patient and guardian, or guardian advocate in treatment and discharge planning.</td>
</tr>
<tr>
<td>(e) Use of age sensitive interventions in the implementation of seclusion or in the use of physical force as well as the authorization and training of staff to implement restraints, including the safe positioning of persons in restraints. Policies, procedures and services shall incorporate special provisions regarding the restraining of minors, elders, and persons who are frail or with special medical problems such as potential problems with respiration.</td>
</tr>
<tr>
<td>(f) Plain language documentation in the patient’s clinical record of all uses of “as needed” or emergency applications of medications, and all uses of physical force, restraints, seclusion, or “time-out” procedures upon patients, and the explicit reasons for their use.</td>
</tr>
<tr>
<td>(g) The prohibition of standing orders or similar protocols for the emergency use of psychotropic medication.</td>
</tr>
<tr>
<td>(h) Timely provision of required training for guardian advocates including protection of the patient or others.</td>
</tr>
<tr>
<td>d. Review the policies and procedures to ensure the inclusion of the four required elements related to express and informed consent and involvement of the patient and substitute decision-makers in the treatment planning process.</td>
</tr>
<tr>
<td>a) Review policies and procedures to ensure special recognition is given in the application of seclusion or restraints to minors, elders, or persons with special medical problems.</td>
</tr>
<tr>
<td>b) Review clinical records to ensure that the reasons for any use of emergency interventions is specified in such a way that the patient or other authorized person may understand its necessity.</td>
</tr>
<tr>
<td>c) Review clinical records to ensure that any emergency use of psychotropic medications is based on an individual order by a physician and not standing orders.</td>
</tr>
</tbody>
</table>
| d) Review clinical records of patients who
activities and available resources designed to assist family members and guardian advocates in understanding applicable treatment issues and in identifying and contacting local self-help organizations.

| BA 050 | **Title:** TRAINING  
| Cite: 65E-5.330, F.A.C. |

(1) In order to ensure the protection of the health, safety, and welfare of patients treated in receiving and treatment facilities, required by s. 394.457(5)(b), F.S., the following is required:

(a) Each designated receiving and treatment facility shall develop policies and procedures for abuse reporting and shall conduct training which shall be documented in each employee’s personnel record or in a training log.

(b) All staff with patient contact shall receive training in verbal de-escalation techniques and the use of bodily control and physical management techniques based on a team approach. Less restrictive verbal de-escalation interventions shall be employed before physical interventions, whenever possible.

(c) All staff with patient contact shall receive training in cardiopulmonary resuscitation within the first six months of employment if not already certified when employed and shall maintain current certification as long as duties require direct patient contact.

(d) A personnel training plan that prescribes and assures that direct care staff, consistent with their assigned duties, shall receive and complete before providing direct care or assessment services, 14 hours of basic orientation training, documented in the employee’s personnel record, in the following:

|  |
|---|---|
| have had a guardian advocate proposed/appointed by the court to ensure the required training has been provided to assist in treatment and discharge planning. |  |

a) Review facility policies and procedures (see Policy and Procedure Worksheet) to ensure staff are correctly instructed to immediately report suspected abuse, neglect, or exploitation of any child, elder, or disabled person, without internal review. Review personnel records (see Personnel Worksheet) to ensure documentation is present of staff training in these policies and procedures.

b) Review personnel records (see Personnel Worksheet) to ensure each employee with patient contact has received training in a team approach to physical management techniques.

c) Review personnel records (see Personnel Worksheet) to ensure each employee with patient contact has received training in CPR within the timeframes permitted.

d) Review the facility’s personnel training plan to ensure it contains the type and length of training events required in rule. See Training Worksheet. Also see Personnel Worksheet. Also review the personnel record of a sample of these

2. Confidentiality laws including psychiatric, substance abuse, HIV and AIDS;

3. Facility incident reporting;

4. Restrictions on the use of seclusion and restraints, consistent with unit policies and procedures, and this chapter;

5. Abuse reporting required by chapter 415, F.S.;

6. Assessment for past or current sexual, psychological, or physical abuse or trauma;

7. Cross-training for identification of, and working with, individuals recently engaging in substance abuse;

8. Clinical risk and competency assessment;

9. Universal or standard practices for infection control;

10. Crisis prevention, crisis intervention and crisis duration services; and


Staff to ensure the training events detailed in the plan were actually provided. In staff interviews, ask staff if they remember receiving the specified training events.

**BA 051**  
**Title:** TRAINING  
**Cite:** 65E-5.330(2), F.A.C.

In addition to the training required in this rule, procedures must assure that mental health services staff shall annually receive 12 hours continuing training in the skills and knowledge employed in performing their respective responsibilities. Employees during their first year of employment shall undergo no less than the 14 hours of orientation, as described in 65E-5.330(1)(c) and 12 hours of in-service training.

Review the training plan to ensure the continuing education is included and review personnel records to ensure the planned training was actually provided.

**BA 052**  
**Title:** TRAINING  
**Cite:** 65E-5.330(3), F.A.C.
### BA 053  
**Title:** TRAINING  
**Cite:** 65E-5.330(4), F.A.C.  

A plan shall be developed and implemented providing for the mandatory training for employees, emergency room personnel and physicians in the Baker Act, relative to their positions and responsibilities, and any implementing local coordination agreements or protocols.

Review the facility’s training plan to determine if a comprehensive training schedule has been prepared to address the needs of the specified personnel.

### Title: PATIENT RIGHTS – QUALITY OF TREATMENT – COMPLAINT INVESTIGATION  
**Cite:** 65E-5.180(6), F.A.C.  

Each designated receiving and treatment facility shall develop a written procedure for the receipt, review, and prompt investigation of oral or written complaints by a patient about his or her care while hospitalized, which shall be documented in the patient’s clinical record.

Review the policy and procedure manual to ensure the presence of an approved procedure for handling patient complaints. Interview staff to determine if they understand their facility's procedure. Interview patients to determine how any complaints they made were addressed. Review clinical records to ensure the presence of any patient complaint, if any.

### BA 062  
**Title:** PATIENT RIGHTS – QUALITY OF TREATMENT- BODILY CONTROL AND PHYSICAL MANAGEMENT TECHNIQUES  
**Cite:** 65E-5.180(7), F.A.C.  

(a) All staff with patient contact shall receive training in:
1. Verbal de-escalation techniques designed to reduce confrontation; and
2. Use of bodily control and physical management techniques based on a team approach.

(b) All staff with patient contact shall receive training in safe and effective techniques that are alternatives to seclusion and restraint for managing violent behavior. Training shall include techniques that are consistent with

a) Review personnel records to ensure each staff member with direct patient care responsibilities has received training in verbal de-escalation and team oriented physical management techniques.

b) Review personnel records to ensure that staff members who have patient contact receive training in alternatives to seclusion...
the age of patients being served by the facility.

| BA 063 | Title: PATIENT RIGHTS – QUALITY OF TREATMENT- BRIEF ISOLATION  
|        | Cite: 65E-5.100(3), F.A.C. |
|        | (c) Review clinical records of persons for whom the unit logbook indicates restraints have been applied. The clinical record should document less restrictive interventions were attempted and failed before the use of restraints, unless physical injury was imminent. |

| BA 064 | Title: PATIENT RIGHTS – QUALITY OF TREATMENT – BRIEF ISOLATION  
|        | Cite: 65E-5.180(8), F.A.C. |
|        | (a) In the event of two or more isolation interventions which exceed 15 minutes each or a cumulative total of isolation in excess of 60 minutes during any 24-hour period, a meeting of the treatment team to assess the cause of the isolation, review the adequacy of the intervention, and if appropriate, to develop more appropriate therapeutic interventions is required. |
|        | (b) Each use of brief isolation lasting more than 15 minutes shall be documented in the patient’s clinical record. |

| BA 065 | Title: PATIENT RIGHTS - QUALITY OF TREATMENT-RESTRAINT AND SECLUSION  
|        | Cite: 394.459(4)(b), F.S. |
|        | Review policies and procedures to ensure criteria for use of these interventions is in place as well as staff training, incident review, |

(c) Less restrictive verbal de-escalation interventions shall be employed before physical interventions, unless physical injury is imminent. Use of the “De-Escalation Preference Form” (CF-MH 3124) for the purpose of guiding individualized intervention techniques is recommended. If used, this form shall be completed at or soon as practical after admission.

Review clinical records of persons for whom the unit logbook indicates restraints have been applied. The clinical record should document less restrictive interventions were attempted and failed before the use of restraints, unless physical injury was imminent.

Brief isolation means an involuntarily imposed isolation or segregation of the patient from others, not requiring a physician’s order, such as time-out types of intervention but which cannot include closed or locked doors.

Interview patients (see Patient Interview Worksheet) to determine if they had been isolated from others. If so, review clinical record to ensure the isolation was recorded. If two or more incidents of 15 minutes or more each or a cumulative total of 60 minutes in a 24-hour period occur, seek documentation that the treatment team had met to perform its required functions.

Receiving and Treatment Facilities shall develop and maintain, in a form accessible to and readily understandable by patients, the following:
1. Criteria, procedures, and required staff training for any use of:
   (a) Close or elevated levels of supervision,
   (b) Restraint, seclusion, or isolation, or
   (c) Emergency treatment orders, and
   (d) The use of bodily control and physical management techniques.

2. Procedures for documenting, monitoring and requiring clinical review of all uses of the procedures described in paragraph 1, and for documenting and requiring review of any incidents resulting in injury to patients.

3. A system for the review of complaints by patients or their families or guardians.

| BA 066 | Title: PATIENT RIGHTS - QUALITY OF TREATMENT – RESTRAINT & SECLUSION  
| Cite: 394.459(4)(c), F.S. |
A facility may not use seclusion or restraint for punishment, to compensate for inadequate staffing, or for the convenience of staff. Facilities shall ensure that all staff is made aware of these restrictions on the use of seclusion and restraint and shall make and maintain records which demonstrate that this information is conveyed to individual staff members.

| BA 067 | Title: PATIENT RIGHTS - QUALITY OF TREATMENT – RESTRAINT & SECLUSION  
| Cite: 65E-5.180(13), F.A.C. |
Each facility utilizing seclusion or restraint procedures shall establish and utilize a committee, that includes medical staff, to conduct timely reviews of each use of seclusion and restraint, and monitor patterns of use, for the purpose of assuring least restrictive approaches are utilized to reduce the frequency and duration of use upon patients.

| BA 069 | Title: PATIENT RIGHTS – QUALITY OF TREATMENT – SECLUSION |
and complaint review. Such information must be made available to staff, guardian advocates and patients.

Interview selected staff and patients to see if they are aware of such policies and procedures.

Review restraint and seclusion log to determine frequency of use.

Review clinical records to determine what prompted use of the intervention, what alternatives were attempted, and whether adequate justification existed for their use.

Were restraints and seclusion terminated as soon as the behavior which prompted their use is no longer a factor?

Review policies and procedures to ensure use of restraint and seclusion is prohibited for reasons of punishment, inadequate staffing or staff convenience. Review personnel files to ensure each staff member has received training in these policies.

Interview staff to determine the composition and function of the committee to oversee restraint and seclusion. Determine how frequently it meets and any results of its meetings in reducing the frequency and duration of such interventions.
<table>
<thead>
<tr>
<th>Cite: 65E-5.180(9), F.A.C.</th>
<th>Seclusion means an emergency response in which, as a means of controlling a patient’s immediate symptoms or behavior, the patient’s ability to move about freely has been limited by staff or in which a patient has been physically segregated in any fashion from other patients. Seclusion is an involuntarily imposed closed door or locked door isolation of the patient from others and requires a written order by a physician except as described and authorized in section 65E-5.1602, F.A.C.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(b) Brief isolation shall be attempted prior to imposing seclusion, whenever possible.</td>
<td>Interview patients to determine if they have been involuntarily secluded in a locked or closed door setting. Ensure that such events are documented in the clinical record and that alternatives to seclusion were attempted by staff before seclusion was implemented.</td>
</tr>
<tr>
<td>(c) In order to assure patient safety, a written order by a physician shall be required for each use of seclusion.</td>
<td>The seclusion process shall evidence consideration that alternatives have been considered by implementing staff. In order to enhance patient safety, each patient shall be searched for contraband before placing the patient into seclusion.</td>
</tr>
<tr>
<td>(d) In an emergency, any registered nurse or the highest level staff member who is immediately available and who is trained in seclusion procedures, may initiate seclusion if in accord with specific written facility policies. If imposed without a prior written order, an order must be obtained from a physician and written within one hour of initiation of seclusion or the patient must be immediately released from seclusion. All verbal orders for</td>
<td>c) Review clinical records to ensure the presence of a physician order for any seclusion.</td>
</tr>
<tr>
<td></td>
<td>d) Review facility policies and procedures to ensure that policies permit staff other than physicians to initiate seclusion in an emergency situation. If such emergency initiation of seclusion is permitted, review unit logbook to determine if seclusion has</td>
</tr>
</tbody>
</table>
seclusion must be signed within 24 hours of the initiation of seclusion by an authorizing physician. If seclusion is initiated by a staff member other than an advanced registered nurse practitioner or a registered nurse, an advanced registered nurse practitioner or a registered nurse shall assess the need for seclusion and document it in the chart within 15 minutes of initiation. Patients released from seclusion due to the lack of an order or without the nursing assessment may not again be placed into seclusion within the following 12 hours without an accompanying order.

(e) Physicians authorized by the facility to order seclusion in a receiving or treatment facility, shall exercise this authority under the oversight of the facility’s medical oversight committee.

(f) Where seclusion is ordered, it may only be ordered by a physician and it may be ordered for a period up to:
   1. One hour for minors under nine years of age;
   2. Two hours for minors over nine years of age and under the age of 18; and
   3. Four hours for adults.

(g) A seclusion order may be extended by repeating these timeframes after review by a physician or advanced registered nurse practitioner.

(h) Where seclusion is to be used upon the occurrence of specific behavior, this intervention must comply with the provisions of rule governing Individual Behavior Management Programs (65E-5.1602, F.A.C.)

(i) Each use of seclusion and the name of the person initiating the seclusion must be documented in a unit log book or similar automated registry maintained for this purpose; each use and explicit reason for seclusion shall also be recorded in the patient’s clinical record. Upon initiation of seclusion, the log book shall sequentially record all uses of seclusion, and for each use, the date and time of initiation and release, and elapsed time.

(j) During each period of seclusion, the patient must:
   1. Be offered reasonable opportunity to drink, to toilet, and to have range of motion.

been implemented on any current patients. Review those patient’s clinical records to ensure that a verbal physician order was received within one hour and that a written order was signed within 24 hours. Also ensure that a RN or ARNP assessed the patient within 15 minutes if emergency seclusion was initiated by other than a RN or ARNP.

e) Review by-laws, policies, and minutes of the facility’s medical oversight committee to ensure it had authorized each physician who had ordered seclusion.

f) Review clinical records to ensure no physician order for seclusion exceeds the period of time permit by rule.

(g) Review clinical records to ensure that any extension of seclusion orders was reviewed by a physician or ARNP.

h) See Tag BA 031

i) Ensure each unit that uses restraint or seclusion maintains a logbook or similar registry. Examine the logbook to determine that it sequentially records all uses of seclusion and other data required by rule. Examine clinical records to ensure the seclusion events were documented.

j) Review policies and procedures to ensure that the facility has informed its staff of
2. Be observed by staff trained in this function at least every 15 minutes, for injury and respiration, and the findings immediately documented. Documentation of the observations and the staff person’s name shall be recorded at the time the observation takes place. At least once every hour, such documented observation shall be conducted by a nurse.

(k) Every secluded patient shall be immediately informed of the behavior that caused their seclusion and the behavior and conditions necessary for their release.

(l) Facilities shall develop and staff shall use criteria to guide early termination from seclusion. When seclusion is terminated early and the same symptomatic behavior which caused the application of seclusion is still evident, the original order can be reapplied.

(m) Upon release from seclusion, the patient’s physical condition shall be observed, evaluated, and documented. After the patient’s release, therapeutic discussion of the event and alternative means of responding must be offered to the patient by staff not involved with the event. The results of this offer and any resulting discussion shall be documented.

(n) If two or more incidents of seclusion of a patient are necessary within a 24-hour period, the treatment team shall analyze the patient’s clinical record for trends or patterns relating to conditions, events, or individuals present immediately before or upon the onset of the behavior warranting the seclusion, and of the conditions presented upon the patient’s release from seclusion. The treatment team shall review the adequacy of the emergency intervention, and if appropriate, develop more appropriate therapeutic interventions. Documentation of this review shall be placed in the patient’s clinical record.

(k) Interview patients who had been secluded to ensure that staff had informed them of the conditions to exit from seclusion immediately upon being placed into seclusion.

(l) Review facility policies and procedures that define early termination from seclusion.

(m) Review clinical records of persons who had been placed into seclusion to ensure documentation of their satisfactory physical condition upon release from seclusion and that the required therapeutic discussion of the seclusion is documented.

(n) Review the unit logbook to determine if any patients had been placed into seclusion at least twice in a 24-hour period. If so, review their clinical record to ensure the required treatment team meeting occurred and the elements to be addressed are documented.
Cite: 65E-5.180(10), F.A.C.

(a) In imposing restraints on a patient, use of age and physical fragility sensitive techniques shall be utilized. If a device is used for age or fragility reasons, it should be so documented in the patient’s clinical record.

(b) Walking restraints may only be used during transportation under the supervision of trained staff. The use of walking restraints is prohibited except for purposes of off-unit transportation.

(c) Restraints are an emergency medical psychiatric measure to be used only for the immediate physical protection of the patient or others and may be imposed only upon the order of a physician. The order shall include:

1. The specific behavior prompting the use of restraints,
2. The type of restraint ordered,
3. Time limit for restraint use,
4. The positioning of the patient for respiratory and other medical safety considerations, and
5. The behavior necessary for the patient’s release from restraint.

Any use of restraint, including medical risk considerations of positioning shall be in accordance with facility policies and procedures which shall require staff proficiency in age and fragility-sensitive appropriate techniques the patient. The restraint process shall evidence consideration that individual’s choice alternatives as identified in the recommended “De-
Escalation Preference Form” (CF-MH 3124) have been considered.

(d) In an emergency, a registered nurse or the highest level staff member who is immediately available and who is trained in restraint procedures, may initiate restraints. However, an order by a physician must be obtained and written within the patient’s clinical record within one hour of initiation or the patient must be immediately released from the restraints. If restraints are initiated by a staff member other than a nurse, the nurse shall assess the need for restraints and document it in the chart within 15 minutes of initiation. All orders for restraint must be signed within 24 hours of the initiation of the restraints.

d) Review facility policies and procedures to ensure that policies permit staff other than physicians to initiate restraint in an emergency situation. If such emergency initiation of restraint is permitted, review unit logbook to determine if restraint has been implemented on any current patients. Review those patient’s clinical records to ensure that a verbal physician order was received within one hour and that a written order was signed within 24 hours. Also ensure that a RN or ARNP assessed the patient within 15 minutes if emergency restraint was initiated by other than a RN.

(e) If a physician is authorized to order restraints in a receiving or treatment facility, such professional shall practice under the oversight of the facility’s medical oversight committee.

e) Review any policy or procedure or committee meeting minutes to ensure the physician who has ordered restraints is authorized to do so.

(f) Where restraint is ordered, it may only be ordered by a physician and it may be ordered for an initial period up to:

1. One hour for minors under nine years of age;
2. Two hours for minors over nine years of age and under the age of 18; and
3. Four hours for adults.

(f) Review clinical records to ensure no physician order for restraint exceeds the period of time permit by rule.

(g) A restraint order may be extended by repeating these timeframes, after review by a physician or an advanced registered nurse practitioner.

(g) Review clinical records to ensure that any extension of restraint orders was reviewed by a physician or ARNP.

(h) In order to protect patient safety, each patient shall be:
1. Searched for contraband before or immediately after being placed into restraints; and
2. Evaluated medically to determine the need or lack of need to elevate the patient’s head and torso during restraint prior to placing the patient into restraints. Such evaluation of the need or lack of need shall be

(h) Review policies and procedures to ensure that staff are required to search each patient for contraband when placed into restraints and that each patient is required to be medically evaluated for restraints. Review clinical records to ensure that staff
documented in the order for restraints.

(i) Each use of restraint and the name of the person initiating the restraint must be documented in a unit log book or similar automated registry maintained for this purpose; each use and explicit reason for restraint shall also be recorded in the patient’s clinical record. Upon initiation of restraints, the log book shall sequentially record all uses of restraints, and for each use, the date and time of initiation, release, and elapsed time.

(j) During each period of restraint, the patient must:
1. Be offered reasonable opportunity to drink, to toilet, and to have range of motion;
2. Be located in areas, whenever possible, not subject to view by persons other than staff or where they are exposed to potential injury by other patients; and
3. Be observed by staff trained in this function at least every 15 minutes, for circulation, injury, and respiration, and the findings immediately documented. Documentation of the observations and the staff person’s name shall be recorded at the time the observation takes place. At least once every hour, such documented observation shall be conducted by a nurse.

(k) Every restrained patient shall be informed of the behavior that caused their restraint and the behavior and conditions necessary for their release after 15 minutes of calm.

(l) Facilities shall develop and staff shall use criteria to guide early termination from restraint. When restraint is terminated early and the same behavior which caused the application of restraints is still evident, the original order can be re applied.

(m) Upon release from restraints, the patient’s physical condition shall be have charted the documentation of these actions.

i) Ensure each unit that uses restraint or seclusion maintains a logbook or similar registry. Examine the logbook to determine that it sequentially records all uses of restraint and other data required by rule. Examine clinical records to ensure the restraint events were documented.

j) Review policies and procedures to ensure that the facility has informed its staff of restraint requirements. Review clinical records of persons placed in restraint to ensure each observation of patients is recorded, that the frequency of observation is no more than 15 minutes apart, and that one observation per hour is conducted by a nurse. Conduct interviews of patients who were restrained to ensure that they were offered the opportunity to drink, toilet, and have range of motion while in restraints. Observe the room in which restrained patients are held to ensure it is located outside the view of persons other than staff and that no obvious safety risks exist.

k) Interview patients who had been restrained to ensure that staff had informed them of the conditions to exit from restraints immediately upon being placed into restraints.

l) Review facility policies and procedures that define early termination from restraints.

m) Review clinical records of persons who had
observed, evaluated, and documented. After the patient’s release from seclusion, discussion of the event and alternative means of responding must be offered to the patient by staff not involved with the event. The results of this discussion shall be documented.

(n) Since restraint is an emergency procedure, within 48 hours after any use of restraint, the circumstances preceding its imposition and the patient’s treatment plan must be reviewed to determine whether changes in the plan are advisable in order to prevent the further need of restraint.

BA 072  
Title: PATIENT RIGHTS - QUALITY OF TREATMENT – USE OF PROTECTIVE MEDICAL DEVICES WITH FRAIL OR MOBILITY IMPAIRED PATIENTS  
Cite: 65E-5.180(1), F.A.C.

(a) When using safety or protective devices such as posey vests, geri-chairs, mittens, and bed rails which also restrain, facility staff shall consider alternative means of providing such safety so that the patient’s need for regular exercise is accommodated to the greatest extent possible.

(b) Where frequent or prolonged use of safety or protective devices are required, the patient’s treatment plan shall address debilitating effects due to decreased exercise levels such as circulation, skin, and muscle tone and the patient’s need for maintaining or restoring bowel and bladder continence.

(c) The treatment plan shall include scheduled activities to lessen deterioration due to the usage of such protective medical devices.

BA 073  
Title: PATIENT RIGHTS - QUALITY OF TREATMENT - ELEVATED LEVELS OF SUPERVISION  
Cite: 65E-5.180(12), F.A.C.

Receiving and treatment facilities shall ensure that where one-on-one supervision is required, it shall be continuous and shall not be interrupted as a result of shift changes or due to conflicting staff assignments. Such
supervision shall be continuous until documented as no longer medically necessary by a physician.

| BA 074 | Title: PATIENT RIGHTS - COMMUNICATION, ABUSE REPORTING AND VISITS  
         | Cite: 394.459(5), F.S. |
|--------|---------------------------------------------------------------|
| (a) Each person receiving services in a facility providing mental health services under ch. 394, Part I, F.S. has the right to communicate freely and privately with persons outside the facility unless it is determined that such communication is likely to be harmful to the person or others.  
(d) Each facility shall establish reasonable rules governing visitors, visiting hours, and the use of telephones by patients in the least restrictive possible manner. Patients shall have the right to contact and to receive communication from their attorneys at any reasonable time. |

Review policies and procedures to ensure that all patients, regardless of age or stage of development, are assured of free and open communication by telephone, mail, and visitation, unless restricted for safety reasons.

Review rules to ensure reasonableness as to patient right to communicate vs. hospital need to maintain order and provide scheduled treatment.

| BA 075 | Title: PATIENT RIGHTS – COMMUNICATION, ABUSE REPORTING AND VISITS  
         | Cite: 394.459(5)(c), F.S. |
|--------|---------------------------------------------------------------|
| If a patient's right to communicate or to receive visitors is restricted by the facility, written notice of such restriction and the reasons for the restriction shall be served on the patient, the patient’s attorney, and the patient’s guardian, guardian advocate, or representative; and such restriction shall be recorded on the patient's clinical record with the reasons therefor.  
The restriction of a patient's right to communicate or to receive visitors shall be reviewed at least every 7 days. The right to communicate or receive visitors shall not be restricted as a means of punishment. |

Interview patients to determine if their ability to communicate with others outside the facility has at any time been restricted. If a patient’s communication was restricted, verify that:

1. Full documentation of the extent and justified reasons for the restrictions are found in the patient chart;  
2. That the patient and others required by statute have been notified in writing; and  
3. That reviews have been completed at least every seven days.

| BA 076 | Title: PATIENT RIGHTS - COMMUNICATION, ABUSE REPORTING AND VISITS  
         | Cite: 65E-5.190(1), F.A.C. |
|--------|---------------------------------------------------------------|
| If the treatment team imposes any restrictions, such as with whom the patient in a receiving or treatment facility may communicate, such restrictions and which the supervision is suspended for any reason, without the order of a physician. Document the precise date and time for the record.  
Review clinical records to determine if any restrictions reported by patients during |

Interview patients to determine if their ability to communicate with others outside the facility has at any time been restricted. If a patient’s communication was restricted, verify that:

1. Full documentation of the extent and justified reasons for the restrictions are found in the patient chart;  
2. That the patient and others required by statute have been notified in writing; and  
3. That reviews have been completed at least every seven days.

Review clinical records to determine if any restrictions reported by patients during
justification shall be recorded in the patient’s clinical record. Facility staff shall make adult competent patients aware that they have the ability to waive the confidentiality of their presence in a receiving or treatment facility and allowing all or specified persons the patient selects access to free and open communication with the patient.

| BA 077 | Title: PATIENT RIGHTS - COMMUNICATION, ABUSE REPORTING AND VISITS  
| Cite: 394.459(5)(b), F.S. |
|--------|-----------------------------------------------------------|
| Interview patients and staff and review policies and procedures to determine that people have the right to send and receive unopened mail unless restricted. Determine if stationery and stamps are provided to patients by the facility if needed. |

Each patient admitted to a facility under the provisions of this part shall be allowed to receive, send, and mail sealed, unopened correspondence; and no patient’s incoming or outgoing correspondence shall be opened, delayed, held, or censored by the facility unless there is reason to believe that it contains items or substances which may be harmful to the patient or others, in which case the administrator may direct reasonable examination of such mail and may regulate the disposition of such items or substances.

| BA 078 | Title: PATIENT RIGHTS - VISITORS  
| Cite: 394.459(5)(c), F.S. |
|--------|-----------------------------------------------------------|
| Review facility policies to ensure that family, guardians, guardian advocates, HRAC members, and attorney have immediate access to a person unless it is considered detrimental to the person or unless the person chooses not to see the person. Telephone the HRAC to determine whether they have free access to any patient at any time. |

Each facility must permit immediate access to any patient, subject to the patient’s right to deny or withdraw consent at any time, by the patient’s family members, guardian, guardian advocate, representative, human rights advocacy committee, or attorney, unless such access would be detrimental to the patient.

| BA 079 | Title: PATIENT RIGHTS - ACCESS TO TELEPHONES  
| Cite: 394.459(5)(a), F.S. |
|--------|-----------------------------------------------------------|
| Confirm availability of a private and toll-free telephone, particularly to report abuse. |

Each facility shall make available as soon as reasonably possible to persons receiving services a telephone that allows for free local calls and access to a long-distance service. A facility is not required to pay the costs of a patient’s long-distance calls. The telephone shall be readily accessible to the patient and shall be placed so that the patient may use it to communicate privately and confidentially. The facility may establish reasonable rules for the use of the telephone, provided that the rules do not interfere with a patient’s access to interviews are adequately justified.

Use of recommended form “Restriction of Communication or Visitors” (CF-MH 3049 ).

Interview patients and staff and review policies and procedures to determine that people have the right to send and receive unopened mail unless restricted. Determine if stationery and stamps are provided to patients by the facility if needed.
### BA 080
**Title:** PATIENT RIGHTS - COMMUNICATION, ABUSE REPORTING AND VISITS – TELEPHONES  
**Cite:** 65E-5.190(2), F.A.C.

Prompt access to a telephone shall be provided to each patient requesting to call his or her legal counsel, Florida Abuse Registry, Human Rights Advocacy Committee, or the Advocacy Center for Persons with Disabilities.

Tour the units to ensure the presence of toll-free telephones available adjacent to the site where rights/advocacy information is posted. Patients should be able to dial the phone, rather than relying on staff to do so. The phone should be located far enough away from the nurse’s station to permit privacy of conversation. The cord may be shortened to prevent the phone’s use as a weapon.

### BA 081
**Title:** PATIENT RIGHTS - ABUSE REPORTING  
**Cite:** 394.459(5)(e), F.S.

Each patient receiving mental health treatment in any facility shall have ready access to a telephone in order to report an alleged abuse.

The facility staff shall orally and in writing inform each patient of the procedure for reporting abuse and shall make every reasonable effort to present the information in a language the patient understands.

A written copy of that procedure, including the telephone number of the abuse registry and reporting forms, shall be posted in plain view.

Interview patients to confirm that staff has advised them of procedures for reporting abuse.

Observe the location of a telephone available for reporting abuse and the posting of the Abuse Registry’s telephone number close to the phone.

Tour the unit to view the posted abuse reporting procedure.

### BA 082
**Title:** PATIENT RIGHTS - CARE AND CUSTODY OF PERSONAL EFFECTS OF PATIENTS  
**Cite:** 394.459(6), F.S.

A patient's right to the possession of his or her clothing and personal effects shall be respected. The facility may take temporary custody of such effects when required for medical and safety reasons.

A patient's clothing and personal effects shall be inventoried upon their removal into temporary custody. Copies of this inventory shall be given to the patient and to the patient's guardian, guardian advocate, or representative and shall be recorded in the patient's clinical record. This inventory may be

Review policies and procedures to ensure compliance with statute.

Interview patients and staff to determine that patients have the right to retain their clothing and personal effects. Sample patient charts to confirm presence of the required inventory.
amended upon the request of the patient or the patient’s guardian, guardian advocate, or representative. The inventory and any amendments to it must be witnessed by two members of the facility staff and by the patient, if able.

All of a patient’s clothing and personal effects held by the facility shall be returned to the patient immediately upon the discharge or transfer of the patient from the facility, unless such return would be detrimental to the patient. If personal effects are not returned to the patient, the reason must be documented in the clinical record along with the disposition of the clothing and personal effects, which may be given instead to the patient’s guardian, guardian advocate, or representative.

As soon as practicable after an emergency transfer of a patient, the patient’s clothing and personal effects shall be transferred to the patient’s new location, together with a copy of the inventory and any amendments, unless an alternate plan is approved by the patient, if able, and by the patient’s guardian, guardian advocate, or representative.

| BA 083 | Title: PATIENT RIGHTS - CARE AND CUSTODY OF PERSONAL EFFECTS  
Cite: 65E-5.200, F.A.C. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Each designated receiving and treatment facility shall develop policies and procedures governing what personal effects will be removed from patients for reasons of personal or unit safety, how they will be safely retained by the facility, and how and when they will be returned to the patient or other authorized person on the patient’s behalf. Policies and procedures shall specify how contraband and other personal effects determined to be detrimental to the patient will be addressed when not returned to the patient or other authorized person. An inventory of personal effects shall be witnessed by two staff and by the patient, if able, at the time of admission, at any time the inventory is amended, and at the time the personal effects are returned or transferred.</td>
<td></td>
</tr>
</tbody>
</table>

| BA 084 | Title: PATIENT RIGHTS - VOTING IN PUBLIC ELECTIONS  
Cite: 394.459(7), F.S. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A patient in a facility who is eligible to vote according to the laws of the state has the right to vote in the primary and general elections.</td>
<td></td>
</tr>
</tbody>
</table>

| BA 085 | Title: PATIENT RIGHTS - VOTING IN PUBLIC ELECTIONS  
Cite: 65E-5.210, F.A.C. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The facility shall have voter registration forms and applications for absentee</td>
<td></td>
</tr>
</tbody>
</table>

witnessed by two staff and by the patient, if possible. See Clinical Records Checklist.

Upon discharge or transfer, does the clinical record reflect that personal effects were returned to the patient, representative, or guardian advocate?
| BA 086 | Title: PATIENT RIGHTS - HABEAS CORPUS  
Cite: 394.459(8), F.S.  
(a) At any time, and without notice, a person held in a receiving facility, or a relative, friend, guardian, guardian advocate, representative, or attorney, or the department, on behalf of such a person, may petition for a writ of Habeas corpus to question the cause and legality of such detention and request that the court order a return to the writ in accordance with chapter 79. Each patient held in a facility shall receive a written notice of the right to petition for a writ of habeas corpus.  
(b) At any time, and without notice, a person who is a patient in a receiving or treatment facility, or a relative, friend, guardian advocate, representative, or attorney or the department, on behalf of such person, may file a petition in the circuit court where the patient is being held alleging that the patient is unjustly denied a right or privilege granted herein or that a procedure authorized herein is being abused. Upon filing of such a petition, the court shall have the authority to conduct a judicial inquiry and to issue any order needed to correct an abuse of the provisions of this part.  
(c) The administrator of any receiving or treatment facility receiving a petition under this subsection shall file the petition with the clerk of the court on the next court working day. |
| --- | --- |
| BA 087 | Title: PATIENT RIGHTS - HABEAS CORPUS  
Cite: 65E-5.220, F.A.C.  
(1) Upon admission to a receiving or treatment facility, each patient shall be given notice of their right to petition for a writ of habeas corpus and for redress of grievances. A copy of the notice shall be provided to the guardian, guardian advocate, representative, or the health care surrogate or proxy, and the patient’s clinical record shall contain documentation that |
| 1) Review clinical records to ensure that all patients admitted to a facility and other required persons have been notified of this right. Use of recommended form “Notice of Right to Petition for Writ of Habeas Corpus...” |
| BA 088 | **Title:** PATIENT RIGHTS - RIGHT TO PARTICIPATE IN TREATMENT AND DISCHARGE PLANNING  
**Cite:** 394.459(11), F.S. | The patient shall have the opportunity to participate in treatment and discharge planning and shall be notified in writing of his or her right, upon discharge from the facility, to seek treatment from the professional or agency of the patient's choice.  
Interview staff and patients to ensure that patient are informed of their right to participate in treatment, discharge planning, and selection of aftercare provider. |
| BA 089 | **Title:** PATIENT RIGHTS - POSTING OF NOTICE OF RIGHTS OF PATIENTS  
**Cite:** 394.459(12), F.S. | Each facility shall post a notice listing and describing, in the language and terminology that the persons to whom the notice is addressed can understand, the rights provided in this section.  
This notice shall include a statement that provisions of the federal Americans with Disabilities Act apply and the name and telephone number of a person to contact for further information.  
This notice shall be posted in a place readily accessible to patients and in a format easily seen by patients.  
This notice shall include the telephone numbers of the local human rights advocacy committee and Advocacy Center for Persons with Disabilities, Inc.  
Tour the unit and observe the following posters/notices:  
- Patient Rights  
- HRAC  
- Advocacy Center  
- ADA Provisions  
Notices must be in simple language and located close to the telephone. |
| BA 095 | **Title:** HUMAN RIGHTS ADVOCACY COMMITTEE ACCESS TO PATIENTS AND RECORDS  
**Cite:** 394.4595, F.S. | Any facility designated by the department as a receiving or treatment facility must allow access to any patient and the clinical and legal records of any patient admitted pursuant to the provisions of this act by members of the  
Call the HRAC to determine if at any time, any member of the HRAC had a request to meet with a patient or to review a clinical record |
| BA 096 | Title: PERSONS TO BE NOTIFIED; PATIENT’S REPRESENTATIVE  
|        | Cite: 394.4597(1), F.S.  
|        | At the time a patient is voluntarily admitted to a receiving or treatment facility, the identity and contact information of a person to be notified in a case of an emergency shall be entered in the patient’s clinical record.  
|        | For **voluntary** patients, there should be an emergency contact listed in the patient’s clinical record. No notice shall be made without the consent of the patient.  
|        | Sample patient charts to confirm a representative has been designated for involuntary patients who have no guardian.  
|        | denoted.  
| BA 097 | Title: PERSONS TO BE NOTIFIED; PATIENT’S REPRESENTATIVE  
|        | Cite: 394.4597(2), F.S.  
|        | **INvoluntary patients**  
|        | (a) At the time a patient is admitted to a facility for involuntary examination or placement, or when a petition for involuntary placement is filed, the names, addresses, and telephone numbers of the patient’s guardian or guardian advocate, or representative if the patient has no guardian, and the patient’s attorney shall be entered in the patient’s clinical record.  
|        | (b) If the patient has no guardian, the patient shall be asked to designate a representative. If the patient is unable or unwilling to designate a representative, the facility shall select a representative.  
|        | (c) The patient shall be consulted with regard to the selection of a representative by the receiving or treatment facility and shall have authority to request that any such representative be replaced.  
|        | (d) When the receiving or treatment facility selects a representative, first preference shall be given to a health care surrogate, if one has been previously selected by the patient. If the patient has not previously selected a health care surrogate, the selection, except for good cause documented in the patient’s record, shall be made from the following list in the order of listing:  
|        | 1. The patient’s spouse.  
|        | Confirm from patient clinical records that the representative selected by the facility (if the patient has not selected his/her own) is one of the seven permitted representatives and that the representative does not belong to one of the prohibited groups listed in paragraph (e).  
|        | Ensure that the clinical chart documents the representative was notified by telephone or in person within 24 hours by the facility of the patient’s admission. |
### DISCHARGE OF VOLUNTARY PATIENTS

<table>
<thead>
<tr>
<th>Title: DISCHARGE OF VOLUNTARY PATIENTS</th>
<th>Cite: 394.4625(2)(a)2, F.S.</th>
</tr>
</thead>
</table>

A facility shall discharge a voluntary patient who revokes consent to admission or requests discharge. A voluntary patient or a relative, friend or attorney of the patient may request discharge either orally or in writing at any time following admission to the facility.

The patient must be discharged within 24 hours of the request, unless the request is rescinded or the patient is transferred to involuntary status pursuant to this section. The 24-hour time period is may be extended by a treatment facility (state hospital only) when necessary for adequate discharge planning, but shall not exceed 3 days exclusive of weekends and holidays.

If the patient, or another on the patient’s behalf, makes an oral request for discharge to a staff member, such request shall be immediately entered in the patient’s clinical record. If the request for discharge is made by a person other than the patient, the discharge may be conditioned upon the express and informed consent of the patient.

### GUARDIAN ADVOCATE

<table>
<thead>
<tr>
<th>Title: GUARDIAN ADVOCATE</th>
<th>Cite: 394.4598(1), F.S.</th>
</tr>
</thead>
</table>

The administrator may petition the court for the appointment of a guardian advocate based upon the opinion of a psychiatrist that the patient is incompetent to consent to treatment.

Review policies and procedures to ensure they are consistent with the statute.

Interview facility staff and patients to ensure voluntary patients are notified of their right to request discharge.

Interview voluntary patients to determine if they, at any time, had requested discharge. If so, review their clinical records to determine if requests for discharge were handled appropriately by the staff.

Sample patient charts to ensure that a guardian advocate is requested for all patients.
| BA 100 | **Title:** GUARDIAN ADVOCATE  
**Cite:** 65E-5.230(1), F.A.C. | determined by staff to be incompetent to consent to treatment.  
A copy of the completed recommended form “Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate or its equivalent, shall be given to the patient, the patient’s representative if any, and to the prospective guardian advocate with a copy retained in the patient’s clinical record.  
Review the clinical records of patients who are believed to be incompetent to consent to treatment to ensure that a petition has been completed and filed with the court. “Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate” (CF-MH 3106) is considered by the department to be sufficient for this purpose. |
| BA 101 | **Title:** GUARDIAN ADVOCATE  
**Cite:** 394.4598(2), F.S. | Does the chart reflect that the staff provided the prospective guardian advocate with the required information?  
Does the chart reflect that the guardian advocate met with the patient and his/her physician in person if possible or by telephone if not prior to consenting to treatment?  
Does the chart contain a court order authorizing the guardian advocate to:  
• consent to mental health treatment?  
• consent to medical treatment? (as applicable)  
• consent to ECT? (as applicable) |
| BA 102 | **Title:** GUARDIAN ADVOCATE  
**Cite:** 394.4598(3), F.S.  
**Title:** GUARDIAN ADVOCATE  
**Cite:** 65E-5.230(2), F.A.C. | Review the clinical records of patients who have had a guardian advocate appointed by the court (usually at the same time as a hearing for involuntary placement). Look for a recommended form entitled “Certification of Guardian Advocate Training Completion (MH-
### BA 103
**Title:** GUARDIAN ADVOCATE  
**Cite:** 394.4598(6), F.S.

The Guardian Advocate shall not consent to medical treatment unless specifically provided this authority by the court. The Guardian Advocate shall not consent to electroconvulsive treatment, psychosurgery, experimental treatments, abortion, or sterilization without express court approval in a proceeding separate from the proceeding to determine the competence of the patient to consent to medical treatment.

Review the clinical records of any patient for whom a Guardian Advocate has consented to non-psychiatric medical treatment. Ensure that the signed court order delegates the authority to consent to medical as well as mental health treatment. If extraordinary treatment, such as ECT has been authorized by the Guardian Advocate, ensure that a separately signed court order authorizing the Guardian Advocate to consent to the procedure is in the clinical record.

### BA 104
**Title:** GUARDIAN ADVOCATE  
**Cite:** 65E-5.230(5), F.A.C.

If a guardian advocate is required by s. 394.4598, F.S., or otherwise to petition the court for authority to consent to extraordinary treatment, a copy of the completed petition form shall be given to the patient, a copy to the attorney representing the patient, and a copy retained in the patient’s clinical record. Any order issued by the court in response to such a petition shall be given to the patient, attorney representing the patient, guardian advocate, and to the facility administrator, with a copy retained in the patient’s clinical record.

Review the clinical records of any patient for whom the Guardian Advocate has filed a petition for authority to consent to extraordinary treatment. Ensure that copies of the petition have been provided, as required by rule. Use of recommended form “Petition Requesting Court Approval for Guardian Advocate to Consent to Extraordinary Treatment” (CF-MH 3108) is considered by the department to be sufficient for such documentation. Any resultant court order should also be found in the clinical record prior to any consent for such extraordinary treatment. Use of recommended form “Order Authorizing Guardian Advocate to Consent to Extraordinary Treatment” (CF-MH 3109), or
| BA 105 | **Title:** GUARDIAN ADVOCATE  
Cite: 394.4598(7), F.S.  

The guardian advocate shall be discharged when the patient is discharged from a receiving or treatment facility to the community or when the patient is transferred from involuntary to voluntary status. | other order used by the court is considered by the department to be sufficient for such documentation.  
In reviewing clinical records, ensure that any consent for treatment provided by a Guardian Advocate is based upon a court order issued since the patient’s most recent admission. Also ensure that no Guardian Advocate has authorized any treatment for a patient after the patient has been permitted to transfer from involuntary to voluntary status.  
Use of recommended form “Notification to Court of Patient's Competence to Consent to Treatment and Discharge of Guardian Advocate” (CF-MH 3121) for documentation is considered by the department to be sufficient. |
| BA 106 | **Title:** GUARDIAN ADVOCATE  
Cite: 65E-5.230(3), F.A.C.  

When a guardian advocate previously appointed by the court cannot or will not continue to serve in that capacity, and the patient remains incompetent to consent to treatment, the facility administrator shall petition the court for a replacement guardian advocate. A copy of the completed petition shall be given to the patient, the current guardian advocate, the prospective replacement guardian advocate, patient’s attorney, and representative, with a copy retained in the patient’s clinical record. | At any time a Guardian Advocate has not been reasonably available to discuss treatment planning options, ensure that the facility administrator or his/her designee has made efforts to involve the Guardian Advocate. If these efforts have been unsuccessful, ensure that the administrator has petitioned the court for a successor Guardian Advocate, providing copies of the petition to all required parties. Use of recommended form, “Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate” (CF-MH 3106) is considered by the department to be sufficient for this documentation if parts I and III are completed. |
<p>| BA 107 | <strong>Title:</strong> GUARDIAN ADVOCATE |</p>
<table>
<thead>
<tr>
<th><strong>Baker Act Chapter 394, Part I, F.S. and Chapter 65E-5 F.A.C</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cite:</strong> 65E-5.230(6), F.A.C.</td>
<td>In reviewing clinical records, the surveyor should recognize any documentation by a physician that a patient continuing to reside at the facility may be currently competent to provide express and informed consent or to transfer from involuntary to voluntary status. In such cases, the Guardian Advocate should be discharged by the facility administrator and the court so informed. Use of recommended form “Notification to Court of Patient’s Competence to Consent to Treatment and Discharge of Guardian Advocate” (CF-MH 3121) for documentation is considered by the department to be sufficient.</td>
</tr>
<tr>
<td>At any time a patient, who has previously been determined to be incompetent to consent to treatment and had a guardian advocate appointed by the court, has been found by the attending physician to have regained competency to consent to treatment, the facility shall notify the court which appointed the guardian advocate of the patient’s competence and the discharge of the guardian advocate.</td>
<td></td>
</tr>
<tr>
<td><strong>BA 108</strong></td>
<td></td>
</tr>
</tbody>
</table>
| **Title:** HEALTH CARE SURROGATE OR PROXY  
**Cite:** 65E-5.2301, F.A.C. |  |
| (1) During the interim period between the time a patient is determined by two physicians to be incompetent to consent to treatment and the time a guardian advocate is appointed by a court to provide express and informed consent to the patient’s treatment, a health care surrogate designated by the patient, pursuant to chapter 765, part II, F.S., may provide such consent to treatment. | 1) Due to the extended time between the patient’s admission to a facility and the time at which a Guardian Advocate may be appointed by a court, it may be necessary for the patient to have treatment provided for which the patient is not competent to provide consent. In such cases, a health care surrogate designated through an advance directive or a health care proxy may be available to provide substituted judgment for the patient, i.e. that decision concerning treatment that the patient would have made had he or she been competent to do so. |
| (2) In the absence of an advance directive, a health care proxy, pursuant to chapter 765, part IV, F.S., may also provide interim consent to treatment. | 3) Use of recommended form “Certification of Patient’s Incompetence to Consent to Treatment and Notification of Health Care Surrogate/Proxy” (CF-MH 3122) is considered by the department to be sufficient for this purpose. |
| (3) Upon the documented determination by two physicians that a patient is incompetent to make health care decisions for himself or herself, the facility shall notify the surrogate or proxy in writing that the conditions under which he or she can exercise his or her authority under the law have occurred. |  |
(4) A petition for adjudication of incompetence to consent to treatment and appointment of a guardian advocate shall be filed with the court within two court working days of the determination by the physicians of the patient's incompetence to consent to treatment.

4) No authorization for treatment from a health care surrogate or proxy should be accepted by a facility until the physicians have documented the patient's incapacity and a petition has been filed with the court.

| BA 109 | Title: HEALTH CARE SURROGATE OR PROXY  
Cite: 65E-5.2301(5), F.A.C. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The facility shall immediately provide to the health care surrogate or proxy the same information required by statute to be provided to the guardian advocate. In order to protect the safety of the patient, the facility shall make available to the health care surrogate or proxy the training required of guardian advocates and ensure that the surrogate or proxy communicate with the patient and patient's physician prior to giving express and informed consent to treatment.</td>
<td></td>
</tr>
<tr>
<td>Review clinical records of patients for whom consent to treatment has been provided by a health care surrogate or proxy to ensure that the record includes documentation that same requirements of Guardian Advocates has been extended to the surrogate/proxy.</td>
<td></td>
</tr>
</tbody>
</table>

| BA 110 | Title: NOTICES - VOLUNTARY PATIENTS  
Cite: 394.4599(1), F.S. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Notice of a voluntary patient's admission shall only be given at the request of the patient, except that in an emergency, notice shall be given as determined by the facility.</td>
<td></td>
</tr>
<tr>
<td>Review policies and procedures to ensure that notice of a voluntary patient's admission is only given at the request of the patient, unless there is an emergency.</td>
<td></td>
</tr>
</tbody>
</table>

| BA 111 | Title: NOTICES – INVOLUNTARY PATIENTS  
Cite: 394.4599(2), F.S. |
| --- | --- |
| (a) Whenever notice is required to be given under this part, such notice shall be given to the patient and the patient's guardian, guardian advocate, attorney, and representative.  
1. When notice is required to be given to a patient, it shall be given both orally and in writing, in the language and terminology that the patient can understand, and if needed, the facility shall provide an interpreter for the patient.  
2. Notice to a patient's guardian, guardian advocate, attorney, and representative shall be given by United States mail and by registered or certified mail with the receipts attached to the patient's clinical record. Hand delivery by a facility employee may be used as an alternative, with delivery documented in the clinical record. If notice is given by a state attorney or an attorney for the department, a certificate of service shall |
| a) Review policies and procedures to ensure that notice of an involuntary patient’s whereabouts are given to specified persons by telephone or in person within 24 hours of arrival at the facility unless it is documented that the patient requested no notice be made.  
Sample patient charts to verify that notice was made and that all contact attempts were documented.  
Notices to the patient should be given orally and in writing in the language and terminology that the person understands. If
be sufficient to document service.

(b) A receiving facility shall give prompt notice of the whereabouts of a patient who is being involuntarily held for examination, by telephone or in person within 24 hours after the patient’s arrival at the facility, unless the patient requests that no notification be made. Contact attempts shall be documented in the patient’s clinical record and shall begin as soon as reasonably possible after the patient’s arrival. Notice that a patient is being admitted as an involuntary patient shall be given to the local human rights advocacy committee no later than the next working day after the patient is admitted.

(d) A treatment facility shall provide notice of a patient’s involuntary admission on the next regular working day after the patient’s arrival at the facility.

(e) When a patient is to be transferred from one facility to another, notice shall be given by the facility where the patient is located prior to the transfer.

| BA 115 | Title: CLINICAL RECORDS, CONFIDENTIALITY  
Cite: 394.4615(1), F.S. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1) A clinical record shall be maintained for each patient. The record shall include data pertaining to admission and such other information as may be required under rules of the department. A clinical record is confidential and exempt from the provisions of s. 119.07(1).</td>
<td></td>
</tr>
</tbody>
</table>

Unless waived by express and informed consent, by the patient or the patient’s guardian or guardian advocate or, if the patient is deceased, by the patient's personal representative or the family member who stands next in line of intestate succession, the confidential status of the clinical record shall not be lost by either authorized or unauthorized disclosure to any person, organization, or agency.

### BA 115

<table>
<thead>
<tr>
<th>1) A “Clinical Record” means all parts of the record required to be maintained and includes all medical records, progress notes, charts, and admission and discharge data, and all other information recorded by a facility which pertains to the patient’s hospitalization and treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review policies and procedures to ensure compliance with statute.</td>
</tr>
<tr>
<td>Examine patient charts to ensure they are marked “confidential.”</td>
</tr>
<tr>
<td>Review charts to see if releases of information are present when they are requested. Confirm there is no release of information unless a competent patient</td>
</tr>
</tbody>
</table>

1) Someone is hard of hearing or deaf, have interpreters been used?

b) Has the notice been either hand delivered to the patient, guardian, guardian advocate, representative, and attorney or sent by US mail and certified or registered mail with receipts contained in the chart?

d) A treatment facility is generally a state operated mental hospital rather than a community-based receiving facility.

e) Are notices of transfer and discharge provided as required?
Baker Act Chapter 394, Part I, F.S. and Chapter 65E-5 F.A.C

| Title: CLINICAL RECORDS, CONFIDENTIALITY |
| Cite: 65E-5.250(1), F.A.C. |
| Except as otherwise provided by law, verbal or written information about a patient shall only be released when the competent patient, or a duly authorized legal decision-maker such as guardian, guardian advocate, or health care surrogate or proxy provides consent to such release. When such information is released, a copy of a signed authorization form shall be retained in the patient’s clinical record. Consent or authorization forms may not be altered in any way after signature by the patient or other authorized decision-maker nor may a patient or other authorized decision-maker be allowed to sign a blank form. |

| Title: CLINICAL RECORDS, CONFIDENTIALITY |
| Cite: 394.4615(3), F.S. |
| Information from the clinical record may be released when: |
| (a) A patient has declared an intention to harm other persons. When such declaration has been made, the administrator may authorize the release |

(2) The clinical record shall be released when:

(a) The patient or the patient’s guardian authorizes the release. The guardian or guardian advocate shall be provided access to the appropriate clinical records of the patient. The patient or the patient’s guardian or guardian advocate may authorize the release of information and clinical records to appropriate persons to ensure the continuity of the patient’s health care or mental health care.

(b) The patient is represented by counsel and the records are needed by the patient’s counsel for adequate representation.

(c) The court orders such release.

Ensure from review of clinical records that no release of confidential information is made by a facility without an authorization from a competent patient or his or her substitute decision-maker. Use of recommended form “Authorization for Release of Information” (CF-MH 3044) is considered by the department to be sufficient if used as documentation.

Ensure that there are no signed blank release forms in the chart.
of sufficient information to provide adequate warning to the person threatened with harm by the patient.

(b) The administrator of the facility or secretary of the department deems release to a qualified researcher as defined in administrative rule, and aftercare treatment provider, or an employee or agent of the department is necessary for treatment of the patient, maintenance of adequate records, compilation of treatment data, aftercare planning, or evaluation of programs.

| BA 118 | **Title:** CLINICAL RECORDS, CONFIDENTIALITY  
**Cite:** 394.4615(8), F.S. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing in this section is intended to prohibit the parent or next of kin of a person who is held in or treated under a mental health facility or program from requesting and receiving information limited to a summary of that person’s treatment plan and current physical and mental condition. Release of such information shall be in accordance with the code of ethics of the profession involved.</td>
<td></td>
</tr>
</tbody>
</table>

This section of the law does not require information be provided to parent or next of kin, but does permit it to occur without patient consent if the professional releasing the permitted information believes it to be within his or her code of ethics.

Interview staff to ensure their understanding of this provision

| BA 120 | **Title:** CLINICAL RECORDS; CONFIDENTIALITY  
**Cite:** 65E-5.250(2), F.A.C. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility staff shall advise patients that they have the ability to waive, in writing, the confidentiality of their presence in a receiving or treatment facility, to the extent the patient may choose, allowing all or only specified persons free and open communication with the patient, such as telephone calls.</td>
<td></td>
</tr>
</tbody>
</table>

If patient rights materials signed by the patient at admission do not include the required notice, review policies to ensure the facility has procedures in place to inform patients at some early time in their hospitalization. Interview patients to ensure they know their right to have open access initiated by others outside the facility. Limiting contact to only those who know an access code is prohibited without the consent of the patient.

| BA 121 | **Title:** CLINICAL RECORDS; CONFIDENTIALITY  
**Cite:** 394.4615(9), F.S. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients shall have reasonable access to their clinical records, unless such access is determined by the patient’s physician to be harmful to the patient.</td>
<td></td>
</tr>
</tbody>
</table>

Interview patients to determine if they know they have the right to access their own clinical
the patient’s right to inspect his or her clinical record is restricted by the facility, written notice of such restriction shall be given to the patient and the patient’s guardian, guardian advocate, attorney, and representative. In addition, the restriction shall be recorded in the clinical record, together with the reasons for it. The restriction of a patient’s right to inspect his or her clinical record shall expire after 7 days, but may be renewed, after review, for subsequent 7-day periods.

If access to the clinical record is restricted, verify that there is written notice in the clinical record with the reasons for the restriction. The reason for the restriction should be given to the person, the person’s guardian, guardian advocate, representative and attorney.

If access to the clinical record is restricted, verify that there is written notice in the clinical record with the reasons for the restriction. The reason for the restriction should be given to the person, the person’s guardian, guardian advocate, representative and attorney.

Patient charts should be sampled to ensure that any restriction to accessing one’s own record is documented and that the restriction is reviewed and renewed at least every 7 days.

Staff should be interviewed to determine if they know how to respond to patient requests for accessing their record.

### BA 122

**Title:** CLINICAL RECORDS; CONFIDENTIALITY  
**Cite:** 65E-5.250(4), F.A.C.

When a patient’s access to his or her clinical record or any part of his or her record is restricted by written order of the attending physician, such restriction shall be documented in the patient’s clinical record. If the request is denied or such access is restricted, a written response shall be provided to the patient.

Review clinical records of patients who state that requested access to the record had been denied. Use of recommended form “Restriction of Patient Access to Own Record” (CF-MH 3110) is considered by the department to be sufficient for such documentation.

### BA 123

**Title:** CLINICAL RECORDS; CONFIDENTIALITY  
**Cite:** 65E-5.250(5), F.A.C.

Each receiving facility shall develop detailed policies and procedures governing release of records to patients, including criteria for determining what type of information may be harmful to patients, establishing a reasonable time for responding to requests for access, and identifying methods of providing records, unless restricted by a physician. If any patients indicate they have requested, but been denied, access to their records, review the clinical record to determine if the required procedures had been followed and required documentation is present.

Policies and procedures should specify in detail how reasonable access to a patient’s own record will be assured. This should include what records will be released, to
| BA 124 | Title: **CLINICAL RECORDS; CONFIDENTIALITY**  
Cite: 394.4615(10), F.S.  
Any person who fraudulently alters, defaces, or falsifies the clinical record of any person receiving mental health services in a facility subject to this part, or causes or procures any of these offenses to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.  
Review of patient charts should include observation of methods of correcting mistakes in charting to ensure that medical records are not altered or defaced in any way. Use of “wite-out” or eradication of errors is unacceptable; a simple line drawn through the error, with the date/time and person’s initials and credentials who made the entry is acceptable. | whom, when, where, and how. |
| BA 125 | Title: **TRANSPORTATION**  
Cite: 394.462(1)(j), F.S.  
The nearest receiving facility must accept persons brought by law enforcement officers for involuntary examination.  
Interview law enforcement officials to determine if the facility has, at any time, declined to accept a patient brought for involuntary examination. |  |
| BA 130 | Title: **VOLUNTARY ADMISSIONS**  
Cite: 394.4625(1)(a), F.S.  
A facility may receive for observation, diagnosis, or treatment any person 18 years of age or older making application by express and informed consent for admission or any person age 17 or under for whom such application is made by his or her guardian. If found to show evidence of mental illness, to be competent to provide express and informed consent, and to be suitable for treatment, such person 18 years of age or older may be admitted to the facility. A person age 17 or under may be admitted only after a hearing to verify the voluntariness of the consent.  
Review policies and procedures to ensure compliance with statute especially regarding limitation of voluntary status to persons who are competent to provide express and informed consent for admission and treatment.  
Any admission of a person under the age of 18 requires an application for admission by the minor’s guardian (usually the biological parent). In the absence of an application by the minor’s guardian, a judicial hearing is required. The minor’s concurrence with the voluntary admission is also required; in the absence of such, the admission must be handled under the involuntary examination |  |
| BA 131 | Title: VOLUNTARY ADMISSION  
Cite: 65E-5.270(1), F.A.C.  

Any application for voluntary admission shall be based on the patient’s express and informed consent. | Use of the following recommended forms, properly completed, is considered by the department to be sufficient to document an application for voluntary admission:  

- “Application for Voluntary Admission” (CF-MH 3040) for a competent adult to a receiving facility;  
- “Application for Voluntary Admission – Minors” (CF-MH 3097) for a guardian’s application for admission of a minor to a receiving facility; or  
- “Application for Voluntary Admission - State Treatment Facility” (CF-MH 3098) for a competent adult for admission to a state treatment facility.  

Review records to ensure that one of the above forms are in the clinical records of each patient considered at any time to be on voluntary status.  

Interview patients to ensure that they were not coerced into voluntary status and that they appear able to make well-reason, willful and knowing decisions. |
### BA 132

**Title:** VOLUNTARY ADMISSIONS  
*Cite: 394.4625(1)(b), F.S.*

A mental health overlay program or mobile crisis response service or a licensed professional who is authorized to initiate an involuntary examination pursuant to s. 394.463 and is employed by a mental health center or clinic must, pursuant to district procedure approved by the respective district administrator, conduct an initial assessment of the ability of the following persons to give express and informed consent to treatment before such persons may be admitted voluntarily:

1. A person 60 years of age or older for whom transfer is being sought from a nursing home, assisted living facility, adult day care center or adult family-care home, when such person has been diagnosed as suffering from dementia.

2. A person 60 years of age or older for whom transfer is being sought from a nursing home pursuant to s.400.0255 (6).

3. A person for whom all decisions concerning medical treatment are currently being lawfully made by the health care surrogate or proxy designated under chapter 765.

Review facility records to ensure that the specified types of people have been admitted voluntarily only after their ability to provide express and informed consent has been assessed by an authorized service or professional while the patient is still at his or her licensed residence.

### BA 133

**Title:** VOLUNTARY ADMISSION  
*Cite: 65E-5.270(3), F.A.C.*

Documenting the assessment of persons pursuant to s. 394.4625(1)(b), F.S., shall be done prior to moving the person from their residence to a receiving facility.

Review the clinical records of persons who have been admitted to the receiving facility.

2. The notice of emergency discharge or transfer must have been given to the resident’s legal guardian or representative by telephone or in person, prior to the transfer, if possible. The resident is still entitled to a hearing on the transfer or discharge.

3. The statute doesn’t specify that this group of persons must be from a facility licensed under Ch. 400, F.S. However, since the entire paragraph relates to licensed facilities, one can presume this was the legislature’s intent. Further, the Baker Act prohibits a health care surrogate or proxy from consenting to the provision of mental health treatment for a voluntary patient; requiring that the patient be discharged or transferred to involuntary status.
<table>
<thead>
<tr>
<th>Title: VOLUNTARY ADMISSION</th>
<th>Cite: 394.4625(1)(c), F.A.C.</th>
</tr>
</thead>
<tbody>
<tr>
<td>When an initial assessment of the ability of a person to give express and informed consent to treatment is required under this section, and a mobile crisis response service does not respond to the request for an assessment within 2 hours after the request is made or informs the requesting facility that it will not be able to respond within 2 hours after the request is made, the requesting facility may arrange for assessment by any licensed professional authorized to initiate an involuntary examination pursuant to s. 394.463 who is not employed by or under contract with, and does not have a financial interest in, either the facility initiating the transfer or the receiving facility to which the transfer may be made.</td>
<td></td>
</tr>
<tr>
<td>Ensure that the assessor used by the sending facility was an authorized professional and one without any conflict of interest and that the service designated by DCF was unable to respond within the two-hour time frame.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Title: VOLUNTARY ADMISSIONS - INCAPACITATED PERSONS</th>
<th>Cite: 394.4625(1)(d), F.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A facility may not admit as a voluntary patient a person who has been adjudicated incapacitated, unless the condition of incapacity has been judicially removed. If a facility admits as a voluntary patient a person who is later determined to have been adjudicated incapacitated, and the condition of incapacity had not been removed by the time of the admission, the facility must either discharge the patient or transfer the patient to involuntary status.</td>
<td></td>
</tr>
<tr>
<td>Review policies and procedures and patient charts to confirm that persons who have been adjudicated incapacitated by the court are only admitted on an involuntary basis. Patients, if admitted on voluntary status, who have a health care surrogate or proxy currently making health care decisions for them cannot have such surrogates or proxies give consent to their mental health treatment and must be admitted on an involuntary status.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Title: VOLUNTARY ADMISSIONS - INCAPACITATED PERSONS</th>
<th>Cite: 394.4625(1)(e), F.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The health care surrogate or proxy of a voluntary patient may not consent to the provision of mental health treatment for the patient. A voluntary patient</td>
<td></td>
</tr>
<tr>
<td>Verify through review of clinical records that no voluntary patients have an authorization for</td>
<td></td>
</tr>
</tbody>
</table>
who is unwilling or unable to provide express and informed consent to mental health treatment must either be discharged or transferred to involuntary status.

treatment provided by a health care surrogate or proxy. If the chart reflects that a surrogate or proxy had been consenting to the patient’s medical treatment immediately prior to the patient’s admission on a voluntary basis to psychiatric care, but the patient is currently considered competent to consent to his or her own treatment, determine the circumstances under which the patient’s competency to consent had been restored.

| BA 137 | Title: VOLUNTARY ADMISSIONS-DOCUMENTATION OF COMPETENCE TO CONSENT  
| Cite: 394.4625(1)(f), F.S. |
| Review patient charts to ensure that the admitting physician has documented in the record, within 24 hours after admission, that the person is able to provide express and informed consent. |

| BA 138 | Title: VOLUNTARY ADMISSIONS-COMPETENCE TO CONSENT  
| Cite: 65E-5.270(1)(a), F.A.C. |
| Review clinical records to verify that a physician has certified a voluntary patient’s competence to consent within 24 hours of the patient’s admission or prior to permitting an involuntary patient to convert to voluntary status. Use of recommended form “Certification of Patient’s Competence to Provide Express and Informed Consent” (CF-MH 3104) is considered by the department to be sufficient to document the competence of a person to give express and informed consent to be a voluntary patient. |

| BA 139 | Title: VOLUNTARY ADMISSIONS - NOTICE OF RIGHT TO DISCHARGE  
| Cite: 394.4625(3), F.S. |
| Review clinical records to ensure that at the time of admission and at least every 6 months thereafter, a voluntary patient is provided written notice of the right to be discharged. |
patient shall be notified in writing of his or her right to apply for a discharge. voluntary patients are notified at the time of their admission and at least every 6 months thereafter of their right to apply for a discharge.

<table>
<thead>
<tr>
<th>Title</th>
<th>VOLUNTARY ADMISSION-RIGHT TO REQUEST DISCHARGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cite</td>
<td>65E-5.270(2), F.A.C.</td>
</tr>
<tr>
<td></td>
<td>Voluntary patients shall be advised of their right to request discharge. A copy of the notice or its equivalent shall be given to the patient and to the patient’s parent if a minor, with the original of each completed application and notice retained in the patient’s clinical record.</td>
</tr>
<tr>
<td></td>
<td>Review clinical records to verify that the patient has been notified of his or her right to request discharge.</td>
</tr>
<tr>
<td></td>
<td>Use of recommended forms “Notice of Voluntary Patient’s Right to Request Discharge from a Receiving Facility” (CF-MH 3051a) or “Notice of Voluntary Patient’s Right to Request Discharge from a Treatment Facility” (CF-MH 3051b) is considered by the department to be sufficient to document the giving of such advice.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Title</th>
<th>VOLUNTARY ADMISSION - DISCHARGE OF VOLUNTARY PATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cite</td>
<td>394.4625(2)(a), F.S.</td>
</tr>
<tr>
<td></td>
<td>(a) A facility shall discharge a voluntary patient:</td>
</tr>
<tr>
<td></td>
<td>1. Who has sufficiently improved so that retention in the facility is no longer desirable. A patient may also be discharged to the care of a community facility.</td>
</tr>
<tr>
<td></td>
<td>2. Who revokes consent to admission or requests discharge. A voluntary patient or a relative, or attorney of the patient may request discharge either orally or in writing at any time following admission to the facility. The patient must be discharged within 24 hours of the request, unless the request is rescinded or the patient is transferred to involuntary status pursuant to this section. The 24-hour time period may be extended by a treatment facility (state hospital only) when necessary for adequate discharge planning, but shall not exceed 3 days exclusive of weekends and holidays. If the patient, or another on the patient’s behalf, makes an oral request for discharge to a staff member, such request shall be immediately entered in the patient's clinical record. If the request for</td>
</tr>
<tr>
<td></td>
<td>Review policies and procedures to ensure consistency with statute.</td>
</tr>
<tr>
<td></td>
<td>Sample clinical records of discharged patients to ensure that patients are discharged within 24 hours when they are determined to be sufficiently improved or when they have revoked consent to admission/treatment or requested discharge, unless the request is rescinded or the person is transferred to involuntary status.</td>
</tr>
</tbody>
</table>
discharge is made by a person other than the patient, the discharge may be conditioned upon the express and informed consent of the patient.

(b) A voluntary patient who has been admitted to a facility and who refuses to consent to or revokes consent to treatment shall be discharged within 24 hours after such refusal or revocation, unless transferred to involuntary status pursuant to this section or unless the refusal or revocation is freely and voluntarily rescinded by the patient.

| BA 142 | Title: TRANSFER TO VOLUNTARY STATUS  
|        | Cite: 394.4625(4), F.S.  
|        | An involuntary (competent) patient who applies to be transferred to voluntary status shall be transferred to voluntary status immediately, unless the patient has been charged with a crime, or has been involuntarily placed for treatment by a court pursuant to s. 394.467 and continues to meet the criteria for involuntary placement. When transfer to voluntary status occurs, notice shall be given as provided in s. 394.4599.  
|        | The process begins immediately but the actual transfer from involuntary to voluntary status requires that a physician or clinical psychologist first examine the patient to certify competence to provide express and informed consent.  
|        | Review patient clinical records and interview patients to see if there are methods in place to accomplish patient transfer to voluntary status, when requested and only when patient is competent to provide well-reasoned, willing, and knowing decisions about his or her medical and mental health treatment.  

| BA 143 | Title: TRANSFER TO VOLUNTARY STATUS  
|        | Cite: 65E-5.270(1)(b), F.A.C.  
|        | The original of the completed form certifying a patient's competence to provide express and informed consent shall be filed in the patient's clinical record. A change in legal status must be followed by notice sent to persons pursuant to s. 394.4599, F.S.  
|        | If a patient is transferred from involuntary to voluntary status, use of recommended form “Certification of Patient’s Competence to Provide Express and Informed Consent” (CF-MH 3104) is considered by the department to be sufficient to document a person applying for transfer is competent to provide express and informed consent.  

| BA 144 | Title: TRANSFER TO INVOLUNTARY STATUS  
|        | Cite: 394.4625(5), F.S.  
|        | When a voluntary patient, or an authorized person on the patient’s behalf,  
|        | Review policies and procedures to ensure
makes a request for discharge, the request for discharge, unless freely and voluntarily rescinded, must be communicated to a physician, clinical psychologist, or psychiatrist as quickly as possible, but not later than 12 hours after the request for discharge is made. If the patient meets the criteria for involuntary placement, the administrator of the facility must file with the court a petition for involuntary placement, within 2 court working days after the request for discharge is made. If the petition is not filed within 2 court working days, the patient shall be discharged. Pending the filing of the petition, the patient may be held and emergency treatment rendered in the least restrictive manner, upon the written order of a physician, if it is determined that such treatment is necessary for the safety of the patient or others.

Determine how and when the treating professional is notified when a person on voluntary status requests discharge.

Interview staff and review clinical records to assure that a person who refuses or revokes consent to treatment is discharged within 24 hours unless transferred to involuntary status.

If transferred to involuntary status, confirm that the petition was filed with the court within 2 working days.

Review clinical records of patients admitted on a voluntary basis to ensure that a valid consent to treatment has been signed by a competent adult patient or the guardian of a minor. Review progress notes to determine if the patient had ever refused consent to treatment. If so, recommended form “Refusal or Revocation of Consent to Treatment” (CF-MH 3105) should have been completed. The facility should have discharged the patient within 24 hours unless the patient withdrew the refusal to consent, in which case, the patient shall be asked to complete Part II of recommended form “Refusal or Revocation of Consent to Treatment” (CF-MH 3105).

Interview voluntary patients to determine if they know they have the right to request discharge and if, at any time, had requested discharge from the facility. If so, review their...
### BA 147 Title: VOLUNTARY ADMISSION  
Cite: 65E-5.270(6), F.A.C.

When a voluntary patient refuses treatment or requests discharge and the facility administrator makes the determination that the patient will not be discharged within 24 hours from a designated receiving or treatment facility, a petition for involuntary placement shall be filed with the court by the facility administrator.

The first expert opinion by a psychiatrist shall be obtained on the petition form within 24 hours of the request for discharge or refusal of treatment to justify the continued detention of the patient and the petition shall be filed with the court within two court working days after the request for discharge or refusal to consent to treatment was made.

In each case where a voluntary patient is transferred to involuntary status following refusal of treatment or request for discharge, ensure that a petition for involuntary placement has been initiated. Use of recommended form “Petition for Involuntary Placement” (CF-MH 3032) is considered to be sufficient.

### BA 150 Title: INVOLUNTARY EXAMINATION – CRITERIA  
Cite: 394.463(2), F.S.

A facility may not detain a person involuntarily for examination unless the statutory criteria of 394.463, F.S. have been met, and the facility is a designated receiving facility.

(1) CRITERIA. – A person may be taken to a receiving facility for involuntary examination if there is reason to believe that he or she is mentally ill and because of his or her mental illness:

(a) 1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or

(b) 1. Without care or treatment, the person is likely to suffer from neglect or...
refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or

2. There is substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, evidenced by recent behavior.

### BA 151 Title: INVOLUNTARY EXAMINATION – INITIATION

Cite: 394.463(2)(a) F.S.

A facility may not detain a person involuntarily for examination unless the involuntary examination has been initiated by one of the statutory authorities detailed below:

1. A court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is based. The order of the court shall be made a part of the patient’s clinical record.

2. A law enforcement officer shall take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to the nearest receiving facility for examination. The officer shall execute a written order detailing the circumstances under which the person was taken into custody, and the report shall be made a part of the patient’s clinical record.

3. A physician, clinical psychologist, psychiatric nurse or clinical social worker (see statutory definitions for each of these three professionals) may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. The law enforcement officers shall execute a written report detailing the circumstance under which the person was taken into custody. The report and certificate shall be made a part of the patient’s clinical record. A law enforcement officer shall take the person named in the certificate into custody and deliver him or her to the nearest

Review patient charts to verify that a copy of an ex parte order, a law enforcement report, or a certificate of a mental health professional is present and completed by an authorized person.

1. The ex parte order for involuntary examination, with attached document giving the findings, shall accompany the patient to the receiving facility and be retained in the patient’s clinical record.

2. Mandatory form “Report of Law Enforcement Officer Initiating Involuntary Examination (CF-MH 3052a) shall accompany the patient to the nearest receiving facility for retention in the patient’s clinical record.

3. Mandatory form “Certificate of Professional Initiating Involuntary Examination” (CF-MH 3052b) shall expire seven days after the certificate is signed, unless the patient has been taken into custody and delivered to a receiving facility. The certificate is valid throughout the state. The completed certificate shall accompany the patient to a receiving facility and be retained in the person’s clinical record.
| BA 152 | Title: INITIATION OF INVOLUNTARY EXAMINATION  
Cite: 394.463(2) F.S. |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Any receiving facility accepting the patient based on an ex parte order, law enforcement officer’s report, or certificate of a professional must send a copy of this documentation to the Agency on Health Care Administration on the next working day.</td>
</tr>
<tr>
<td>Review clinical records to ensure that the initiating documents are sent to the BA Reporting Center on the next working day.</td>
</tr>
</tbody>
</table>
| BA 153 | Title: INVOLUNTARY EXAMINATION  
Cite: 65E-5.280(5), F.A.C. |
| Designated receiving facilities shall forward copies of each form initiating an involuntary examination and the cover sheet to: BA Reporting Center, FMHI-MHC 2618, 13301 Bruce B. Downs Boulevard, Tampa, Florida 33612-3807. |
| These forms include: |
| - Recommended form “Ex Parte Order for Involuntary Examination” (CF-MH 3001) or other order provided by the court, |
| - Mandatory form “Report of Law Enforcement Officer Initiating Involuntary Examination” (CF MH 3052a), |
| - Mandatory form “Certificate of Professional Initiating Involuntary Examination” (CF-MH 3052b), |
| Regardless of which of the above three methods was used to initiate the involuntary examination, the form must be accompanied by the mandatory form “Cover Sheet to Agency for Health Care Administration” (CF-MH 3118). |
| BA 154 | Title: INVOLUNTARY EXAMINATION – INITIATION  
Cite: 394.463(2)(b), F.S. |
| A person shall not be removed from any program or residential program under chapter 400 and transported to a receiving facility for involuntary examination unless an ex parte order, a professional certificate or law enforcement officer’s report is first prepared. If the condition of the person is such that presentation of a law enforcement officer’s report is not practicable before removal, the report shall be completed as soon as possible after removal, but in any case before the person is transported to a receiving facility. A receiving facility admitting a person for involuntary examination who is not accompanied by the |
| Ensure that the facility notifies AHCA by certified mail on the next working day if a facility or service licensed under s.400 F.S. sends a person on involuntary status to a receiving facility without an order/report/certificate. |
| Inquire as to whether the chapter 400 facility |
required ex parte order, professional certificate or law enforcement officer’s report shall notify the Agency for Health Care Administration of such admission by certified mail no later than the next working day. The provisions of this paragraph do not apply when transportation is provided by the patient’s family or guardian.

| BA 155 | Title: INVOLUNTARY EXAMINATION – NOTIFICATION TO AHCA  
Cite: 65E-5.280(6), F.A.C. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>If a patient is delivered to a receiving facility for an involuntary examination from any program or residential placement licensed under the provisions of chapter 400, F.S., without an ex parte order, the mandatory form “Report of Law Enforcement Officer Initiating Involuntary Examination” or mandatory form “Certificate of Professional Initiating Involuntary Examination” the receiving facility shall notify the Agency for Health Care Administration by the method and timeframe required by law.</td>
<td></td>
</tr>
</tbody>
</table>

| BA 156 | Title: INVOLUNTARY EXAMINATION  
Cite: 65E-5.280(7). F.A.C. |
|---|---|
| routinely sends such patients to hospital emergency rooms for involuntary examinations to be initiated, rather than carrying out their legal responsibilities.  
AHCA staff responsible for the licensure and survey of chapter 400 facilities should be notified of the failure of such facilities to abide by the Baker Act requirements.  
Review the clinical record for each patient referred to the facility from a chapter 400 licensed facility. The record should include one of the following three forms, completed prior to the patient’s removal from the chapter 400 facility:  
- Recommended form “Ex Parte Order for Involuntary Examination” (CF-MH 3001) or other order provided by the court,  
- Mandatory form “Report of Law Enforcement Officer Initiating Involuntary Examination” (CF-MH 3052a), or  
- Mandatory form “Certificate of Professional Initiating Involuntary Examination” (CF-MH 3052b)  
The receiving facility’s use of recommended form “Notification of Non-Compliance with Required Certificate” (CF-MH 3119) sent to the BA Reporting Center is considered by the department to be sufficient for AHCA notification. |
Documentation that each completed form was submitted in a timely way shall be retained in the patient’s clinical record.

**BA 157**

**Title:** INVOLUNTARY EXAMINATION  
**Cite:** 394.463(3)(f), F.S.

A patient shall be examined by a physician or clinical psychologist at a receiving facility without unnecessary delay and may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is necessary for the safety of the patient or others.

The patient shall not be released by the receiving facility or its contractor without the documented approval of a psychiatrist or clinical psychologist. However, a patient may not be held in a receiving facility for involuntary examination longer than 72 hours.

Review the clinical records of patients presented to a receiving facility for involuntary examination. Each patient’s chart, regardless of the length of time retained at the facility, should include documentation that AHCA, through the BA Reporting Center, was properly notified in a timely way.

**BA 158**

**Title:** INVOLUNTARY EXAMINATION  
**Cite:** 65E-5.100(7), F.A.C.

Examination means the integration of the medical physical examination required under s. 394.459(2), F.S., with other diagnostic activities to determine if the patient is medically stable and to rule out abnormalities of thought, mood, or behavior that mimic psychiatric symptoms but are due to non-psychiatric medical causes such as disease, infection, injury, toxicity, or metabolic disturbances. Examination includes the identification of person-specific risk factors for treatment such as elevated blood pressure, organ dysfunction, substance abuse, or trauma.

While a clinical psychologist can perform part of the legally required examination, the process of ruling out non-psychiatric medical causes of the symptoms requires medical expertise.

**BA 159**

**Title:** INVOLUNTARY EXAMINATION – MINIMUM STANDARDS FOR INVOLUNTARY EXAMINATION  
**Cite:** 65E-5.2801(1), F.A.C.

The involuntary examination at chapter 394 or 395, F.S., licensed facilities shall include:

A full neurological examination, with all related laboratory and diagnostic tests, is not
(a) A determination of whether the person is medically stable;
(b) A determination that abnormalities of thought, mood, or behavior due to non-psychiatric causes have been ruled out;
(c) A thorough review of any observations of the person’s recent behavior;
(d) A review of mandatory form “Transportation to Receiving Facility” (CF-MH 3100), and recommended form “Ex Parte Order for Involuntary Examination” (CF-MH 3001) or other form provided by the court, or mandatory form “Report of Law Enforcement Officer Initiating Involuntary Examination” (CF-MH 3052a) or mandatory form “Certificate of Professional Initiating Involuntary Examination” (CF-MH 3052b).
(e) A brief psychiatric history; and
(f) A face-to-face examination of the person in a timely manner to determine if the patient meets criteria for release.

reasonable for each patient presented to a receiving facility. However, a physician should incorporate into his or her documentation that the examination included consideration of non-psychiatric medical causes.

<table>
<thead>
<tr>
<th>BA 160</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title:</strong> INVOLUNTARY EXAMINATION - MINIMUM STANDARDS FOR INVOLUNTARY EXAMINATION</td>
</tr>
<tr>
<td><strong>Cite:</strong> 65E-5.2801(4), F.A.C.</td>
</tr>
<tr>
<td>All results and documentation of all elements of the initial mandatory involuntary examination shall be retained in the patient’s clinical record.</td>
</tr>
<tr>
<td>BA 161</td>
</tr>
<tr>
<td><strong>Title:</strong> INVOLUNTARY EXAMINATION - MINIMUM STANDARDS FOR INVOLUNTARY EXAMINATION</td>
</tr>
<tr>
<td><strong>Cite:</strong> 65E-5.2801(5), F.A.C.</td>
</tr>
<tr>
<td>If the patient is not released or does not become a voluntary patient as a result of giving express and informed consent to admission and treatment in the first part of the involuntary examination, the patient shall be examined by a psychiatrist to determine if the criteria for involuntary placement are met.</td>
</tr>
<tr>
<td>Review clinical records to verify that patients who are admitted on involuntary status are examined by a psychiatrist, if not earlier released or transferred to voluntary status following certification by a physician.</td>
</tr>
<tr>
<td>If not released, use of recommended, “Application for Voluntary Admission” form</td>
</tr>
</tbody>
</table>
(CF-MH 3040) or recommended form "Application for Voluntary Admission - Minors" (CF-MH 3097) will be considered by the department to be sufficient if the patient wishes to apply for voluntary admission.

If not released and the patient wishes to transfer from involuntary to voluntary status, use of recommended form "Certification of Patient's Competence to Provide Express and Informed Consent" (CF-MH 3104) documenting the patient is competent to provide express and informed consent, will be considered by the department to be sufficient.

BA 163  
Title: INVOLUNTARY EXAMINATION – CLINICAL RECORDS CONTENTS  
Cite: 65E-5.2801(6), F.A.C.

After the initial mandatory involuntary examination, the patient’s clinical record shall include:

(a) An intake interview;

(b) The mandatory form “Transportation to Receiving Facility” (CF-MH 3100) and recommended form, “Ex Parte Order for Involuntary Examination” (CF-MH 3001) or other form provided by the court, or mandatory form “Report of Law Enforcement Officer Initiating Involuntary Examination” (CF-MH 3052a) or mandatory form “Certificate of Professional Initiating Involuntary Examination” (CF-MH 3052b); and

(e) The psychiatric evaluation, including the mental status examination or the psychological status report.

BA 164  
Title: INVOLUNTARY EXAMINATION  
Cite: 394.463(2)(I), F.S.

Within the 72 hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime in which case the patient shall be returned to the custody of a law enforcement facility on a timely basis; no more than 72 hours from arrival at a receiving facility.

Review clinical records to verify the required forms are included.

Review clinical records to determine that patients determined not to meet the criteria for involuntary placement are released from the facility on a timely basis; no more than 72 hours from arrival at a receiving facility.
2. The patient shall be released, subject to the provisions of subparagraph 1., for outpatient treatment;

3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient, and if such consent is given the patient shall be admitted as a voluntary patient; or

4. A petition for involuntary placement shall be filed in the appropriate court executed by the facility administrator when treatment is deemed necessary; in which case, the least restrictive treatment consistent with the optimum improvement of the patient’s condition shall be made available.

| BA 165 | Title: NOTICE OF RELEASE  
| Cite: 394.463(3), F.S. | Notice of the release shall be given to the patient’s guardian or representative, to any person who executed a certificate admitting the patient to the receiving facility, and to any court which ordered the patient’s evaluation. |

| BA 166 | Title: INVOLUNTARY EXAMINATION – EMERGENCY MEDICAL SERVICES  
| Cite: 65E-5.280(4)(b), F.A.C. | The 72-hour involuntary examination period set out in s. 394.463(2)(f), F.S., may not be exceeded. |

Review policies and procedures and patient charts to determine that the receiving facility ensures that no patient is detained in excess of 72 hours unless a competent patient has given informed consent to voluntary admission and signed recommended form entitled “Application for Voluntary Admission” (CF-MH 3040) or the administrator has filed a Petition for Involuntary Placement (CF-MH 3032).
| BA 170 | **Title: INVOLUNTARY PLACEMENT**  
Cite: 394.467(2) F.S. | A patient may be retained by a receiving facility or involuntarily placed in a treatment facility upon the recommendation of the administrator of a receiving facility where the person has been examined and after adherence to the notice and hearing procedures provided in s. 394.4599.

The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary placement are met, however, in counties of less than 50,000 population, if the administrator certifies that no psychiatrist or clinical psychologist is available to provide the second opinion, such second opinion may be provided by a licensed physician with postgraduate training and experience in diagnosis and treatment of mental and nervous disorders or by a psychiatric nurse.

Such recommendation shall be entered on an involuntary placement certificate, which certificate shall authorize the receiving facility to retain the patient pending transfer to a treatment facility or completion of a hearing. | Review the patient’s clinical record to make sure the petition was filed promptly in the court in the county where the person is located.

Sample clinical records to ensure that the recommended form “Petition for Involuntary Placement” (CF-MH 3032) was completed by both experts and by the administrator within the 72-hour period.

Document that the “Petition for Involuntary Placement” was filed with the court within the permitted 72 hours period, or if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter. |
| BA 171 | **Title: PETITION FOR INVOLUNTARY PLACEMENT**  
Cite: 394.467(3), F.S. | The administrator of the facility shall file a petition for involuntary placement in the court in the county where the patient is located. | Review patient charts to ensure petitions are filed promptly in the court of the county where the person is located. It is suggested that the surveyor call the clerk of the court and the judge to determine the receiving facility’s compliance in practice. |
| BA 172 | **Title: INVOLUNTARY PLACEMENT**  
Cite: 65E-5.290, F.A.C. | (1) If a patient is retained involuntarily, a petition for involuntary placement shall be filed with the court by the facility administrator within the 72-hour examination period, or if the 72 hours ends on a weekend or legal holiday, the petition shall be filed no later than the next court working day thereafter. A copy of the completed petition shall be retained in the patient’s clinical record. | (1) Use of recommended form “Petition for Involuntary Placement” (CF-MH 3032) is considered by the department to be sufficient. |
(2) Notice of a petition for involuntary placement shall be retained in the patient’s clinical record. In all cases involving potential involuntary placement in a state treatment facility, a copy of the completed form shall also be provided to the designated community mental health center or clinic for purposes of conducting a transfer evaluation.

(3) A notice to court shall be used by the counsel representing a patient in requesting a continuance. A completed copy of the form used shall be provided to the facility administrator for retention in the patient’s clinical record.

(4) Request for appointment of an expert examiner.

(5) If the facility administrator seeks to withdraw the petition for involuntary placement prior to the hearing, he or she will notify the court. The facility will retain a copy in the patient’s clinical record. When a facility withdraws a petition for involuntary placement, it shall immediately notify by telephone the court, state attorney, attorney for the patient, and guardian or representative of its decision to withdraw the petition. In all cases involving potential involuntary placement in a state treatment facility, a copy of the notification form shall also be provided to the designated community mental health center or clinic responsible for conducting a transfer evaluation.

(7) If the court concludes that the patient meets the criteria for involuntary placement pursuant to s. 394.467, F.S., it shall prepare an order. This signed order shall be given to the patient, guardian, guardian advocate or representative, counsel for the patient, state attorney, and administrator of the receiving or treatment facility, with a copy of the order retained in the patient’s clinical record.

(2) Use of recommended form “Notice of Petition for Involuntary Placement” (CF-MH 3021) when properly completed, is considered by the department to satisfy the requirements of s. 394.4599, F.S.

(3) Use of recommended form “Notice to Court – Request for Continuance of Involuntary Placement Hearing” (CF-MH 3113) is considered by the department to be sufficient.

(4) Use of recommended form “Application for Appointment of Independent Expert Examiner” (CF-MH 3022) is considered by the department to be sufficient.

(5) Use of recommended form “Notification to Court of Withdrawal of Petition on Involuntary Placement” (CF-MH 3033) is considered by the department to be sufficient.

(7) Use of recommended form “Order for Involuntary Placement” (CF-MH 3008) or other order used by the court, is considered by the department to be sufficient for this purpose.

**Title:** PROCEDURE FOR CONTINUED INVOLUNTARY PLACEMENT  
**Cite:** 394.467(7)(b), F.S.

If the patient continues to meet the criteria for involuntary placement, the administrator shall, prior to the expiration of the period during which the “Petitions for Continued Involuntary Placement” are rarely filed by receiving facility
treatment facility is authorized to retain the patient, file a petition requesting authorization for continued involuntary placement.

The request shall be accompanied by a statement from the patient's physician or clinical psychologist justifying the request, a brief description of the patient's treatment during the time he or she was involuntarily placed and an individualized plan of continued treatment. Notice of the hearing shall be provided as set forth in s. 394.4599.

administrators, since the patient would have had to exceed the maximum period of the court order, usually six months.

However, petitions filed with the state Division of Administrative Hearings should be filed at least 25 days prior to the person's expiration of the order for involuntary placement or for a person involuntarily placed while as a minor who is about to reach the age of 18.

Review clinical records to see if hearings for continued involuntary placement are conducted for people who remain at the facility.

Check clinical records of patients who are involuntarily placed to see the petitions are present requesting continued authorization for involuntary placement and that the petitions are accompanied by the person's clinical psychologist or physician noting what the person's treatment and continued response to treatment has been documented.

| BA 174 | Title: CONTINUED INVOLUNTARY PLACEMENT AT TREATMENT FACILITIES  
|        | Cite: 65E-5.300, F.A.C.  

(1) In order to request continued involuntary placement, the treatment facility administrator shall, prior to the expiration of the period during which the treatment facility is authorized to retain the patient, file a request for continued placement. The petition shall be filed with the Division of Administrative Hearings within 20 days prior to the expiration date of a patient’s authorized period of placement or, in the case of a minor, the date when the patient will reach the age of majority. The petition shall contain the signed statement of the patient’s physician, as defined in s. 394.455(21), F.S., or clinical psychologist justifying the request and shall be accompanied by the following additional documentation:

(a) Support for the facts in the statement of the physician, as defined in s.

Use of recommended form “Petition Requesting Authorization for Continued Involuntary Placement” (CF-MH 3035) is considered by the department to be sufficient as documentation of the request.
Baker Act Chapter 394, Part I, F.S. and Chapter 65E-5 F.A.C

| BA 175 | Title: PROCEDURE FOR CONTINUED INVOLUNTARY PLACEMENT  
Cite: 394.467(7)(e), F.S.  
If continued involuntary placement is necessary for a patient admitted while serving a criminal sentence, but whose sentence is about to expire, or for a patient involuntarily placed while a minor, but who is about to reach the age of 18, the administrator shall petition the hearing officer for an order authorizing continued involuntary placement.  
Review clinical records of such patients to ensure that petitions were filed with the Division of Administrative Hearings in a timely manner. |
|---|---|
| BA 176 | Title: DISCHARGE OF INVOLUNTARY PATIENTS  
Cite: 394.469, F.S.  
(1) POWER TO DISCHARGE.—At any time a patient is found to no longer meet the criteria for involuntary placement, the administrator shall:  
(a) Discharge the patient, unless the patient is under a criminal charge, in which case the patient shall be transferred to the custody of the appropriate law enforcement officer.  
(b) Transfer the patient to voluntary status on his or her own authority or at the patient’s request, unless the patient is under criminal charge or adjudicated incapacitated; or  
(c) Place an improved patient, except a patient under a criminal charge, on convalescent status in the care of a community facility.  
Review policies and procedures to ensure compliance with the statute.  
Review closed patient charts to ensure the patients were discharged appropriately.  
c) a “community facility” is defined in the Baker Act as any community service provider contracting with the department to furnish substance abuse or mental health services under part IV of this chapter |
| BA 177 | Title: DISCHARGE OF INVOLUNTARY PATIENTS  
Cite: 65E-5.320, F.A.C.  
A receiving or treatment facility administrator shall provide prompt written notice of the discharge of an involuntary patient to the patient, guardian, guardian advocate, representative, initiating professional, and circuit court, with a copy retained in the patient’s clinical record. If the discharge occurs while a court hearing for involuntary placement or continued involuntary placement is pending, all parties including the state attorney and attorney representing the patient, shall be given telephonic notice of the discharge by Use of recommended form “Notice of Release or Discharge” (CF-MH 3038) is considered by the department to be sufficient to document such notice. |
| **BA 178** | **Title:** TRANSFERS OF PATIENTS AMONG FACILITIES  
**Cite:** 394.4685, F.S. |
| --- | --- |
| **(1) TRANSFER BETWEEN PUBLIC FACILITIES.**  
(a) A patient who has been admitted to a public receiving facility, or the family member, guardian, or guardian advocate of such patient, may request the transfer of the patient to another public facility, or the family member, guardian, or guardian advocate of such patient, may request the transfer of the patient to another public treatment facility. Depending on the medical treatment of mental health treatment needs of the patient and the availability of appropriate facility resources, the patient may be transferred at the discretion of the department. If the department approves the transfer of an involuntary patient, notice according to the provisions of s. 394.4599 shall respond to the request for transfer within 2 working days after receipt of the request by the facility administrator.  
(b) When required by the medical treatment or mental health treatment needs of the patient or the efficient utilization of a public receiving or public treatment facility, a patient may be transferred from one receiving facility to another, or one treatment facility to another, at the department’s discretion, or, with the express and informed consent of the patient or the patient’s guardian or guardian advocate, to a facility in another state. Notice according to the provisions of s. 394.4599 shall be given prior to the transfer by the transferring facility. If prior notice is not possible notice of the transfer shall be provided as soon as practicable after the transfer. |
|  | **Review policies and procedures to ensure compliance with statutes permitting transfer of patients between receiving and treatment facilities.**  
**Sample closed clinical records of patients who have been transferred to confirm prior approval of the patient’s transfer by the facility that received the person.**  
**Are time lines met? Verify that the transfer to the facility occurred as planned.**  
**Provisions of the Federal COBRA law governs the appropriate transfer of patients from a hospital after stabilization of an emergency medical condition, including psychiatric or substance abuse conditions. Emergency access to care is also governed by chapter 395, F.S.** |
| **(2) TRANSFER FROM PUBLIC TO PRIVATE FACILITIES**  
A patient who has been admitted to a public receiving or public treatment facility and has requested, either personally or through his or her guardian or guardian advocate, and is able to pay for treatment in a private facility shall be transferred at the patient’s expense to a private facility upon acceptance of the patient by the private facility. |
|  |  |
| **(3) TRANSFER FROM PRIVATE TO PUBLIC FACILITIES**  
(a) A patient or the patient’s guardian or guardian advocate may request the...**
transfer of the patient to a public facility and the patient may be so transferred upon acceptance of the patient by the public facility.

(b) A private facility may request the transfer of a patient from the facility to a public facility and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.

(c) A public facility must respond to a request for the transfer of a patient within 2 working days after receipt of the request.

(4) TRANSFER BETWEEN PRIVATE FACILITIES

A patient in a private facility or the patient’s guardian or guardian advocate may request the transfer of the patient to another private facility at any time, and the patient shall be transferred upon acceptance of the patient by the facility to which transfer is sought.

---

<table>
<thead>
<tr>
<th>BA 179</th>
<th>Title: TRANSFER OF PATIENTS AMONG FACILITIES</th>
<th>Cite: 65E-5.310, F.A.C.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) An application form shall be used to request the transfer of a patient to another receiving or treatment facility. This application shall be completed and filed with the facility administrator or designee. A copy of the completed application shall be retained in the patient’s clinical record.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) The administrator of the facility or designee at which the patient resides shall, without delay, submit an application for transfer to the administrator of the facility to which a patient has requested transfer. Upon acceptance of the patient by the facility to which the transfer is sought, the administrator of the transferring facility or his or her designee shall mail the statutorily required notices to the patient, the patient’s attorney, guardian, guardian advocate or representative, retaining a copy in the patient’s clinical record.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) If the proposed transfer of a patient originates with the administrator of the facility or his or her designee or with the treating physician, as defined in chapter 458 or 459, F.S., a notice of transfer is required. The notice shall be completed by the administrator or designee of the transferring facility, after acceptance of the patient by the facility to which he or she will be transferred, with copies provided prior to the transfer to those required by</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(1) Use of recommended form “Application for and Notice of Transfer to Another Facility” (CF-MH 3046) is considered by the department to be sufficient.

(2) Use of recommended form “Application for and Notice of Transfer to Another Facility” (CF-MH 3046) is considered by the department to be sufficient for this documentation.

(3) Use of recommended form “Application for and Notice of Transfer to Another Facility” (CF-MH 3046) will be considered by the department to be sufficient for this purpose.
| Title: MINORS; ADMISSION AND PLACEMENT IN MENTAL FACILITIES |
|-----------------|-----------------|
| Cite: 394.4785(1)(b), F.S. |
| A minor under the age of 14 who is admitted to any hospital licensed pursuant to chapter 395 shall not be admitted to a bed in a room or ward with an adult patient in a mental health unit or share common areas with an adult patient in a mental health unit. |
| However, a minor 14 years of age or older may be admitted to a bed in a room or ward in the mental health unit with an adult if the admitting physician documents in the case record that such placement is medically indicated or for reasons of safety. Such placement shall be reviewed by the attending physician or a designee or on-call physician each day and documented in the case record. |
| Review policies and procedures to confirm compliance with statute. |
| Review clinical records and also observe where people are sharing common areas to ensure that minors under 14 years of age are not sharing common areas with adults. |
| Review clinical records of patients age 14 or older who are sharing a room or ward with an adult to ensure that the placement is documented initially and on a daily basis by the physician as medically necessary. |

THE FOLLOWING ISSUES ARE APPLICABLE TO EMERGENCY ROOMS

| Title: ACCESS TO EMERGENCY SERVICES AND CARE; RIGHTS OF PERSONS BEING TREATED |
|-----------------|-----------------|
| Cite: 395.1041(6), F.S. |
| A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s.394.463 shall adhere to rights of patients specified in part I of chapter 394 and regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394, and regardless of whether the person is admitted |
| BA 191 | **Title:** EMERGENCY MEDICAL CONDITIONS  
**Cite:** 394.463(2)(g), F.S.  
A person for whom an involuntary examination has been initiated who is being evaluated or treatment at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency condition. |
| BA 192 | **Title:** EMERGENCY MEDICAL CONDITIONS  
**Cite:** 394.463(2)(g), F.S.  
If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary placement, the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary placement must be entered into the patient’s clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization provided the requirements of s.395.1041 (3)(c) have been met. |
| BA 193 | **Title:** EMERGENCY MEDICAL CONDITIONS  
**Cite:** 394.463(2)(h), F.S.  
One of the following must occur within 12 hours after the patient’s attending physician documents that the patient’s medical condition has stabilized or that an emergency medical condition does not exist:  
1. The patient must be examined by a designated receiving facility and released; or  
2. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient’s condition has been stabilized or after determination that an emergency medical condition does not exist. |
| BA 194 | **Title:** EMERGENCY MEDICAL CONDITIONS  
**Cite:** 65E-5.280(4)(a), F.A.C.  
Documentation of the results of the mandatory involuntary examination completed in a hospital providing emergency medical services which is not designated as a receiving facility shall be recorded in the patient’s clinical record. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Use of recommended form “Emergency Medical Services’ Determination that Person Does Not Meet Involuntary Placement Criteria” (CF-MH 3101) is considered by the department to be sufficient.</strong></td>
</tr>
</tbody>
</table>