UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

James and Lorie Jensen, et al.,

Plaintiffs,

vs.

Minnesota Department of Human Services, et al.

Defendants.

Case No. 09-cv-01775 (DWF/BRT)

DECLARATION OF KYLEEANN STEVENS

I, KyleeAnn Stevens, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am the Executive Medical Director for Behavioral Health of the Department of Human Services ("DHS"). I am a physician and am board-certified by the American Board of Neurology and Psychiatry in both Psychiatry and Forensic Psychiatry. Before holding my current position, I was the Medical Director for Forensic Services in St. Peter, and before that, I was Director of Forensic Services at St. Elizabeth's Hospital in Washington, D.C. All told, I have served in a directorial capacity at public psychiatric facilities for the past eight years. This declaration is based on my personal knowledge.

2. The Direct Care and Treatment ("DCT") division of DHS operates facilities providing direct care and treatment to individuals with mental illness, developmental disabilities, and substance use disorders. I have responsibility for and oversight of all medical services provided at all DCT facilities, including Forensic Services in St. Peter and Anoka-Metro Regional Treatment Center ("AMRTC").

3. The Forensic Mental Health Program (formerly known as the Minnesota Security Hospital) is licensed by DHS as a supervised living facility to provide care and treatment for individuals civilly committed for an indeterminate time as mentally ill and dangerous (see Minn. Stat. § 253B.18). The Forensic Mental Health Program also serves other civilly committed individuals who require higher security or who have been civilly committed after being found incompetent in a criminal case. The Forensic Mental Health Program is also accredited by the Joint Commission, a nonprofit organization that accredits U.S. health care organizations and programs.

4. AMRTC is licensed by the Minnesota Department of Health as a psychiatric hospital and serves civilly committed individuals from across the state, and is not licensed by DHS.

5. In my current position, I am familiar with the policies governing, and the practices employed, at AMRTC and the Forensic Mental Health Program to protect the immediate physical safety of patients, staff, and others when a patient's behavior poses an immediate danger to the physical safety of self or others.

6. Based on my medical judgment and my familiarity with the field of medical professionals providing care to individuals at facilities like AMRTC and the Forensic Mental Health Program, use of restraint and seclusion at those facilities in the manner described below represents best practices nationally for similar facilities. Additionally, use of mechanical restraint and seclusion at AMRTC and the Forensic Mental Health Program is regulated and monitored not just by their state licensing agencies, as described

above, but also by the Centers for Medicare and Medicaid Services (CMS) which regulates AMRTC, and the Joint Commission, which accredits the Forensic Mental Health Program. Each of these bodies has standards governing how AMRTC and the Forensic Mental Health Program may use mechanical restraint and seclusion. A true and correct copy of the applicable CMS regulation is attached as Exhibit A. A true and correct copy of the applicable Joint Commission standards is attached as Exhibit B. A true and correct copy of the applicable MDH rule on the use of restraint and seclusion at AMRTC is attached as Exhibit C. A true and correct copy of the applicable DHS rule for the Forensic Mental Health Program (which incorporates the Positive Supports Rule) is attached as Exhibit D. These bodies engage in oversight and monitoring of implementation of the standards at AMRTC and the Forensic Mental Health Program. AMRTC and the Forensic Mental Health Program are in compliance with these standards.

7. These regulatory structures prohibit restraint of any kind within AMRTC or the Forensic Mental Health Program, including manual restraint, mechanical restraint or seclusion, except when necessary to protect the immediate physical safety of the patient, staff or others. In addition, internal DCT policies specify measures for employing restraints in ways that minimize the risk of injury to the patient and others when it does become necessary to use restraint.

8. Two internal policies address the use of restraint and seclusion: one is applicable to all Mental Health and Substance Abuse Treatment Services, including

AMRTC (a true and correct copy of which is attached as Exhibit E) and the other is applicable to the Forensic Mental Health Program (a true and correct copy of which is attached as Exhibit F). Restraint and seclusion may only be used in accordance with applicable policies. Both policies permit use of restraint only in the presence of behavior that is likely to cause harm to self or others in the immediate future. For example, if a patient begins punching a staff or another patient in the head or face, DCT policies permit employment of manual or mechanical means to immobilize or reduce the patient's ability to move his or her arms, legs, body, or head freely. Within the past five years, for example, staff at the Forensic Mental Health Program have received serious and debilitating head injuries as a result of patient aggression.

9. DCT policies require all staff providing direct care to be trained on restraint interventions. In addition, staff are trained on interventions and methods to de-escalate behavioral situations before the behavior poses an imminent risk of harm, and are required to use the least restrictive means necessary to protect the patient and others for the shortest period of time necessary. This includes protecting both the patient being restrained and the staff implementing the restraint from potential injury from the restraint itself.

10. The type of restraint that is the least restrictive and safest to use is assessed on a case-by-case basis and depends on unique characteristics of the patient and behavioral incident. After a manual restraint is used, staff evaluate whether the patient no longer poses a risk of harm, or if the manual restraint is insufficient to protect the safety

of the patient or others from imminent risk of harm. Manual restraint is sometimes not the optimal intervention. For example, in some situations, manual restraint may pose a potential for musculoskeletal or internal injury to both the patient and staff, if the patient does not calm, if the restraint intensifies the patient's physical struggle, or if the continued use of manual restraint requires additional staff. Use of manual restraint for extended periods of time poses significant safety threats to the patient and staff, including musculoskeletal injuries, trauma and respiratory, renal and cardiovascular injuries. Moreover, patients with a history of physical or sexual trauma may find manual restraint re-traumatizing by triggering memories of times when another person restrained their freedom in order to cause physical harm. Individual-specific admissions and other treatment documents, which are continually reviewed and updated as clinically appropriate, describe specific characteristics of a patient that are relevant for determining whether manual restraint should be continued or whether mechanical restraint or seclusion is a safer or medically indicated alternative.

11. The applicable restraint policies in Exhibits E and F are intended to protect patient health and prevent overuse and abuse of restraint. In addition to other items, they require medical review and authorization of the restraint as well as continuous monitoring of the patient and regular checks on patient health during the restraint. The policies also require review and debriefing after the event, with both staff and the patient, in order to minimize future use of restraint or seclusion, as well as notification of the patient's

guardian. Staff must end the restraint or seclusion as soon as the patient no longer poses an imminent risk of harm.

12. Patients at AMRTC or the Forensic Mental Health Program have been civilly committed by a judge based on evidence provided by one or more physicians that the patient poses a danger to themselves or others and requires acute care. The commitment follows a judicial proceeding in which one or more physicians provided evidence supporting a finding that the person's psychiatric needs cannot be effectively managed in the community. For patients committed as mentally ill and dangerous, this includes physician testimony and a judicial finding that only a secure treatment facility will meet the patient's needs and protect the public. For patients admitted to AMRTC, the patient is either in jail after being found incompetent on a felony, or the patient is acutely ill in another community setting, including a hospital. In my clinical experience, patients admitted to AMRTC and the Forensic Mental Health Program often exhibit more severe and dangerous behaviors, increased frequency of dangerous behavior or increased duration of dangerous behaviors than patients in community hospitals and other community settings.

13. Typically, a patient faces the most severe behavioral challenges when they are first admitted to AMRTC or the Forensic Mental Health Program. Depending on the patient, it takes varying amounts of time for a patient's psychiatric symptoms to stabilize, for medical practitioners to prescribe and adjust medications, for the patient to become more trusting of staff and adapt to the new environment, and for the staff to determine

what the best strategies are to de-escalate the patient's dangerous behavior. In general, over time as the patient stabilizes, or as their mental health symptoms cycle, the need for use of restraint and seclusion to protect the safety of the patient or others decreases. DCT staff, to the extent possible, work to reduce or ideally eliminate the need for the use of restraint or seclusion by attempting to address the individual issues that may cause behaviors posing an imminent risk of physical injury to self, staff, or others.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on: August 29, 2019

s/ KyleeAnn Stevens
KYLEEANN STEVENS

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Declaration of KyleeAnn Stevens

Exhibit A

(i) Under the direction of the governing body; and

(ii) By a committee consisting of representatives of the governing body, the administrative staff, and the medical staff of the institution.

(e) *Standard: Contracted services.* The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services.

(1) The governing body must ensure that the services performed under a contract are provided in a safe and effective manner.

(2) The hospital must maintain a list of all contracted services, including the scope and nature of the services provided.

(f) *Standard: Emergency services.* (1) If emergency services are provided at the hospital, the hospital must comply with the requirements of §482.55.

(2) If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate.

(3) If emergency services are provided at the hospital but are not provided at one or more off-campus departments of the hospital, the governing body of the hospital must assure that the medical staff has written policies and procedures in effect with respect to the off-campus department(s) for appraisal of emergencies and referral when appropriate.

[51 FR 22042, June 17, 1986; 51 FR 27847, Aug. 4, 1986, as amended at 53 FR 6549, Mar. 1, 1988; 53 FR 18987, May 26, 1988; 56 FR 8852, Mar. 1, 1991; 56 FR 23022, May 20, 1991; 59 FR 46514, Sept. 8, 1994; 63 FR 20130, Apr. 23, 1998; 63 FR 33874, June 22, 1998; 68 FR 53262, Sept. 9, 2003; 76 FR 25562, May 5, 2011]

§482.13 Condition of participation: Patient's rights.

A hospital must protect and promote each patient's rights.

(a) *Standard: Notice of rights*—(1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.

(2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum:

(i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.

(ii) The grievance process must specify time frames for review of the grievance and the provision of a response.

(iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.

(b) *Standard: Exercise of rights.* (1) The patient has the right to participate in the development and implementation of his or her plan of care.

(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

(3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who

provide care in the hospital comply with these directives, in accordance with § 489.100 of this part (Definition), § 489.102 of this part (Requirements for providers), and § 489.104 of this part (Effective dates).

(4) The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.

(c) *Standard: Privacy and safety.* (1) The patient has the right to personal privacy.

(2) The patient has the right to receive care in a safe setting.

(3) The patient has the right to be free from all forms of abuse or harassment.

(d) *Standard: Confidentiality of patient records.* (1) The patient has the right to the confidentiality of his or her clinical records.

(2) The patient has the right to access information contained in his or her clinical records within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.

(e) *Standard: Restraint or seclusion.* All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

(1) *Definitions.* (i) A *restraint* is—

(A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or

(B) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

(ii) *Seclusion* is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

(2) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient a staff member or others from harm.

(3) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.

(4) The use of restraint or seclusion must be—

(i) In accordance with a written modification to the patient's plan of care; and

(ii) Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.

(5) The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under § 482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.

(6) Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).

(7) The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.

(8) Unless superseded by State law that is more restrictive—

(i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical

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safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:

(A) 4 hours for adults 18 years of age or older;

(B) 2 hours for children and adolescents 9 to 17 years of age; or

(C) 1 hour for children under 9 years of age; and

(ii) After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) of this part and authorized to order restraint or seclusion by hospital policy in accordance with State law must see and assess the patient.

(iii) Each order for restraint used to ensure the physical safety of the nonviolent or non-self-destructive patient may be renewed as authorized by hospital policy.

(9) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

(10) The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy.

(11) Physician and other licensed independent practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other licensed independent practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.

(12) When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention—

(i) By a—

(A) Physician or other licensed independent practitioner; or

(B) Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section.

(ii) To evaluate—

(A) The patient's immediate situation;

(B) The patient's reaction to the intervention;

(C) The patient's medical and behavioral condition; and

(D) The need to continue or terminate the restraint or seclusion.

(13) States are free to have requirements by statute or regulation that are more restrictive than those contained in paragraph (e)(12)(i) of this section.

(14) If the face-to-face evaluation specified in paragraph (e)(12) of this section is conducted by a trained registered nurse or physician assistant, the trained registered nurse or physician assistant must consult the attending physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) as soon as possible after the completion of the 1-hour face-to-face evaluation.

(15) All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored—

(i) Face-to-face by an assigned, trained staff member; or

(ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.

(16) When restraint or seclusion is used, there must be documentation in the patient's medical record of the following:

(i) The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;

(ii) A description of the patient's behavior and the intervention used;

(iii) Alternatives or other less restrictive interventions attempted (as applicable);

(iv) The patient's condition or symptom(s) that warranted the use of the restraint or seclusion; and

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(v) The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

(f) *Standard: Restraint or seclusion: Staff training requirements.* The patient has the right to safe implementation of restraint or seclusion by trained staff.

(1) *Training intervals.* Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion—

(i) Before performing any of the actions specified in this paragraph;

(ii) As part of orientation; and

(iii) Subsequently on a periodic basis consistent with hospital policy.

(2) *Training content.* The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:

(i) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.

(ii) The use of nonphysical intervention skills.

(iii) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.

(iv) The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia);

(v) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.

(vi) Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation.

(vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

(3) *Trainer requirements.* Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.

(4) *Training documentation.* The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.

(g) *Standard: Death reporting requirements:* Hospitals must report deaths associated with the use of seclusion or restraint.

(1) The hospital must report the following information to CMS:

(i) Each death that occurs while a patient is in restraint or seclusion.

(ii) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.

(iii) Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

(2) Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.

(3) Staff must document in the patient's medical record the date and time the death was reported to CMS.

(h) *Standard: Patient visitation rights.* A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation. A hospital must meet the following requirements:

(1) Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, when he or she is informed of

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his or her other rights under this section.

(2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.

(3) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

(4) Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.

[71 FR 71426, Dec. 8, 2006, as amended at 75 FR 70844, Nov. 19, 2010]

Subpart C—Basic Hospital Functions

§482.21 Condition of participation: Quality assessment and performance improvement program.

The hospital must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

(a) *Standard: Program scope.* (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes and identify and reduce medical errors.

(2) The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations.

(b) *Standard: Program data.* (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization.

(2) The hospital must use the data collected to—

(i) Monitor the effectiveness and safety of services and quality of care; and

(ii) Identify opportunities for improvement and changes that will lead to improvement.

(3) The frequency and detail of data collection must be specified by the hospital's governing body.

(c) *Standard: Program activities.* (1) The hospital must set priorities for its performance improvement activities that—

(i) Focus on high-risk, high-volume, or problem-prone areas;

(ii) Consider the incidence, prevalence, and severity of problems in those areas; and

(iii) Affect health outcomes, patient safety, and quality of care.

(2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.

(3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.

(d) *Standard: Performance improvement projects.* As part of its quality assessment and performance improvement program, the hospital must conduct performance improvement projects.

(1) The number and scope of distinct improvement projects conducted annually must be proportional to the scope and complexity of the hospital's services and operations.

(2) A hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. This project, in its initial stage of development, does not

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Declaration of KyleeAnn Stevens

Exhibit B

Revised Standard CTS.05.06.05

For organizations that use restraint or seclusion: Staff are trained and competent to minimize the use of restraint and seclusion and, when use is indicated, to use restraint or seclusion safely.

Revised Elements of Performance for CTS.05.06.05

1. For organizations that use restraint or seclusion: The organization educates staff about minimizing the use of restraint and seclusion and, before they participate in any use of restraint or seclusion, assesses the competence of staff to use them safely.
2. For organizations that use restraint or seclusion: To minimize the use of restraint and seclusion, all direct care staff and any other staff involved in the use of restraint and seclusion receive ongoing training in and demonstrate an understanding of the following:
   - The underlying causes of threatening behaviors exhibited by individuals served
   - That sometimes an individual served may exhibit an aggressive behavior that is related to an individual's medical condition and not related to his or her emotional condition (for example, threatening behavior that may result from delirium in fevers)
   - How staff behaviors can affect the behaviors of individuals served
   - Escalation, mediation, self-protection, and other techniques such as time-out
   - How to recognize signs of physical distress in individuals who are being held, restrained, or secluded
3. For organizations that use restraint or seclusion: Staff who are authorized to apply restraint or seclusion receive the training and demonstrate the competence as required in Standard CTS.05.06.05, EP 2.
4. For organizations that use restraint or seclusion: Direct care staff members receive ongoing training in and demonstrate competence in the safe use of restraint, including physical holding techniques, take-down procedures, and the application and removal of mechanical restraints.
5. For organizations that use restraint or seclusion: Staff who are authorized to perform 15-minute assessments of individuals in restraint or seclusion receive the training and demonstrate the competence as required in Standard CTS.05.06.05, EP 2.
6. For organizations that use restraint or seclusion: Staff authorized to perform 15-minute assessments receive ongoing training and demonstrate competence in the following:
   - Taking vital signs and interpreting their relevance to the physical safety of the individual in restraint or seclusion
   Note: Taking vital signs may include the use of a pulse oximeter to assess the oxygenation status of the individual in restraint or seclusion.
   - Recognizing nutritional and hydration needs
   - Checking circulation and range of motion in the extremities
   - Addressing hygiene and elimination
   - Addressing physical and psychological status and comfort
   - Helping individuals meet behavior criteria for discontinuing restraint or seclusion
   - Recognizing readiness for discontinuing restraint or seclusion
   - Recognizing signs of any incorrect application of restraints
   - Recognizing when to contact a medically trained licensed independent practitioner or emergency medical services to evaluate and/or treat the physical status of the individual
7. For organizations that use restraint or seclusion: Staff who, in the absence of a licensed independent practitioner, are authorized to initiate restraint or seclusion, and/or perform evaluations/re-evaluations of individuals in restraint or seclusion to assess their readiness for discontinuation or establish the need to secure a new order, receive training and demonstrate competence as required in Standard CTS.05.06.05, EPs 1-6.

8. For organizations that use restraint or seclusion: Staff are educated about and demonstrate competence in the following:
   - Recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which an individual served reacts to physical contact
   - Using behavior criteria for discontinuing restraint or seclusion and how to help individuals in meeting these criteria
9. For organizations that use restraint or seclusion: A sufficient number of staff with direct care responsibility receive additional training so that staff who are competent to initiate first aid and CPR are available at all times.
10. For organizations that use restraint or seclusion: The organization has a plan for providing emergency medical services.
11. For organizations that use restraint or seclusion: The viewpoints of individuals who have experienced restraint or seclusion are incorporated into staff training and education to help staff better understand all aspects of restraint and seclusion.
12. For organizations that use restraint or seclusion: Whenever possible, individuals who have experienced restraint or seclusion contribute to the training and education curricula and/or participate in staff training and education.
    Note: Requirements related to ongoing education and the continuous assessment of staff competence are addressed in the "Human Resources" (HR) chapter.

Revised Standard CTS.05.06.07

For organizations that use restraint or seclusion: The initial assessment of each individual at admission or intake assists in obtaining information about the individual that could help minimize the use of restraint or seclusion.

Revised Elements of Performance for CTS.05.06.07

1. For organizations that use restraint or seclusion: The initial assessment of an individual who is at risk of harming himself or herself, staff, or others identifies techniques that would help the individual control his or her behavior.
2. For organizations that use restraint or seclusion: When indicated, the initial assessment of an individual who is at risk of harming himself or herself, staff, or others identifies the individual's need for methods or tools to manage his or her aggressive behavior.
3. For organizations that use restraint or seclusion: The initial assessment of an individual who is at risk of harming himself or herself, staff, or others identifies preexisting medical conditions or any physical disabilities and limitations that would place the individual at greater risk during restraint or seclusion.
4. For organizations that use restraint or seclusion: The initial assessment of an individual who is at risk of harming himself or herself, staff, or others identifies any history of sexual or physical abuse or other trauma that would place the individual at greater psychological risk during restraint or seclusion.
5. For organizations that use restraint or seclusion: As appropriate, the individual served and/or his or her family helps in identifying techniques that would help minimize the use of restraint or seclusion.
6. For organizations that use restraint or seclusion: The individual served and his or her family are educated about the organization's philosophy on restraint and seclusion to the extent that such information is not clinically contraindicated.
7. For organizations that use restraint or seclusion: The family's role, including their notification of a restraint or seclusion episode, is discussed with the individual served and, as appropriate, his or her family, and in conjunction with the right to confidentiality of the individual served.

Revised Standard CTS.05.06.09

For organizations that use restraint or seclusion: Nonphysical techniques are the preferred intervention in managing behaviors of individuals served.

Revised Elements of Performance for CTS.05.06.09

1. For organizations that use restraint or seclusion: Whenever possible, the organization uses nonphysical techniques in managing behaviors of individuals served.
   Note: Such interventions may include redirecting the focus of the individual served or employing verbal de-escalation.

Revised Standard CTS.05.06.11

For organizations that use restraint or seclusion: Restraint or seclusion is limited to emergencies in which there is an imminent risk of an individual served physically harming himself or herself, staff, or others, and when nonphysical interventions would not be effective.

Revised Elements of Performance for CTS.05.06.11

1. For organizations that use restraint or seclusion: Restraint or seclusion is used only when nonphysical interventions are ineffective or not viable and when there is an imminent risk of an individual served physically harming himself or herself, staff, or others.
2. For organizations that use restraint or seclusion: The type of physical intervention (restraint or seclusion) selected considers information learned from the initial assessment of the individual served.
3. For organizations that use restraint or seclusion: The organization does not permit restraint or seclusion for any other purpose, such as coercion, discipline, convenience, or retaliation by staff.
4. For organizations that use restraint or seclusion: The use of restraint or seclusion is not based on the restraint or seclusion history of an individual served or solely on a history of dangerous behavior.

Revised Standard CTS.05.06.13

For organizations that use restraint or seclusion: A licensed independent practitioner orders the use of restraint or seclusion.
Note: This standard is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to physician assistants and advanced practice nurses to the extent recognized under state law or a state's regulatory mechanism and allowed by the organization.

Revised Elements of Performance for CTS.05.06.13

1. For organizations that use restraint or seclusion: All restraint and seclusion are applied and continued pursuant to an order by the licensed independent practitioner who is primarily responsible for the ongoing care of the individual served, or his or her licensed independent practitioner designee, or other licensed independent practitioner.
   Note: Because restraint and seclusion use is limited to emergencies (in which a licensed independent practitioner may not be immediately available), the organization may authorize qualified, trained staff members who are not licensed independent practitioners to initiate restraint or seclusion before an order is obtained from the licensed independent practitioner. In addition, restraint and seclusion may be ordered by licensed practitioners (for example, registered nurses, licensed social workers) if permitted by state law and by the organization.
2. For organizations that use restraint or seclusion: As soon as possible, but no longer than one hour after the initiation of restraint or seclusion, qualified staff do the following:
   - Notifies and obtains an order (verbal or written) from the licensed independent practitioner
   - Consults with the licensed independent practitioner about the physical and psychological condition of the individual served
3. For organizations that use restraint or seclusion: The licensed independent practitioner does the following:
   - Reviews with staff the physical and psychological status of the individual served
   - Determines whether restraint or seclusion should be continued
   - Supplies staff with guidance in identifying ways to help the individual regain control so that restraint or seclusion can be discontinued
   - Supplies an order for restraint or seclusion

Revised Standard CTS.05.06.15

For organizations that use restraint or seclusion: The family of the individual served is notified promptly of the use of restraint or seclusion.

Revised Elements of Performance for CTS.05.06.15

1. For organizations that use restraint or seclusion: The organization asks the individual served whether his or her family is to be informed about the individual's care, treatment, or services.
2. For organizations that use restraint or seclusion: The organization asks the individual's family whether they want to be informed about the individual's care, treatment, or services.
3. For organizations that use restraint or seclusion: In cases in which the individual served has consented to have the family kept informed about his or her care, treatment, or services and the family has agreed to be notified, staff attempts to contact the family as soon as possible to notify them of the use of restraint or seclusion.

Revised Standard CTS.05.06.17

For organizations that use restraint or seclusion: A licensed independent practitioner sees and evaluates the individual in restraint or seclusion in person.

Revised Elements of Performance for CTS.05.06.17

1. For organizations that use restraint or seclusion: The licensed independent practitioner primarily responsible for the ongoing care, treatment, or services of the individual served, or his or her licensed independent practitioner designee, or other licensed independent practitioner, evaluates the individual in restraint or seclusion in person within four hours of the initiation of restraint or seclusion for individuals ages 18 or older, and within two hours of initiation for children and youth ages 17 and under.
2. For organizations that use restraint or seclusion: At the time of the in-person evaluation of the individual in restraint or seclusion, the licensed independent practitioner does the following:
   - Works with the individual and staff to identify ways to help the individual regain control
   - Revises the individual's plan for care, treatment, or services as needed
   - If necessary, provides a new written order
3. For organizations that use restraint or seclusion: The licensed independent practitioner evaluates the individual in restraint or seclusion in person within 24 hours of the initiation of restraint or seclusion if the individual is no longer in restraint or seclusion when an original verbal order expires.

Revised Standard CTS.05.06.19

For organizations that use restraint or seclusion: Written and verbal orders for initial and continuing use of restraint and seclusion are time limited.

Revised Elements of Performance for CTS.05.06.19

1. For organizations that use restraint or seclusion: Written and verbal orders for restraint and seclusion are limited to the following:
   - Four hours for adults ages 18 and older
   - Two hours for children and youth ages 9 to 17
   - One hour for children under age 9
2. For organizations that use restraint or seclusion: Orders for restraint or seclusion are not written as a standing order or for use on an as-needed basis (that is, PRN).
3. For organizations that use restraint or seclusion: If restraint or seclusion use needs to continue beyond the expiration of the time-limited order, a new order for restraint or seclusion is obtained from the licensed independent practitioner primarily responsible for ongoing care, treatment, or services of the individual served, or his or her licensed independent practitioner designee, or other licensed independent practitioner.

Revised Standard CTS.05.06.21

For organizations that use restraint or seclusion: Individuals in restraint or seclusion are regularly re-evaluated.

Revised Elements of Performance for CTS.05.06.21

1. For organizations that use restraint or seclusion: By the time the order for restraint or seclusion expires, the individual served is evaluated in person by one of the following:
   - The licensed independent practitioner primarily responsible for the ongoing care, treatment, or services of the individual served
   - His or her licensed independent practitioner designee
   - Another licensed independent practitioner or qualified, trained individual authorized by the organization to perform this function
2. For organizations that use restraint or seclusion: In conjunction with reevaluation of the individual in restraint or seclusion, a new written or verbal order is given by the licensed independent practitioner primarily responsible for the individual's ongoing care, treatment, or services, or his or her licensed independent practitioner designee, or other licensed independent practitioner if the restraint or seclusion is to be continued.
3. For organizations that use restraint or seclusion: The licensed independent practitioner or other qualified, authorized staff member re-evaluates the efficacy of the treatment plan of the individual served and works with the individual to identify ways to help him or her regain control.
4. For organizations that use restraint or seclusion: If the licensed independent practitioner of the individual served, or his or her licensed independent practitioner designee, is not the licensed independent practitioner who gave the order, the licensed independent practitioner of the individual served is notified of the individual's status if the restraint or seclusion is continued.
5. For organizations that use restraint or seclusion: The individual in restraint or seclusion is re-evaluated as follows:
   - Every four hours for adults ages 18 and older
   - Every two hours for children and youth ages 9 to 17
   - Every hour for children under age 9
6. For organizations that use restraint or seclusion: The licensed independent practitioner conducts an in-person re-evaluation of the individual in restraint or seclusion at least every eight hours for adults ages 18 and older and every four hours for children and youth ages 17 and younger.

Revised Standard CTS.05.06.23

For organizations that use restraint or seclusion: Clinical leaders are told of individuals who experience extended or multiple episodes of restraint or seclusion.

Revised Elements of Performance for CTS.05.06.23

1. For organizations that use restraint or seclusion: Clinical leaders are immediately notified when an individual remains in restraint or seclusion for more than 12 hours or experiences, within 12 hours, two or more separate episodes of restraint or seclusion of any duration.
2. For organizations that use restraint or seclusion: Clinical leaders are notified every 24 hours if an individual remains in restraint or seclusion for more than 12 hours or experiences, within 12 hours, two or more separate episodes of restraint or seclusion of any duration.

Revised Standard CTS.05.06.25

For organizations that use restraint or seclusion: Individuals in restraint or seclusion are assessed and assisted.

Revised Elements of Performance for CTS.05.06.25

1. For organizations that use restraint or seclusion: The organization prohibits the use of restraint techniques that restrict the flow of air to the individual's lungs.
2. For organizations that use restraint or seclusion: A staff member who is trained and competent in accordance with Standard CTS.05.06.05 assesses the individual at the initiation of restraint or seclusion and every 15 minutes thereafter.
3. For organizations that use restraint or seclusion: Staff assessment of the individual at initiation of restraint or seclusion and every 15 minutes thereafter includes, as relevant to the type of restraint or seclusion, the following:
   - Signs of any injury associated with applying restraint or seclusion
   - Nutrition and hydration status
   - Circulation and range of motion in the extremities
   - Vital signs
   - Hygiene and elimination
   - Physical and psychological status and comfort
   - Readiness for discontinuation of restraint or seclusion
4. For organizations that use restraint or seclusion: Staff help individuals in restraint or seclusion to meet behavior criteria for discontinuing restraint or seclusion.

Revised Standard CTS.05.06.27

For organizations that use restraint or seclusion: Individuals in restraint or seclusion are monitored.

Revised Elements of Performance for CTS.05.06.27

1. For organizations that use restraint or seclusion: Monitoring of individuals in restraint or seclusion is done through continuous in-person observation by an assigned staff member who is competent and trained in accordance with Standard CTS.05.06.05.
2. For organizations that use restraint or seclusion: After the first hour, an individual in seclusion without restraints may be continuously monitored using simultaneous video and audio equipment, if consistent with the individual's condition or wishes.

Revised Standard CTS.05.06.29

For organizations that use restraint or seclusion: Restraint and seclusion use are discontinued when the individual served meets the behavior criteria for their discontinuation.

Revised Elements of Performance for CTS.05.06.29

1. For organizations that use restraint or seclusion: As early as feasible in the restraint or seclusion process, the individual served is made aware of the rationale for restraint or seclusion and the behavior criteria for its discontinuation.
   Note: Examples of behavior criteria include the ability of an individual served to contract for safety, whether the individual is oriented to the environment, and/or cessation of verbal threats.
2. For organizations that use restraint or seclusion: Restraint or seclusion is discontinued as soon as the individual served meets his or her behavior criteria.

Revised Standard CTS.05.06.31

For organizations that use restraint or seclusion: The individual served and staff participate in a debriefing about the restraint or seclusion episode.

Revised Elements of Performance for CTS.05.06.31

1. For organizations that use restraint or seclusion: The individual served and, if appropriate, the individual's family participate with staff members who were involved in the episode and who are available in a debriefing about each episode of restraint or seclusion.
2. For organizations that use restraint or seclusion: The debriefing about each episode of restraint or seclusion occurs as soon as possible, but no longer than 24 hours after the episode.
3. For organizations that use restraint or seclusion: The debriefing about each episode of restraint or seclusion is used to do the following:
   - Identify what led to the incident and what could have been handled differently
   - Ascertain that the physical well-being, psychological comfort, and right to privacy of the individual served were addressed
   - Counsel the individual served for any trauma that may have resulted from the incident
   - When indicated, modify the individual's plan for care, treatment, or services
4. For organizations that use restraint or seclusion: Information obtained and documented from debriefings is used in performance improvement activities.

Revised Standard CTS.05.06.33

For organizations that use restraint or seclusion: The organization collects data on the use of restraint and seclusion.

Revised Elements of Performance for CTS.05.06.33

1. For organizations that use restraint or seclusion: The leaders determine the frequency with which data on the use of restraint and seclusion are aggregated.
2. For organizations that use restraint or seclusion: Individual identifiers are included in data collected on the use of restraint or seclusion.
3. For organizations that use restraint or seclusion: Data on all restraint and seclusion episodes are collected from and classified for all settings/locations by the following:
   - Shift
   - Staff who initiated the process
   - The length of each episode
   - Date and time each episode was initiated
   - Day of the week each episode was initiated
   - The type of restraint used
   - Whether injuries were sustained by the individual or staff
   - Age of the individual
   - Sex of the individual
   - Debriefing data
4. For organizations that use restraint or seclusion: Particular attention is paid to the following restraint and seclusion data: Multiple instances of restraint or seclusion experienced by an individual within a 12-hour time frame.
5. For organizations that use restraint or seclusion: Particular attention is paid to the following restraint and seclusion data: The number of episodes per individual served.
6. For organizations that use restraint or seclusion: Particular attention is paid to the following restraint and seclusion data: Instances of restraint or seclusion that extend beyond 12 consecutive hours.
7. For organizations that use restraint or seclusion: Particular attention is paid to the following restraint and seclusion data: Use of psychotropic medications as an alternative to, or to enable discontinuation of, restraint or seclusion.
8. For organizations that use restraint or seclusion: Licensed independent practitioners participate in measuring and assessing use of restraint and seclusion for all individuals served.

Revised Standard CTS.05.06.35

For organizations that use restraint or seclusion: Organization policies and procedures address prevention of restraint and seclusion and, when employed, guide their use.

Revised Elements of Performance for CTS.05.06.35

1. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Staffing.
2. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Staff competence and training.
3. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Initial assessment of the individual served.
4. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: The role of nonphysical techniques in behavioral contingencies.
5. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Limiting the use of restraint or seclusion to emergencies.
6. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Notification of the family of the individual served when restraint or seclusion is initiated.
7. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Ordering of restraint and seclusion by a licensed independent practitioner.
8. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: In-person evaluations of the individual in restraint or seclusion.
9. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Initiation of restraint or seclusion by staff other than a licensed independent practitioner.
10. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Time-limited orders.
11. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Reassessment of the individual in restraint or seclusion.
12. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Monitoring the individual in restraint or seclusion.
13. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Discontinuation of restraint or seclusion.
14. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Post-restraint or seclusion practices.

15. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Reporting injuries and deaths to the organization's leadership and external agencies in accordance with law and regulation.
16. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Documentation of restraint or seclusion.
17. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Data collection and the integration of restraint or seclusion data into performance improvement activities.

James and Lorie Jensen, et al., Plaintiffs
vs.
Minnesota Department of Human Services, et al., Defendants

Case No. 09-cv-01775 (DWF/BRT)

Declaration of KyleeAnn Stevens

Exhibit C

4640.3800 PROTECTION OF PATIENTS AND PERSONNEL.

Subpart 1. **Security.** Every reasonable precaution shall be taken for the security of patients and personnel. Drugs, narcotics, sharp instruments, and other potentially hazardous articles shall be inaccessible to patients.

Subp. 2. **Segregation of patients.** Patients with tuberculosis or other communicable disease shall be segregated.

Subp. 3. **Seclusion and restraints.** Patients shall not be placed in seclusion or mechanical restraints without the written order of the physician in charge unless, in the judgment of the supervisor in charge of the service, the safety and protection of the patient, hospital employees, or other patients require such immediate seclusion or restraint. Such seclusion or restraint shall not be continued beyond eight hours except by written or telephone order of the attending physician. Emergency orders given by telephone shall be reduced to writing immediately upon receipt and shall be signed by the staff member within 24 hours after the order is given. Such patient shall be under reasonable observation and care of a nurse or attendant at all times.

Statutory Authority: *MS s 144.55; 144.56*

Published Electronically: *November 12, 1997*

James and Lorie Jensen, et al., Plaintiffs
vs.
Minnesota Department of Human Services, et al., Defendants

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Exhibit D

Version March 24, 2016

Variance to Minnesota Rules, parts 9520.0500 to 9520.0690 (Rule 36) for Minnesota Security Hospital (MSH)

MSH.0001. OVERVIEW.

Subpart 1. **Overview.** Minnesota Security Hospital is a mental health care organization. This variance establishes the licensing requirements for the services provided.

Subpart 2. **Purpose.** The purpose is to define and recognize three distinct levels of care and establish the licensing standards that pertain to each level. The requirements for each service level are further defined within the body of this document.

Subpart 3. **Programs and levels of care.** The license holder must have one DHS license that includes three programs:
(1) Minnesota Security Hospital (MSH);
(2) Transition Services; and
(3) Competency Restoration Program (CRP).

One or more levels of care must be identified for each unit. Within all three levels of service delivery, the treatment service components must be designed to promote recovery and psychiatric stability through the use of established rehabilitative principles and evidence based practices. The needs of individuals are addressed through the development of individualized treatment plans that include necessary treatment interventions. Crisis response will be implemented in all service levels.

MSH.0002. APPLICABLE REGULATIONS.

In addition to the requirements in this variance, license holders must also comply with all other applicable laws, requirements, and standards, some of which are not enforced as licensing standards. In addition to this variance, the following requirements are enforced by the Department of Human Services, Licensing Division:
(1) Minnesota Statutes, chapter 245A;
(2) Minnesota Statutes, sections 626.556, 626.557, and 626.5572;
(3) Minnesota Statutes, chapter 245C; and
(4) Minnesota Rules, chapter 9544.

MSH.0003. DEFINITIONS.

Subpart 1. **Scope.** The terms used in this variance have the meanings given them in this section.

Subpart 2. **Best practice and/or evidenced based practices.** "Evidence-based practices" means a set of practices that evaluation research has shown to be effective. Substance Abuse and Mental Health Service Administration (SAMHSA) defines evidence-based as those interventions that are included in federal registries of evidence-based interventions; reported (with positive effects on the primary targeted outcome) in peer-reviewed journals; or has documented evidence of effectiveness, based on guidelines developed by SAMHSA/ Center for Substance Abuse Prevention (CSAP) and/or the state, tribe or jurisdiction.

Examples of current Evidenced Based Practices/Best practices would include Trauma Informed Care, Person Centeredness, Positive Behavior Supports, Illness, Management and Recovery, Integrated Dual Disorder Treatment, etc.

Subpart 3. **Case manager.** "Case manager" means a person who is employed by a county or tribe or an agency contracted with the county or tribe who is responsible to provide the individual with assistance to gain access to needed medical, social, educational, vocational and other necessary services.

Subpart 4. **Certified peer specialist.** "Certified peer specialist" means a staff person who meets the training and certification requirements identified by the commissioner in accordance with Minnesota Statutes, section 256B.0615, subdivision 5.

Subpart 5. **Clinical direction.** "Clinical direction" means the mental health professional must provide direction in the development, modification, and implementation of ITP and the service components provided by each program. All treatment areas are driven by the mental health professional through clinical oversight, role modeling, review and evaluation of treatment.

Subpart 6. **Commissioner**. "Commissioner" means the Commissioner of Human Services or the commissioner's designated representative including county agencies and private agencies.

Subpart 7. **Competency restoration program**. "Competency restoration program (CRP)" means a program that provides comprehensive treatment and evaluation of individuals who have been committed as mentally ill and court ordered for competency restoration pursuant to Minnesota Rule of Criminal Procedure Rule 20.01 and 20.02. The comprehensive services include, but are not limited to, legal education (group and individual), psycho-social groups, psychiatric consultation and rehabilitation programming in order to restore an individual's capacity to meaningfully participate in their criminal proceedings.

Subpart 8. **Department**. "Department" means the Minnesota Department of Human Services.

Subpart 9. **Direct care.** "Direct care" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the program

Subpart 10. **Family**. "Family" means a person or people committed to the support of the individual receiving services, regardless of whether they are related or live in the same household.

Subpart 11. **Forensic risk assessment**. "Forensic risk assessment" is a specialized assessment conducted by qualified examiners and addresses factors for risk of general and/or sexual violence, identifies risk management strategies, and offers recommendations for treatment teams and supervisory agencies.

Subpart 12. **Functional behavior assessment (FBA)**: "Functional behavior assessment" means an assessment that operationally defines the target behaviors, identifies the situations in which the target behaviors are likely to occur and not occur, and generates a hypothesis of why the behaviors occur.

Subpart 13. **Imminent risk of harm.** "Imminent risk of harm" means a behavior that is likely to cause physical harm to self or others that is highly likely to occur in the immediate future.

Subpart 14. **Individual**. "Individual" means a person who is receiving services from a provider who is licensed in accordance with this variance.

Subpart 15. **Individual treatment plan (ITP).** "Individual treatment plan" or "ITP" means a written plan of mental health treatment services developed based on the assessment of the individual's needs and revised as necessary. The plan specifies goals and objectives and interventions to achieve the objectives as identified by the individual and treatment team. The plan also identifies the staff who are responsible to provide the interventions. Associated plans to the ITP may include Individual Abuse Prevention Plans, Behavior Timelines, Positive Support Plans, Positive Behavioral Support Plans, Individual Support Plans, Behavior Management Plans, and Aftercare/Transition Plans.

Subpart 16. **Level A – Acute**. "Level A – Acute" means a level of care where the primary focus is on mental health stabilization, medication adherence, impulse control, and assessment for harm to self and others as well as for victimization.

Subpart 17. **Level B - Residential Treatment**. "Level B – Residential Treatment" means a level of care where the primary focus is on mental health stabilization, medication adherence, impulse control, coping skills, and social supports.

Subpart 18. **Level C - Transitional Services**. "Level C – Transitional Services" means a level of care where the primary focus is on community reintegration and plans for discharge.

Subpart 19. **Level of care determination**. A "level of care determination" means a clinical assessment process approved by the Commissioner to determine level of service.

Subpart 20. **License**. "License" has the meaning given it in Minnesota Statutes, section 245A.02, subdivision 8.

Subpart 21. **License holder**. "License holder" has the meaning given it in Minnesota Statutes, section 245A.02, subdivision 9.

Subpart 22. **Living unit**. "Living unit" means a set of rooms that are physically self-contained, have the defining walls extending from floor to ceiling and include bedrooms, living rooms or lounge areas, bathrooms, and connecting areas.

Subpart 23. **Manual restraint.** "Manual restraint" means physical intervention intended to hold a person immobile or limit a person's voluntary movement by using body contact as the only source of physical restraint.

Subpart 24. **Mechanical restraint.** "Mechanical restraint" means the use of devices, materials, or equipment attached or adjacent to the person's body that limits a person's voluntary movement or holds a person immobile as an intervention precipitated by a person's behavior. Mechanical restraint does not include the following: devices worn by the person that trigger electronic alarms to warn staff that a person is leaving a room or area, which do not, in and of themselves, restrict freedom of movement; or the use of adaptive aids or equipment or orthotic devices ordered by a health care professional used to treat or manage a medical condition.

Subpart 25. **Mental health practitioner**. "Mental health practitioner" has the meaning given it in Minnesota Statutes, section 245.462, subdivision 17.

Subpart 26. **Mental health professional**. "Mental health professional" has the meaning given it in Minnesota Statutes, section 245.462 subdivision 18, 1 through 6.

Subpart 27. **Minnesota Security Hospital**. "Minnesota Security Hospital (MSH)" means a secure treatment program that provides acute psychiatric care and stabilization and psychosocial rehabilitation and treatment services to persons with mental illness, and services for individuals who present with mental health and safety needs. The program primarily provides services to those committed as Mentally Ill and Dangerous.

Subpart 28. **Monthly**. "Monthly" means at least once every calendar month.

Subpart 29. **Person-centered planning**. Person-centered planning means a strategy used to facilitate team-based plans for improving a person's quality of life as defined by the person, the person's family, and other members of the community, and that focuses on the person's preferences, talents, dreams, and goals.

Subpart 30. **Positive support strategy**. "Positive support strategy" means a strength-based strategy based on an individualized assessment that emphasizes teaching a person productive and self-determined skill or alternative strategies and behaviors without the use of restrictive interventions.

Subpart 31. **Psychiatric practitioner**. "Psychiatric practitioner" means a physician licensed under Minnesota Statutes, chapter 147, who is certified by the American Board of Psychiatry and Neurology or is eligible for

board certification. A psychiatric registered nurse who is licensed under Minnesota Statutes, sections 148.171 to 148.285, and is certified as a clinical nurse specialist or a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization.

Subpart 32. **Recovery**. "Recovery" means a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Subpart 33. **Registered nurse (RN)**. "Registered nurse" or "RN" has the meaning given it in Minnesota Statutes, section 148.171, subdivision 20.

Subpart 34. **Restraint**. "Restraint" means physical or mechanical limiting of the free and normal movement of body or limbs.

Subpart 35. **Seclusion**. "Seclusion" means (i) removing a person involuntarily to a room from which exit is prohibited by a staff person or a mechanism such as a lock, a device, or an object positioned to hold the door closed or otherwise prevent the person from leaving the room; or (ii) otherwise involuntarily removing or separating a person from an area, activity, situation, or social contact with others and blocking or preventing the person's return. For the purpose of this definition, secure programs are not to be determined a form of seclusion.

Subpart 36. **Service delivery plan**. "Service delivery plan" means a plan developed by each discipline that identifies the services provided to individuals by that discipline. The service delivery plan must include assessment, services provided, and timeline requirements.

Subpart 37. **Staff or staff member**. "Staff" or "staff member" means a person who works under the direction of the license holder regardless of their employment status. This includes but is not limited to interns, consultants, individuals who work part-time, and individuals who do not provide direct care services, but does not include volunteers.

Subpart 38. **Transition services**. "Transition services" means a non-secure program that provides psychosocial rehabilitation and treatment services to persons committed as Mentally Ill and Dangerous (MI & D). Significant emphasis is placed upon skill acquisition and demonstration, relapse prevention planning and community health maintenance. To best prepare persons in this program for community placements, the majority of programming is held in other settings on the facility campus, in addition to activities in the community.

Subpart 39. **Treatment team**. "Treatment team" means the individual, staff, family and designated agency as applicable who provide services under this variance to individuals.

Subpart 40. **Volunteer**. "Volunteer" means a person who, under the direction of the license holder, provides services or an activity without pay to an individual served by the license holder.

Subpart 41. **Weekly**. "Weekly" means at least once every calendar week. The license holder must define the calendar week.

MSH.0004. REQUIRED SERVICE COMPONENTS AND DOCUMENTATION.

Subpart 1. **Required services**. The license holder must ensure that all services are delivered by staff who are qualified to provide the service.

A. All services must be delivered under the clinical direction of a mental health professional.

B. All services must be delivered with consideration of cultural influences and the impact of such on the individual. Language interpreter services must be available to ensure all individuals being served have access to needed services.

C. All services must be delivered in accordance with the individual's treatment plan (ITP); with consideration of the individual's cultural influences and the impact of such on the individual.

D. On a daily basis, the license holder must provide necessary services for each individual using individualized treatment interventions based on the individuals' assessed needs. The individualized treatment must promote the individual perspective, and engagement in the service planning and recovery processes.

E. Individuals admitted solely under Court Ordered Rule 20.01 Evaluations require the following:

(1) Initial psychiatric, and health and safety assessments within 24 hours of admission.

(2) Initial social work documentation within 3 business days of admission.

(3) An Initial Treatment Plan completed in accordance to MSH variance Subpart 8, Item A.

(4) An Individual Abuse Prevention Plans in accordance to MSH variance Subpart 6, Item A to D.

(5) The opportunity to participate in treatment.

(6) The license holder must develop a policy identifying services for individuals who have consented to participate in treatment.

Subpart 2. **Assessments**. The license holder must provide the assessments in to each individual. Each assessment must include a clinical summary that must describe recommendations and prioritization of needed mental health or other services.

The license holder must have discipline specific service delivery plans that outline timeframes and specific components that are to be addressed in that discipline's specific assessments.

Level A must include a comprehensive assessment and treatment interventions aimed specifically towards stabilization. Level A must be under the clinical direction of a psychiatric practitioner.

Level B must continue a reduction of risk to self or others as well as for victimization and must be assessed on an ongoing basis. Individuals will engage in psychosocial rehabilitation services, practice new skills in multiple settings including on campus and the greater community. This must involve opportunities for integration activities. Level B must be under the clinical direction of a mental health professional

Level C must continue a reduction of risk to self or others as well as for victimization and must be assessed on an ongoing basis. Level C must be under the clinical direction of a mental health professional.

Subpart 3. **Admission assessments**. The license holder must complete admission assessments for Levels A, B and C as set forth in items A to E.

A. A nursing assessment must be completed within 8 hours of admission. The nursing assessment will include vital signs, behavioral health concerns, review of systems, chemical use, and review of functional status, nutrition needs, pain screening, and suicide risk assessment.

B. A history and physical assessment must be completed within 24 hours of admission. The history and physical must include a history of any past and present illnesses, allergies, medications, family history, assessment of basic health needs and a physical.

C. An initial psychiatric assessment must be completed within 24 hours of admission. The initial psychiatric assessment must address the immediate safety and treatment needs of the individual and serve to develop initial treatment inventions until a comprehensive psychiatric assessment is completed.

D. Initial social work documentation must be completed within 3 business days of admission. The initial social work documentation must gather information from family, significant others, legal system and other parties as applicable to present legal situation, known family and support systems, cultural influences and their impact on the individual and recommendations for treatment.

E. A comprehensive psychiatric assessment must be completed within 7 days of admission. The comprehensive psychiatric assessment must include history of present illness, current medications, past psychiatric history, family history, mental status examination, strengths, needs and vulnerabilities, diagnostic impression, treatment and management plan and summary of risk for harm to self or others.

Subpart 4. **Ongoing Assessments**. Ongoing assessments for Level A, B and C must be completed as provided in this subpart.

A. Annual history and physical assessment, as described as provided in subpart 3, item B.

B. Each discipline that is providing treatment must continuously assess and modify treatment to meet the current clinical needs.

C. Any new clinical need identified by the treatment team must be referred to the appropriate discipline with completion of assessment within 30 days.

D. Ongoing safety assessments must be part of the ongoing psychiatric progress notes and treatment team review.

Subpart 5. **Specialized Assessments**. Specialized assessments must be completed as provided in this subpart.

A. Additional assessments must be completed within 30 days of receiving referral as driven by clinical needs. These assessments include psychological, hearing, occupational, vocational, recreation, and education.

B. Substance abuse screening for the possibility of co-occurring substance use disorder must occur for all individuals within 30 days of admission. For individuals whose screening indicates the possibility a substance use disorder, the license holder must conduct assessment of the individual's substance use from 60 days admission. The assessment must meet the requirements of Minnesota Rules, part 9530.6422, subpart 1, items C to G and items I to O, and must be completed by a person licensed or exempted under Minnesota Statutes, chapter 148F.

C. Functional behavior assessment (FBA) must be completed in accordance to Minnesota Rules, part 9544.0040, subparts 1 through 3 or as clinically indicated by referral from the treatment team when target behaviors are identified. A functional behavior assessment must be conducted by a qualified professional and must consist of direct observation and one or more of the following elements: (i) an assessment of biological factors, such as a medical assessment or a dental assessment; (ii) an assessment of psychological factors, such as a diagnostic assessment or a suicidality assessment; (iii) an assessment of environmental factors, such as direct observation or interviewing a significant individual in the person's life; and (iv) an assessment of quality of life indicators based on the person's goals and needs within each domain of a meaningful life.

D. Neuropsychology evaluation is a formal assessment of cognitive functioning which examines the behavioral and cognitive changes resulting from central nervous system disease, brain injury, or severe mental illness must be completed. These evaluations may assess the following areas: intelligence, executive functions, attention, memory, language, perception, sensorimotor functions, motivation, mood state and emotion, quality of life, and personality styles. The areas addressed in an individual's evaluation must be determined by the referral question, patient's symptoms, and observations made during interview and test administration.

E. Forensic risk assessments may be utilized upon finalization of commitment as a person who is mentally ill and dangerous, when reductions of custody or increases of liberties are being considered, or as needed on a consultation basis. Forensic risk assessments employ actuarial tools, structured professional judgment measures, and other assessment methods as needed.

Subpart 6. **Individual abuse prevention plan (IAPP).** The license holder must develop an individual abuse prevention plan for Level A, B and C as provided in items A to D.

A. The license holder must develop an individual abuse prevention plan (IAPP) within 24 hours of an admission and maintain an IAPP in accordance with Minnesota Statutes, sections 245A.65, subdivision 2, paragraph (b), and 626.557, subdivision 14.

B. The IAPP must identify specific measures to minimize risk of abuse as noted in assessments, referral information, or collateral information when behaviors are exhibited that pose a risk of abuse to self or others.

C. The IAPP must be reviewed and updated, as needed, at each treatment plan review.

D. Each initial or updated IAPP must be dated, signed, and approved as follows:

(1) If the IAPP is completed by a mental health professional and signed, the signature of the mental health professional indicates approval by that individual.

(2) If the IAPP is completed by either a registered nurse or a mental health practitioner under clinical direction, it must be signed by who completed it and it must be approved, within 24 hours of admission, by a mental health professional that provided clinical direction. If the approval is provided verbally, it must be documented. The mental health professional who provided the clinical direction must sign the IAPP by the next clinical review meeting.

(3) For individuals admitted to Level A, the IAPP must be approved by a Psychiatric Practitioner.

(4) For Individuals admitted to Level B or C, the IAPP must be approved by a mental health professional.

Subpart 7. **IAPP requirements upon transfer.** Items A to E set forth IAPP requirements when an individual is transferred to another unit.

A. Within 24 hours of a transfer to another unit the IAPP must be reviewed and revised, as appropriate, by a mental health professional, mental health practitioner with clinical direction, or registered nurse with clinical direction.

B. If the IAPP is revised by a mental health practitioner or registered nurse, it must be approved, within 24 hours of transfer, by the mental health professional who provided clinical direction. If the approval is

provided verbally, it must be documented. The mental health professional who provided the clinical direction must sign the IAPP by the next weekly clinical review meeting.

C. For individuals transferred to Level A, the IAPP must be approved by a Psychiatric Practitioner.

D. For individuals transferred to Level B or C, the IAPP must be approved by a mental health professional.

E. Staff must review the admission or transfer IAPP within two hours of the start of their shift after approved by the mental health professional. Any updated IAPP from on-going treatment plan reviews must be reviewed by staff at the next clinical review meeting.

Subpart 8. **Treatment planning.** This subpart sets forth requirements for treatment plans.

A. The initial treatment plan for Level A, B and C must be completed as set forth in subitems (1) to (8).

(1) An initial treatment plan must be completed within 24 hours of the individual's admission to the facility. The initial treatment plan may be expanded to meet the requirements of the individual treatment plan (ITP).

(2) The initial treatment plan must be based on the individual's intake information and assessment of immediate needs, including consideration of strategies that have proven effective in the past. The treatment plans must be completed using person-centered planning, including taking into consideration what is important for and to the person as they move through recovery.

(3) The initial treatment plan must include initial treatment objectives and interventions for the services to be provided.

(4) The initial treatment plan must be completed and signed within 24 hours of admission. It must be completed by: (i) a mental health professional; (ii) a mental health practitioner with clinical direction; or (iii) a registered nurse with clinical direction.

(5) If the initial treatment plan is completed by a mental health practitioner or registered nurse, it must be approved, within 24 hours of admission, by the mental health professional who provided clinical direction. If the approval is provided verbally, it must be documented. The mental health professional who provided the clinical direction must sign the initial treatment plan by the next weekly clinical review meeting.

(6) For individuals admitted at Level A, the initial treatment plan must be approved by a Psychiatric Practitioner;

(7) For individuals admitted at Level B or C, the initial treatment plan must be approved by a mental health professional.

(8) Staff must review the initial ITP within two hours of the start of their shift after approval by the mental health professional until the next clinical review meeting.

B. The individual treatment plan for Level A, B and C must be completed as set forth in subitems (1) to (5).

(1) Within 30 days of admission, the initial treatment plan must be reviewed and updated to an individual treatment plan (ITP) based on the completed assessments.

(2) The ITP must be updated as needed and at minimum per the following schedule after the initial 30 days:
(i) Level A: minimally every 60 days;
(ii) Level B: minimally every 90 days; and
(iii) Level C: minimally every 90 days.

(3) An assessment must be completed as part of the treatment planning process to determine risk, need and prioritization of treatment. Areas assessed and prioritized must include, but are not limited to: relationships, social skills, occupational, recreational, self-care, mental health, substance abuse, medication management and physical health needs.

(4) Treatment planning must include the individual and must be focused on the individual's recovery, their strengths, health and safety as defined by Person Centered Principles. The treatment planning must also include participation by the case manager and input from the individual's family as permitted by the individual.

(5) The ITP must include:
(i) the recovery goal or goals identified by the individual;
(ii) a minimum of one discharge goal that identifies the individual's needs required to successfully transition to a more integrated setting;
(iii) objectives related to the identified goals, and written in observable and measurable terms;
(iv) interventions that will be provided by staff;
(v) identification of the staff who are responsible to deliver the interventions and frequency of the interventions;
(vi) identification of referrals and resources needed to assure the individual's health and safety needs are met and the staff who are responsible to assure that appropriate follow-up occurs. If an individual does not receive a needed service, the license holder must document the reason and determine whether additional follow-up is required;
(vii) a review of all supporting documents;
(viii) the date it was completed or updated; and
(ix) the individual's signature to acknowledge his or her participation in development or the revisions of their ITP. If the individual refuses to participate in the development of their ITP or subsequent revisions, or disagrees with the proposed ITP, the disagreement or refusal to participate must be documented in the individual's file. In this circumstance, the interventions that were used to engage the individual in the development or revision of his/her ITP must also be documented in the individual's file.

C. The ITP and any subsequent updates must be dated, signed, and approved as follows:

(1) If the ITP is completed by a mental health professional and signed, the signature of the mental health professional indicates approval by that individual.

(2) If the ITP is completed by a mental health practitioner, registered nurse or behavioral analyst under clinical direction, it must be signed by the author and it must be approved, within 24 hours of the treatment plan being completed, by a mental health professional that provided clinical direction. If the approval is provided verbally, it must be documented.

The mental health professional who provided the clinical direction must sign the individual treatment plan by the next clinical review meeting.

(3) The ITP and any on-going revisions to the ITP must be reviewed at the next clinical review meeting.

D. Subitems (1) to (5) set forth individual treatment plan requirements when an individual is transferred to another unit.

(1) Within 24 hours of a transfer to another unit, the ITP must be reviewed and revised, as appropriate, by a:
(i) mental health professional, or
(ii) a mental health practitioner with clinical direction, or
(iii) registered nurse with clinical direction.

(2) If the ITP is revised by a mental health practitioner or registered nurse, it must be approved, within 24 hours of transfer, by the mental health professional who provided clinical direction. If the approval is provided verbally, it must be documented. The mental health professional who provided the clinical direction must sign the treatment plan by the next weekly clinical review meeting.

(3) For individuals transferred to Level A, the ITP must be approved by a Psychiatric Practitioner.

(4) For, individuals transferred to Level B or C, the ITP must be approved by a mental health professional.

(5) Staff must review the ITP within two hours of the start of their shift after approval by the mental health professional, until the next clinical review meeting.

Subpart 9. **Level of Care Determination.** The license holder must have a written process to determine the placement of individuals within the appropriate level of care based on their individual needs and assessment information.

A. Minnesota Security Hospital (MSH) and Transition Services (TS) must comply with subitems (1) and (2).

(1) Must assess levels of care to determine appropriate levels of services within the program.

(2) Assessment must be completed at minimum per the following schedule after the initial 30 days:
(i) Level A: minimally every 60 days
(ii) Level B: minimally every 90 days
(iii) Level C: minimally every 90 days.

B. Competency Restoration Program must comply with subitems (1) to (3).

(1) CRP must assess levels of care to determine appropriate levels of services within the program.

(2) The program must focus on comprehensive competency treatment and evaluation.

(3) The assessment must be completed within 5 days of admission and monthly thereafter.

MSH.0005. CLINICAL REVIEW AND RESPONSIBILITIES.

Subpart 1. **Access to a psychiatric practitioner or mental health professional.** The license holder must have the capacity to promptly and appropriately respond to emergent needs of the individuals and make any necessary staffing adjustments to assure the health and safety of individuals. Within 30 minutes staff must have direct access in person or by telephone to a psychiatric practitioner for service level A and a mental health professional for level B and C. The schedule of on-call psychiatric practitioners and mental health professionals must be current and readily available to staff.

Subpart 2. **Clinical review meetings.** The license holder must assure that staff on all shifts exchange information necessary to carry out the individuals' ITP and IAPP utilizing person-centered strategies, respond to the individuals' recovery goals, and inform updates and revisions to the individual's ITP and IAPP.

A. The mental health professional must hold at least one clinical team meeting weekly, as defined by the license holder, and be physically present at the meeting. All staff members who will be providing direct contact with an individual within the identified calendar week must participate in a minimum of one clinical meeting during every calendar week they work. This includes part-time staff and staff who work on an intermittent basis. The license holder must maintain documentation of the weekly meetings, including the names of staff who attended. MSH and CRP programs must review each individual weekly. Transition Services program must review each individual as needed, minimally once every 30 days.

B. Staff who do not participate in the weekly clinical meeting must participate in an ancillary meeting during each week in which they work. During the ancillary meeting, the information that was shared at the most recent weekly team meeting must be verbally reviewed, including revisions to the individuals' ITP, IAPP and other information that was exchanged. The ancillary meeting may be conducted by the mental health professional or a mental health practitioner that participated in the weekly meeting or a mental health practitioner that participated in the ancillary meeting. The license holder may have a primary mental health practitioner that attended the weekly clinical review meeting conduct an ancillary meeting to another secondary mental health practitioner who did not attend the weekly clinical review meeting. The secondary mental health practitioner may then provide additional ancillary meetings on their assigned unit, allowing units to provide timely information to all staff on that unit. The license holder must maintain documentation of the ancillary meetings, including the names of staff who attended.

C. Staff members that provide coverage on a unit other than their primary unit must read and sign off on the clinical review meeting minutes for the unit that they provide coverage. Centralized department staff must read and sign off on the clinical review meeting minutes on the individuals they provide services.

D. A mental health practitioner who conducts an ancillary meeting must have been assessed and documented to be competent noted in the personal file.

Subpart 3. **Clinical review and plan.** The license holder must have a written plan describing how clinical review meetings requirements will be met. The license holder must maintain the names and qualifications of mental health professionals who may provide clinical direction at the program.

Subpart 4. **Individual Treatment plan and individual abuse prevention plan reviews.** The ITP and IAPP must be reviewed during the clinical review meeting. Any needed updates to the ITP and/or IAPP must be documented in the individual's medical record. Revisions to the IAPP must be made in accordance with Minnesota Statutes, section 245A.65, subdivision 2, paragraph (b), clause (2).

Treatment Planning Development and Review Timetable					
	Initial Treatment Plan and IAPP	ITP	Ongoing ITP Review and Update	Review of ITP and IAPP upon transfer	Clinical Review
Level A	24 hours	30 days	60 days	24 hours	Weekly
Level B	24 hours	30 days	90 days	24 hours	Weekly
Level C	24 hours	30 days	90 days	24 hours	Monthly

MSH.0006. RECOVERY AND SUPPORT SERVICES

Subpart 1. **Person centered, trauma informed treatment**. Treatment delivered must be person centered, trauma informed with an understanding of illness management and recovery. It must include wellness self-management, co-occurring substance use disorder treatment, physical health, sexual disorders and intellectual cognitive deficits along with diagnosed mental illnesses.

Subpart 2. **Unit requirement.** Each unit must identify levels of care, have a program description, and define the best practices/evidence based practices utilized.

Subpart 3. **License holder requirements governing services**. License holder must:

A. Offer services based on the individual's needs and as indicated in the individual's ITP.

B. Include a detailed description of groups and treatment modalities, staff training requirements, and staff qualifications needed to carry out services in the discipline specific service delivery plans and program or unit description plans.

C. Document the type of treatment and hours received monthly as indicated per the individualized treatment plan.

Subpart 4. **Available services**. The following services must be available, and must be tailored to the individual's specific recovery needs:

(1) Court ordered evaluations
(2) Competency Restoration Services
(3) Dental Care
(4) Group Therapy
(5) Individual Therapy
(6) Occupational Therapy
(7) Peer Support Services
(8) Psychiatric Care
(9) Physical Health Care
(10) Psychoeducational
(11) Physical Therapy
(12) Recreational Therapy
(13) Spiritual Care
(14) Transition/Discharge planning
(15) Treatment for Sexual Disorders
(16) Treatment of co-occurring substance use disorders
(17) Vocational Services

Subpart 5. **Available Specialty Services.** The license holder must offer a variety of specialized and centralized services as set forth under subparts 6 to12 based on individual treatment needs and initiated by team referrals or physician orders. The license holder must meet best practice standards in that specialty area and specialty services must be delivered by staff who have received adequate training in the provision of the service.

Subpart 6. **Substance use disorder treatment.** The license holder must provide co-occurring substance use disorder treatment, assessment, counseling, and support groups for individuals with identified substance use disorders using the principles of integrated dual disorder treatment. Services must be provided by a person licensed or exempted under Minnesota Statutes, chapter 148F. Treatment recommendations must consider the individual stage of treatment, motivation for change, and strengths; and the symptoms and behaviors related to both disorders. Stage wise group and individual services must meet the needs of individuals with co-occurring substance use disorders.

Subpart 7. **Education services.** The license holder must provide educational opportunities upon assessment of the individual and prioritization of clinical and recovery needs which may include: English language learners, adult basic education, high school equivalency, high school diploma, enrichment classes, and assistance with treatment assignments. Special education teachers must work closely with the multidisciplinary team process, and must be involved in administering assessment tools, develop curriculum, provide feedback to the treatment teams, and assess progress.

Subpart 8. **Interpretive services.** The license holder must provide for effective communication between individuals who are deaf, hard of hearing, deaf-blind, or individuals with limited English proficiency. License holder must provide appropriate access in a timely manner to interpreting services, auxiliary aid services and devices, and appropriate sign language when those services are needed.

Subpart 9. **Occupational therapy.** The license holder must provide occupational therapy that assesses the physical, psychological and social functioning of the individual, identifies areas of functioning, and develops interventions aimed to assist individuals in reaching the maximum level of functioning and independence in all areas of life. The areas assessed and implemented may include, but are not limited to: activities of daily living, sensory integration, functional cognitive assessment, functional mobility assessment, environmental modifications, social participation, and rest and sleep.

Subpart 10. **Physical therapy.** The license holder must provide physical therapy, with the purposes of restoring, maintaining and promoting optimal physical health. The scope of physical therapy practice includes examination, evaluation, diagnosis, intervention and assessment of outcomes. All physical therapy services must be initiated by a physician's order. The areas and services implemented may include, but are not limited to, preventative exercise of the body, post-injury or post-surgical supportive therapies and maintenance therapies.

Subpart 11. **Speech therapy.** The license holder must provide a speech pathology clinician, who is responsible for all aspects of speech pathology service delivery including speech, language, hearing, and dysphagia services. A speech pathology clinician must conduct assessments, diagnose, and provide specialized treatment of communication and swallowing disorders.

Subpart 12. **Vocational Services.** The license holder must provide individuals with opportunities to increase vocational skills.

Subpart 13. **Documentation of treatment services.** Individuals receiving services must be seen as often as necessary based on the individuals' clinical presentation and needs. Staff members must document treatment services and observations according to the following table.

Discipline	**New Admissions (first 8 weeks)**	**Level A**	**Level B**	**Level C**
Direct Care Staff	Daily	Daily	Weekly	Weekly
RN	Weekly	Monthly	Monthly	Monthly

Psychiatric Practitioner	Weekly	Monthly	Minimally every 90 days	Minimally every 90 days
Social Worker	Weekly	Monthly	Monthly	Monthly
Other staff listed on treatment plan	Weekly	Monthly	Monthly	Monthly

Subpart 14. **Other information pertinent to providing services**. The license holder must document in the individual's file any information pertinent to providing services to the individual, if it is not otherwise documented as part of the ITP interventions. This includes but is not limited to:
(1) Case coordination activities;
(2) Medical and other appointments;
(3) Critical incidents; and,
(4) Issues related to medications that are not otherwise documented in the individual's file.

MSH.0007. HEALTH SERVICES

Subpart 1. **Monitoring health needs.** The license holder must provide a system for on-going monitoring that addresses the health needs of individuals, any special needs of the individual population served by the program, and the needs of individuals with co-occurring disorders.

Subpart 2. **Medical and health documentation**. The license holder must maintain medical and health documentation that is accurate, thorough, and maintained appropriately. The documentation must include recording significant medical or health related information, including but not limited to results of assessments of medication benefits, side effects and if applicable individuals ability to self-administer medications.

Subpart 3. **Referrals and coordination.** The license holder must provide referrals to and coordination with psychiatric and medical services must occur in a timely manner.

Subpart 4. **Guidelines for informing registered nurse of health concerns**. The license holder must provide guidelines to staff when to inform the registered nurse of individuals' health concerns and in what circumstances and how to attain medical care for individuals.

Subpart 5. **Ongoing consultation and education to staff**. The license holder must provide ongoing consultation and education to staff concerning the health and medical care of individuals.

Subpart 6. **Medication administration**. The license holder must ensure that medications are administered safely and accurately. This includes establishing methods for:

A. When and how staff are to inform the registered nurse or physician of problems or issues with individuals' administration of medications, including the failure to administer, refusal of medication, adverse reactions to medications and errors in administering medications.

B. Training staff who are responsible for administering medications, including unlicensed staff. When an employee, other than a medically licensed person, is responsible for medication administration, the employee must provide a certificate verifying successful completion of a trained medication program for unlicensed personnel. The program must be offered through a postsecondary institution or the medication administration must be trained according to a formalized training program offered by the license holder that must be taught and supervised by a medically licensed person(s) competent to provide medication administration

education. The specific medication administration training provided by a medically licensed person to unlicensed personnel must be documented and placed in the unlicensed employee's personnel records, and an evaluation of medication administration competency must be re-evaluated at least annually.

C. Routinely assessing individuals for medication side effects and drug interactions.

Subpart 7. **Individual self-administration of medications.** When applicable, the license holder must assess each individual's readiness to self-administer medication; monitoring individual's compliance with prescribed medication regimes; assuring that medications are stored safely and in a manner that protects the other individuals in the program; and, assisting the individual to develop the skills necessary to safely administer his or her own medications.

Subpart 8. **Provisions for control drugs.** The license holder must have in place and implement written policies that include the following:

A. A requirement that all drugs must be stored in a locked compartment. Schedule II drugs, as defined by Minnesota Statutes, section 152.02, must be stored in a separately locked compartment, permanently affixed to the physical plant or medication cart;

B. A system which accounts for all scheduled drugs each shift;

C. A procedure for recording the client's use of medication, including the signature of the administrator of the medication with the time and date;

D. A procedure for destruction of discontinued, outdated, or deteriorated medications;

E. A statement that only authorized personnel are permitted to have access to the keys to the locked drug compartments; and

F. A statement that no legend drug supply for one client will be given to another client.

MSH.0008. BEHAVIORAL EMERGENCY POLICIES

Subpart 1. **Understanding behaviors.** The license holder must have written policies that staff must follow when responding to an individual who exhibits behavior that presents an imminent risk of harm to self or others and when less restrictive interventions have been ineffective to prevent the individual or others from harm. Any revisions to policies require approval from DHS Licensing Division.

Subpart 2. **Philosophy on use of restraint and seclusion.** At a minimum, policies on restraint and seclusion must address the following philosophy:

(1) Commit to reduce and strive to eliminate the need for restraint and seclusion;
(2) Prevent of emergencies that have the potential to lead to the use of restraint or seclusion;
(3) Nonphysical interventions as preferred interventions;
(4) Limit the use of restraint and seclusion to emergencies in which there is an imminent risk of harm to self or others;
(5) Facilitate the discontinuation of restraint or seclusion as soon as possible;
(6) Raise awareness among staff about how restraint or seclusion may be experienced by the individual served;
(7) Preserve the safety and dignity of the individual served when restraint or seclusion is used;

(8) Behavior emergency procedures must not be used to enforce facility rules or for the convenience of staff;

(9) Address the Positive Support Strategies, as required in Minnesota Rules, chapter 9544.

Subpart 3. **Standards for the use of restraint or seclusion.** Level A, B and C services may use one or more of the following restrictive procedures except as prohibited on individuals who fall within the scope of Minnesota Rules, chapter 9544 (Positive Support Rule):

(1) Manual restraints,
(2) Mechanical restraints; and
(3) Seclusion

Restraint and seclusion may only be used when there is an imminent risk of harm to the individual served or others and when less restrictive interventions have been ineffective to prevent the individual or others from harm. The license holder must follow necessary requirements identified in Minnesota Rules, chapter 9544, when serving individuals with developmental disabilities and related conditions. The license holder must have an active treatment milieu/program that promotes engagement and best practice techniques so as to minimize use of restraint and seclusion. If restraint or seclusion are used, they must be carefully monitored by qualified staff and be well documented. At a minimum on a monthly basis, data on these procedures must be collected on an individual and unit basis, analyzed, and used by leadership to reduce their usage as much as possible.

The emergency use of restraint or seclusion must meet the conditions of subitems (1) to (15):

(1) For individuals that display behaviors that may require the use of restraint or seclusion, an individual support plan is developed. The support plan will be developed with the individual's involvement that identifies target behaviors, triggers, coping skills, precursors and a plan to assist the individual during crisis.
(2) An immediate intervention is necessary to protect an individual from imminent risk of harm to self or others, and less restrictive interventions have been ineffective to prevent the individual or others from harm;
(3) The minimum amount of intervention will be utilized for the shortest period of time to meet safety concerns;
(4) Before staff uses restraint or seclusion on any individual, staff must complete the training required regarding the use of restraint and seclusion at the facility, to include the different types of mechanical restraint used;
(5) The Medical Practitioner must document any medical or physical contraindications for the use of restraint or seclusion with the individual.
(6) Staff may initiate the use of manual restraint when necessary to protect the individual or others from imminent risk of harm until restraint and seclusion are assessed and authorized by an RN or psychiatric practitioner;
(7) When the RN assesses and authorizes the initial use of restraint or seclusion, they must contact the Psychiatric Practitioner to obtain an order for the use of restraint or seclusion as soon as it may safely be done, but no later than 60 minutes after the initiation of the restraint or seclusion;
(8) Consideration of individual dignity and privacy must be of highest priority;
(9) At the initiation of the restraint or seclusion, the individual must be informed of the reason for the restraint or seclusion and provided with the release criteria to discontinue the intervention;
(10) The use of restraint or seclusion must end when the imminent risk of harm to self or other ends;
(11) The individual must be observed at all times.
(12) The staff persons who implemented the use of restraint and seclusion must document its use immediately after the intervention.
(13) The room used for seclusion must be well lighted, well ventilated, clean, have an observation window which allows staff to directly monitor an individual in seclusion, fixtures that are tamper resistant.

(14) Objects that may be used by an individual to injure self or others must be removed from the individual and seclusion room before the individual is placed in seclusion.

(15) The individual shall be offered access to items which may assist them to regain control, provided that such access does not endanger self or others. All individual requests for items must be documented. If such requests are denied, the justification for the denial must be documented.

Subpart 4. **Debriefing following use of restraint or seclusion.** The license holder must conduct a debriefing within 48 hours on all uses of restraint or seclusion as provided in this subpart.

A. If the individual chooses to participate in the debriefing, the license holder must conduct a debriefing with the individual on the use of restraint or seclusion. The debriefing must include the following: (i) meeting with the individual; (ii) identifying what led to the incident; (iii) addressing what could have been handled differently by the individual and staff; and (iv) the staff and make making recommendations to modify the individual's treatment plan as needed.

B. If the individual chooses to not participate in the debriefing, the following must occur: (i) a staff person who is able to engage with the individual must attempt to meet with the individual; (ii) the staff must share the information received from the individual with the treatment team; (iii) if the treatment team assesses the debriefing process will be counter-therapeutic this must be documented; and (iv) any treatment changes must be brought back to the individual.

Subpart 5. Documentation of use of restraint or seclusion. The license holder must document all uses of restraint or seclusion. The documentation must include:

(1) Each type of intervention utilized;

(2) Prior events that may have been a contributing factor to the incident;

(3) Less restrictive interventions attempted;

(4) The imminent risk of harm to self and others displayed that required the individual to be restrained or secluded;

(5) How the individual was manually restrained;

(6) Initial assessment by the RN and ongoing 15 minute assessment;

(7) Psychiatric Practitioner order for each type of intervention utilized that are time-limited and include the release criteria and observation level; and

(8) The debriefing.

Subpart 6. **Review of restraint and seclusion use.** The license holder must conduct a review of restraint and seclusion uses. A review of the documentation must be completed by a supervisor within 7 days of the release of the restraint or seclusion. Information from the review will be utilized to provide guidance to staff in ensuring complete and accurate documentation of restraint and seclusion.

Subpart 7. **Restraint and Seclusion Committee.** The license holder must have a Restraint and Seclusion Committee that must provide oversight for the restraint and seclusion processes.

A. The Restraint and Seclusion Committee must have a charter that defines the scope and membership of the committee's responsibility that includes the following:

(1) Use of restraint and seclusion;

(2) Policies and procedures;

(3) Training; and

(4) Documentation.

B. The committee must collect and analyze the data from the use of restraint and seclusion on a monthly basis. The data must be used by leadership to help drive the reduction in the use as much as possible.

C. Monthly meetings must be documented with minutes, action steps and assignment of specific members responsible for implementing each proposed action.

D. Data collection and review to reduce the use of restraint and seclusion must consider the following:

(1) Any patterns or problems indicated by similarities in the time of day, day of the week, duration of the use of a procedure, individuals involved, or other factors associated with the use of restraint and seclusion procedures;
(2) Any injuries resulting from the use of restraint and seclusion procedures;
(3) Actions needed to correct deficiencies in the implementation of restraint and seclusion;
(4) An assessment of opportunities missed to avoid the use of restraint and seclusion; and
(5) Proposed actions to be taken to minimize the use of restraint and seclusion.

E. The Restraint and Seclusion Committee, within input from Leadership, must do the following:

(1) Define restraint and seclusion events that meet outlier criteria and parameters for seeking consultation as identified in subitem E 4.
(2) Identify individuals with high use of restraint and seclusion as outliers:
(3) Complete an audit of the individuals that meet the outlier criteria.
(4) Provide a list of individuals that meet the outlier criteria to designated clinical expertise consultant to complete individual reviews. The consultation must include a review of the individual treatment plan and supporting documents and recommendations as applicable. The license holder must document outcome of the recommendations.

MSH.0009. USE OF RESTRAINTS FOR TRANSPORT FOR OUTSIDE THE SECURE PERIMETER FOR PUBLIC SAFETY

Subpart 1. **Use of restraint during transport.** Use of Restraints for Transport for Outside the Secure Perimeter for Public Safety is approved only for Level A and B.

A. MSH's purpose is to provide a secure treatment facility as defined in Minnesota Statutes, section 253B.02, subdivision 18a. There are times when an individual may need to be transported outside the secure perimeter for emergency or routine care that the individual has been identified as a risk to public safety. To reduce the risk to the public, the individual may be placed in restraint pursuant to Minnesota Statutes, section 253B.03.

B. The license holder must have written policies that staff must follow when it is necessary to transport an individual outside the secure perimeter. Restraints may only be used when it has been determined the individual presents a risk to the public. The policy must include criteria for approval, continuation and discontinuation of the use of restraint. Any revisions to policies require approval from DHS Licensing Division.

C. To determine each individual's risk to the public, an assessment shall be completed upon admission. The assessment will include the individual's legal status, i.e., mentally ill and dangerous, any Department of Corrections requirements, pending legal charges, and elevated risk of elopement. If the treatment team determines that the individual presents a risk to the community, a request shall be made to the Executive Director or Medical Director/designee for approval to use restraints outside the secure perimeter. The decision of the Executive Director or Medical Director/designee will be documented in the individual's medical record. The continued need for the use of restraints outside the secure perimeter shall be reviewed at least quarterly and a new request must be resubmitted annually.

D. Each time an individual requires the use of restraints when transported outside the secure perimeter, staff must document this information in the individual's medical record. The documentation will include the reason why the individual needed to leave the secure perimeter, type of restraint used, and the length of time the individual was in the restraint.

E. The use of restraints for transport outside the secure perimeter is discontinued when the individual has been assessed that restraints are no longer needed. The treatment team submits a request to discontinue the use of restraints for transport outside the secure perimeter to the Forensic Executive Director or Forensic Medical Director/designee for approval. The Forensic Executive Director or Forensic Medical Director/designee will approve the discontinuation of the use of restraints. A completed form must be placed in the individual's medical record.

MSH.0010. ADMISSION AND DISCHARGE REQUIREMENTS.

Subpart 1. **Admissions criteria.** The license holder must develop and maintain admission criteria for each level. The license holder must identify what information the license holder requires to make a determination concerning an admission referral.

Subpart 2. **Discharge Criteria**. In all levels of care, legal action may mandate discharge from all programs. The license holder must remain in compliance with all court orders regardless of other indicators of discharge readiness. Discharge planning must be assessed within the first 30 days of admission. All discharge planning that occurs throughout an individual's care must reflect best practices, and comply with the Olmstead plan and person-centered practices.

Subpart 3. **Clinical readiness for discharge**. The following description outlines the criteria used to determine clinical readiness for discharge from the facility.

A. Criteria to be used to determine clinical readiness for discharge from the facility for Level A.

(1) The level of care assessment must assess the primary areas monitored under acute care.

(2) Prioritized focus for this level of care is on mental health stabilization, medication adherence, impulse control, and assessment for harm to self and others as well as for victimization.

(3) The processes of clinical review, interdisciplinary treatment planning, and ongoing assessments by mental health professionals must drive the process by which transfer or discharge from Level A occurs.

(4) Discharge from Level A must be individualized based upon the individual's strengths, needs, and wishes and continued reduction of risk to self or others as well as for victimization.

B. Criteria to be used to determine clinical readiness for discharge from the facility for Level B.

(1) The level of care assessment must address the primary areas monitored under residential care. Prioritized focus for this level of care is on mental health stabilization, medication adherence, impulse control, coping skills, and social supports. A continued reduction of risk to self or others as well as for victimization.

(2) The processes of clinical review, interdisciplinary treatment planning, and ongoing assessments by mental health professionals must drive the process by which transfer or discharge from Level B occurs.

(3) Discharge from Level B must be individualized based upon the individual's strengths, needs, and wishes and continued reduction of risk to self or others as well as for victimization.

(4) Discharge may mean transition to Level C or on Provisional or Full Discharge with approval from regulatory bodies.

C. Criteria to be used to determine clinical readiness for discharge from the facility for Level C.

(1) The level of care assessment must address the primary areas monitored under Transitional Services. Prioritized focus for this level of care is on community reintegration and plans for discharge. A continued reduction of risk to self or others as well as for victimization will be assessed on an ongoing basis throughout.

(2) The processes of clinical review, interdisciplinary treatment planning, and ongoing assessments by mental health professionals must drive the process by which transfer or discharge from Level C occurs.

(3) Discharge from Level C will be individualized based upon the individual's strengths, needs, and wishes and continued reduction of risk to self or others as well as for victimization.

Subpart 4. **Competency Restoration Program.** Following the court's decision, the License Holder proceeds with transition planning.

Subpart 5. **Provisional or direct discharge**. Discharge may include Provisional or Direct Discharge at all levels with approval from regulatory bodies.

Subpart 6. **Discharge process**. The license holder must coordinate discharge planning with the individual, the individual's attorney, the individual's case manager, the individual's legal guardian (if applicable), and the individual's family as permitted by the individual. Discharge requirements must include a discharge summary completed by a psychiatric practitioner for all discharges and an aftercare plan for discharge to a community provider.

A. The psychiatric practitioner must complete a discharge summary within 5 days of discharge. The discharge summary must include reason for hospitalization, hospital course, the individual's response to treatment, medications and final diagnosis.

B. When an individual is discharged to a community setting, the transition plan, informed by the individual's perspective, must be completed by the social worker and RN upon discharge. The transition plan must be provided to the people and providers who will be subsequently providing services or supports to the individual in the community. The transition plan must include recommended actions or supports to assist the individual with successful transition, including target dates for completion and identifying the people or agencies who are responsible to work with the individual after discharge.

C. When an individual is discharged, information and coordination must occur with the receiving organization. The information must include the individual's current needs, including on-going medical concerns, medications, summary of current status and follow-up appointments.

MSH.0011. INDIVIDUAL RIGHTS AND PROGRAM ORIENTATION.

Subpart 1. **Compliance with health care bill of rights**. The license holder must comply with the health care bill of rights, Minnesota Statutes, section 144.651, Minnesota Statutes, section 253B.03, and Minnesota Rules, part 9520.0630, subpart 5 (resident compensation); subpart 6 (physician appointments); and subpart 7 (photographs of residents). The license holder must provide a copy of the health care bills of rights to the individual upon

admission and post a copy of the bill of rights in each unit. The individual must be oriented to the unit upon admission and transfer to another unit. Additional required rights and notices will be provided to all individuals who meet applicability to Minnesota Rules, chapter 9544, Positive Supports Rule.

Subpart 2. **Restricted rights**. An individual right may be restricted by a Psychiatric Practitioner order, court order or a behavior management plan. The license holder must have policies that direct the process for developing and implementing behavior management plans.

Subpart 3. **Grievance policy**. The license holder must have a grievance policy for individual's being served that must include:

A. The requirement of notification to individuals that a grievance policy exists and must be included in the orientation to MSH.

B. The grievance policy must set forth the different levels of resolution to a grievance and the timeframe for each level. Each level must be resolved within 10 days.

C. The response to the grievant must be in writing at each level of the grievance process, with a copy given to the grievant. The grievant must be given the opportunity to respond in writing, and the opportunity to appeal the decision to the next level if the grievance is not resolved.

D. If the grievance is not resolved at a prior level, the final level must be a formal meeting with the license holder's Executive Director, Program Director or Medical Director. The results of the formal meeting must also be provided in writing to the individual.

E. The grievant may request a representative be present during the formal meeting.

Subpart 4. **Review board meetings and appearance before review board, reports**. The license holder must inform individuals that Minnesota Statutes, section 253B.22 (Review Boards) provides for the following:

A. An opportunity for the individual to appear in front of the Review Board upon written request; and

B. An opportunity for the individual to provide reports to the Review Board. The license holder must post on each unit a notice prior to each Review Board meeting that gives the date and the process the individual shall use to arrange a meeting with the Review Board.

MSH.0012. INDIVIDUAL FILE DOCUMENTATION AND DATA PRIVACY.

Subpart 1. **Data practices.** The license holder must comply with all Minnesota Government Data Practices Act, Minnesota Health Care Provider requirements, and the Health Insurance Portability and Accountability Act (HIPAA). In addition, the license holder must also comply with Minnesota Statutes, section 144.294, subdivision 3, concerning release of mental health records. The license holder's use of electronic record keeping or electronic signatures does not alter the license holder's obligations to comply with applicable state and federal laws and regulations.

Subpart. 2. **Documentation requirements – individual's files**. Documentation in the individuals' file must:

(1) Be typed or legible if hand written;
(2) Identify the individual on each page;
(3) Identify the date of service;
(4) Be signed and dated by the staff person completing the documentation, including the person's title;
(5) Identify who provided the intervention.

MSH.0013. QUALITY ASSURANCE AND IMPROVEMENT.

Subpart 1. **Quality assurance and improvement plan.** The license holder must develop a written quality assurance and improvement plan that at a minimum includes the requirements of in items A to D. The plan must also include processes to review the data or information related to each of the requirements in items A to D every three months, and review and revise annually as necessary. The quality assurance plan must:

A. Measure individual outcomes, including:
(1) Evaluating the outcome data to identify ways to improve the effectiveness of services provided to individuals and improve individual outcomes; and
(2) Attaining and evaluating feedback from individuals, family members, staff, and referring agencies concerning services provided.

B. Review of sentinel events and other significant incidents identified by the license holder including:

(1) Determining whether policies and procedures were followed;
(2) Assessing what could have prevented the significant incidents from occurring; and
(3) Modifying policies, procedures, training plans, or individual's ITPs in response to the findings of the review.

C. Self- monitor of compliance, including:
(1) Evaluating compliance with the requirements of this variance; and
(2) Demonstrating action to improve the program's compliance with the requirements.

D. Review of restraint and seclusion data refer to MSH .0008 subpart 7.

Subpart 2. **Evaluate and Update the Quality Plan.** The quality assurance and improvement plan shall be reviewed, evaluated, and updated at least annually by the leadership team. The review shall include documentation of the actions the license holder took in the past year as a result of the recommendations issued from the quality assurance plan and establish goals for improved service delivery for the next year.

MSH.0014. STAFF MANAGEMENT.

Subpart 1. **Job descriptions.** The license holder must have job descriptions for each position specifying the staff person's responsibilities, degree of authority to execute job responsibilities, and required qualifications.

Subpart 2. **Job evaluation.** The license holder must have a process to conduct work performance evaluations of all staff on a regular basis that includes a written annual review. The program must maintain documentation of these reviews.

Subpart 3. **Good faith communication.** The license holder must not adversely affect a staff member's retention, promotion, job assignment, or pay related to good faith communication between a staff member and the department, the Department of Health, the Ombudsman for Mental Health and Developmental Disabilities, the Minnesota Disability Law Center, law enforcement, or local agencies for the investigation of complaints regarding an individual's rights, health, or safety. For purposes of this requirement, the scope of the department's jurisdiction is solely related to the policy and procedure requirements provided in this part and not related to issues concerning labor and management or disputes between staff and the license holder.

Subpart 4. **Staff files.** The license holder must maintain organized records for each staff member that at a minimum include:

(1) An application for employment or a resume;
(2) Verification of the staff member's qualifications specific to the position including required credentials and other training or qualifications necessary to carry out their assigned job duties;
(3) Documentation required under chapter 245C concerning background studies;
(4) The date of hire;
(5) The date that specific job duties and responsibilities are effective, including the date the staff has direct individual contact;
(6) Documentation of orientation;
(7) An annual job performance evaluation;
(8) An annual development and training plan; and,
(9) Records of training and education activities that were completed during employment.

Subpart 5. **Organizational chart.** The license holder shall maintain a current organizational chart that is available upon request to staff, individuals, and the public. The organizational chart must clearly identify the lines of authority.

Subpart 6. **Volunteers.** If the license holder utilizes volunteers, the license holder must:
(1) Not permit volunteers to provide treatment services.
(2) Not regard volunteers as staff for the purpose of meeting licensing requirements for staffing or service delivery.
(3) Develop job descriptions for volunteers. When volunteers are approved to have contact, the scope of that contact must be identified in the job description.
(4) Provide orientation and training for volunteers.

Subpart 7. **Student Trainees.** If the license holder utilizes student trainees, the license holder must provide notification when student trainees provide treatment services. The treatment services must be overseen by mental health practitioner/professional.

MSH.0015. ORIENTATION AND TRAINING.

Subpart 1. **Program plan for staff orientation and training.** The license holder must develop a plan to assure that staff receives orientation and training. The plan must include the requirements under items A through D.

A. A formal process to provide orientation to all staff at the time of hire that includes topics to be covered, identification of who will conduct the orientation, and the time frame for which the training is to be completed.

B. Interns who are not within sight and hearing of a qualified staff must complete the required orientation and training listed in subpart 15, item B.

C. A formal process to evaluate the training needs of each staff person, such as through an annual performance evaluation. The evaluation of training needs must occur when the staff person is hired and at least annually thereafter.

D. How the program determines when additional training of a staff is needed and how and under what time lines the additional training will be provided.

Subpart 2. **Orientation and training for staff members providing direct care.** The license holder must provide the orientation and training required in this subdivision for staff that provide direct care. The license holder must provide the necessary staff development and offer on-going training opportunities for staff that provide direct care.

A. Orientation to the following topics must be provided prior to the staff providing direct individual care:

(1) Patient rights as identified in Minnesota Statute 144.651 and 253B.03, and subpart 11 of this variance;
(2) Emergency procedures appropriate to the position, including but not limited to fires, inclement weather, missing persons, and individuals' behavioral and medical emergencies;
(3) Recovery concepts and principles, including the perspectives of individuals served;
(4) Training related to the specific activities and job functions that the staff person will be responsible to carry out, including documentation of the delivery of services.
(5) Suicide assessment and risk management.
(6) Training required in Minnesota Rules, chapter 9544.

B. Orientation as required in Minnesota Statutes, section 245A.65, subdivision 3, and sections 626.557 and 626.5572 must be provided within 72 hours of a staff first providing direct care.

C. Orientation to the following topics must be provided within 30 calendar days of a staff first providing direct care.

(1) Facility policies and procedures.
(2) The treatment needs of individuals, including psychiatric disorders and co-occurring disorders.
(3) Treatment models and best practices that are currently used in their primary service unit.

D. Annual training. Each staff person must complete training on the following topics annually.

(1) Vulnerable adult and child maltreatment requirements in Minnesota Statutes, section 245A.65, subdivision 3, and sections 626.556, subdivisions 2, 3, and 7.
(2) Patient rights as identified in Minnesota Statutes, sections 144.651 and 253B.03, and MSH .0011 subpart 1.
(3) Training required in Minnesota Rules, chapter 9544.
(4) Suicide assessment and risk management.
(5) Emergency procedures appropriate for the position, including but not limited to fires, inclement weather, and individuals' behavioral and medical emergencies.
(6) Person-centered thinking principles.
(7) Additional training subjects. Staff who are not licensed mental health professionals must be provided additional annual training. The additional annual training must include a minimum of four of the following subjects.

i. Recovery concepts and principles.
ii. Certified peer support services.
iii. Documentation requirements related to recipient services.
iv. Psychiatric and substance use emergencies including prevention, crisis assessment and de-escalation techniques, and non-physical intervention techniques to address violent behavior.
v. The problems and needs of individuals with mental illness
vi. The problems and needs of individuals with co-occurring disorders.
vii. Psychotropic medications and their side effects.
viii. Assessment and ITPs.
ix. Statutes and rules relating to mental health services.
x. The characteristics, and treatment of individuals with special needs, such as substance abuse, obsessive compulsive disorder, eating disorders, and physical health issues, including weight management, diabetes, smoking.
xi. Topics related to crisis intervention and stabilization of persons with serious mental illness.
xii. Prevention and control of infectious diseases, including human immunodeficiency virus (HIV) infection.
xiii. First aid and cardiopulmonary resuscitation (CPR) training.
xiv. Healthy lifestyles, such as exercise nutrition, stress management, therapeutic recreation.

xv. Motivational interviewing.
xvi. Positive behavior Supports, functional behavior assessments, person centered approaches, illness management and recovery, integrated dual diagnosis treatment , supported employment, community integration , and other research based best practices.

Subpart 3. **Additional training hours**. Staff who are not licensed mental health professionals must receive additional hours of annual training based on their level of experience. The additional training must meet the following requirements.

(1) Staff with less than 4000 hours of experience in the delivery of services to persons with mental illness must receive at least 24 hours of training annually; and
(2) Staff with more than 4000 hours of experience in the delivery of services to persons with mental illness must receive 16 hours of training annually.

Subpart 4. **Documentation of orientation and training**. The license holder must document that orientation and training was provided. The documentation must include the following:

1. Dates of training;
2. Subjects covered;
3. Amount of time the training was provided;
4. Names and credentials of the people who provided the training; and
5. Names of the staff and volunteers who attended.

MSH.0016. STAFF QUALIFICATIONS AND REQUIREMENTS.

Subpart 1. **Staffing levels and ratios.** The license holder must have sufficient staff to safely supervise and direct the activities of individuals taking into account the individuals' level of behavioral and psychiatric stability, treatment needs as defined in the ITP and IAPP, cultural needs, vulnerabilities and all services provided by the program.

The license holder must develop a staffing pattern for each unit based on acuity, indicating the number and positions of staff.

Recovery support services must be offered daily, including weekends.

Subpart 2. **Staff requirements.** The license holder must assure that all staff providing services are qualified to adequately carry out the job duties they are assigned. Staff must demonstrate competency to deliver and document the service components they provide. This includes staff that work overnights, weekends, part-time, and on an infrequent basis. Responsibilities of key leadership staff persons must meet the requirements of this part. In addition, the license holder must assure that key leadership positions meet the requirements of this part.

Subpart 3. **Executive Director.** The license holder must designate one individual to provide executive leadership, management and strategic direction to Forensic Services. The Executive Director must be responsible for overall continuous operations of each program.

Subpart 4. **Medical Director**. The license holder must designate one individual that is Board Certified as a Psychiatrist to provide clinical oversight and direction within each program. The Medical Director must be responsible for the development of policies and procedures, ensure quality of forensic services, direct, guide and serve as the head of the medical staff and all clinical practices provided to individuals.

Subpart 5. **Nurse Administrator**. The license holder must designate one individual responsible that is licensed as a Registered Nurse. The Nurse Administrator shall be responsible for the development of policies, procedures, and forms to assure the health and well-being of the individual is continually assessed, monitored and addressed. The Nurse Administrator is responsible for all care and treatment provided by nursing staff within each program.

Subpart 6. **Mental Health Professional.** Each unit or program area must have a Mental Health Professional designated for the clinical direction of the unit or program. The Mental Health Professional must provide direction of the development, modification, and implementation of individuals' ITP and the service components provided by each program. This includes, but is not limited to, meeting with the staff that is providing treatment services to discuss progress or lack of progress towards the individual treatment received by individuals, including direction of addition, omission or revision of interventions on the ITP and IAPP.

Subpart 7. **Program Director.** An individual designated to provide administrative supervision for this program. The person acting in this capacity must be a Mental Health Practitioner. The program director must know and understand the rules and regulations associated with the delivery of services under this variance. This person must ensure that the overall needs and effectiveness of the program are met, that staff understand the service delivered for the program, and services are provided to promote individual choice and involvement in the treatment process.

Subpart 8. **RN Administrative Supervisor.** The RN Administrative Supervisor must be a licensed RN. This person must provide monitoring and direction as defined in Minnesota Rules, part 6321.0100. This position is responsible to ensure that policies, procedures and competencies are in place to ensure that health needs of individuals must be met. This person is also responsible to ensure that staff are trained and supervised.

Subpart 9. **Unit Director.** If applicable, the Unit Director must comply with items A, B and C.

A. The Unit director must be a mental health practitioner or mental health professional. If the Unit Director is a mental health practitioner he or she must receive clinical direction from the mental health professional at least monthly. If the Unit Director requires clinical direction, the direction must cover the: (i) general needs of the individuals being served; (ii) overall needs and effectiveness of the program; and, (iii) needs and issues related to staff training.

B. The Unit Director must know and understand the rules and regulations associated with the delivery of services under this variance. The Unit Director is responsible for the day to day operations of the treatment unit. The Unit Director must ensure that: (i) staff understand how to implement the individuals' ITPs, including all revisions to the ITPs; (ii) all services are being delivered as defined by the Mental Health Professional providing clinical direction; and, (iii) the services provided to individuals promote individual choice and involvement in the treatment process and that recipient rights are upheld.

C. The Unit Director determines the scope of interaction and involvement that is appropriate for volunteers to have with individuals in the program, and is responsible to ensure that the activities and functions performed by volunteers are directed and monitored appropriately.

MSH.0017. INFORMATION UPDATES

License holder must report to DHS Licensing requested information, including survey results and outside consultant reports on system improvement. The license holder must report serious incidents, on the next business day, that results in any of the following: Death, permanent harm, severe temporary harm, suicide of an individual within 72 hours of discharge, abduction of an individual receiving services, rape, assault (leading to death or permanent loss of function of an individual being served, staff member, visitor, or vendor while on site at the facility.

MSH.0018. INCIDENT REPORTING.

License holder must have a policy to document and maintain incident reports on any situation or occurrence that adversely affects the safety or well-being of individuals, visitors or the operation of the program.

MSH.0019. REVIEW OF POLICIES AND PROCEDURES, AND PLANS.

Policies and procedures must be reviewed by the Executive Director and/or the Medical Director at least annually and updated as needed. Each policy and procedure or plan must identify the date it was initiated and the dates of any revisions. The Executive Director must review the policies and procedures that are specific to the day to day operations of the facility. The Medical Director must review the policies and procedures that are specific to all clinical direction.

MSH.0020. PHYSICAL PLANT.

Subpart 1. **Housing requirements.** The license holder must be licensed as a supervised living facility by the Minnesota Department of Health.

Subpart 2. **Capacity.** Units cannot exceed their licensed bed capacity.

Subpart 3. **Furnishings.** Each living unit must be furnished and maintained in a manner that is appropriate to the psychological, emotional, and developmental needs of individuals.

Subpart 4. **Space.** Each program must have one living room or lounge area per living unit. There shall be space available for services as indicated in the ITPs, such as an area for learning recreation and leisure time skills, spiritual care, and areas for learning independent living skills, such as laundering clothes.

Subpart 5. **Privacy.** The living unit must allow for individual privacy. Each individual, when clinically appropriate, must have the opportunity for privacy during assessment interviews, counseling sessions, and visitation.

MSH.0021. VARIANCES.

The commissioner may permit variances from the requirements in this variance. License holders seeking variances must follow the procedures in Minnesota Statutes, section 245A.04, subdivision 9.

The Minnesota Security Hospital has requested a variance to Minnesota Rules, parts 9520.0500 to 9520.0670 which govern residential care and program services to adult with mental illness.

Under Minnesota Statutes, section 245A.04, subdivision 9, the Office of Inspector General (OIG) Licensing Division may grant variances to Minnesota Rules when requested by a license holder.

The OIG Licensing Division is granting this variance effective June 1, 2016, subject to the signatures of the parties below and the following:

1) **APPROVAL FROM THE OIG LICENSING DIVISION IS REQUIRED PRIOR TO ANY CHANGE OR MODIFICATION TO THE VARIANCE**

The license holder must obtain approval from the OIG Licensing Division prior to any changes or modifications to the conditions set forth in the variance request. Any amendments to this variance must be in writing.

Failure to comply with the conditions or failure to obtain prior approval for changes to the variance may result in revocation of the variance and may be cause for other sanctions under Minnesota Statutes, sections 245A.06 and 245A.07.

2) **THE OIG LICENSING DIVISION RESERVES THE RIGHT TO RESCIND OR CANCEL THIS VARIANCE AT ANY TIME**

The OIG Licensing Division may rescind or cancel this variance at any time, with or without cause, upon written notice to the license holder.

The decision to grant, deny, or rescind a variance request is final and is not subject to appeal under Minnesota Statutes, chapter 14.

The license holder is responsible to comply with all requirements of the variance as of the effective date of the variance unless there is an explicit written agreement with the OIG Licensing Division to the contrary, or the variance specifies a date the requirement is otherwise effective.

Variance Expiration Date: N/A	**Type of Variance**: Continuous
Name and title of the person accepting the terms of the variance: Carol J. Olson, Executive Director, Forensic Services, Direct Care and Treatment	
Signature: Carol J. Olson	**Date**: 3-29-16
Name and title of the person approving the variance request: Jerry Kerber, Inspector General, Office of the Inspector General	
Signature: Jerry Kerber	**Date**: 3-30-16

James and Lorie Jensen, et al., Plaintiffs
vs.
Minnesota Department of Human Services, et al., Defendants

Case No. 09-cv-01775 (DWF/BRT)

Declaration of KyleeAnn Stevens

Exhibit E

SECLUSION OR RESTRAINT

Mental Health and Substance Abuse Treatment Services

Issue Date: January 8, 2019 Effective Date: February 5, 2019 Policy Number: 215-4090

POLICY:
Trained staff will provide for the safety of patients who pose an imminent risk of harm to self or others by using the least restrictive intervention available including seclusion and/or restraint. Seclusion or restraint may only be used when less restrictive interventions are ineffective for the management of aggressive, violent, or self-destructive behavior and cannot be used as a punitive action or for staff convenience.

AUTHORITY:
Minnesota Statutes § 246.014, Services Subd. (d)
Minnesota Statutes § 253B.03, Rights of Patients Subd. 1
Minnesota Statutes § 144.651, Health Care Bill of Rights Subd. 31
42 C.F.R. § 482.13 Condition of Participation: Patient's Rights
The Joint Commission Comprehensive Accreditation Manual for Hospitals – Provision of Care, Treatment, and Services Chapter

APPLICABILITY:
Anoka Metro Regional Treatment Center (AMRTC)
Community Behavioral Health Hospital (CBHH) - Alexandria, Annandale, Baxter, Bemidji, Fergus Falls, Rochester
Child and Adolescent Behavioral Health Services (CABHS)

PURPOSE:
To provide clear safety expectations and processes for Mental Health and Substance Abuse Treatment Services (MHSATS) staff and patients, to use seclusion or restraint only to protect the immediate physical safety of the patient, staff or others.

DEFINITIONS:
Effective and safe engagement (EASE) – learning program that promotes therapeutic and positive engagement which begins with proactive application of therapeutic relationship development, early identification of problematic behavior, and early intervention while using the safest, least restrictive and intrusive means possible to ensure the safety of patients, staff, and others.

Emergency intervention – seclusion or restraint of a patient which is necessary to protect the patient or others from imminent risk of harm.

Face-to-face evaluation – an in-person evaluation of a patient's immediate situation, reaction to the intervention, medical and behavioral condition, and need to continue or terminate the seclusion or restraint conducted by a Medical Practitioner or Registered Nurse (RN) who has demonstrated competency.

Imminent risk – a behavior that is likely to cause harm to self or others and is likely to occur in the immediate future.

Jensen Class Member - all individuals who were subjected to the use of any aversive or deprivation procedures, including restraints or seclusion while a resident at the Minnesota Extended Treatment Options program at any time(s) from July 1, 1997 through May 1, 2011.

Local Authority – see DCT Policy 115-1065, "Critical Incident Stress Management."

Medical Practitioner – see DCT Policy 320-1060, "Medication Administration."

Release criteria – written criteria which defines when an individual must be released from seclusion or restraint. This is located within the medical practitioner's order.

Restraint – any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

a) Manual restraint – physical intervention intended to hold a person immobile or limit a person's voluntary movement by using body contact as the only source of physical restraint, which includes physical guidance or assistance, if the patient exhibits physical resistance.

b) Mechanical restraint – a device used to physically restrain a patient (e.g., wrist restraints, leg restraints, restraint, or restraint chair). Mechanical restraints will not be used on Jensen Class Members in any MHSATS facility.

c) Chemical restraint – a medication or drug when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. Orders for "chemical restraint" will not be accepted.

d) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm.

Seclusion – the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.

PROCEDURES:

A. The Local Authority will ensure implementation of this policy.

B. At the time of admission, each patient will be assessed by an Registered Nurse (RN) for risks associated with potential use of seclusion or restraint, including assessment of pre-existing medical conditions or any physical disabilities or limitations that would place the patient at risk during seclusion or restraint and for mechanisms to prevent or reduce use of seclusion or restraint including patient or family/significant other identified techniques, methods or tools that may help the patient to maintain or regain control of his/her behavior.

C. Staff will incorporate Procedural Modifications to Seclusion and Restraint (215-4090b) while developing and modifying the patient's plan of care.

D. The Local Authority provides training, evaluation of initial and annual competency, and supervision of staff implementing these procedures.

E. The Medical Practitioner:

1. provides a time-limited order to authorize the application of seclusion or restraint when a patient is at imminent risk for self-harm or harming others:
   a) All orders for seclusion and restraint will be time specific and include the rationale,

release criteria, and observation level.

b) Initial orders for seclusion in adult programs will not exceed four hours. Orders may be renewed in up to four hours increments, not to exceed 24 consecutive hours.

c) Initial orders for restraint in adult programs will not exceed four hours. Orders may be renewed up in up to four hour increments, not to exceed 24 consecutive hours.

d) Initial orders for restraint chair in adult programs will not exceed two hours. Orders may be renewed in up to two hour increments, not to exceed 10 consecutive hours.

e) CABHS only: seclusion, restraint, and restraint chair orders will not exceed one hour. Orders may be renewed in up to one hour increments, not to exceed 24 consecutive hours for seclusion and restraints and not to exceed 10 consecutive hours for the restraint chair.

f) Mechanical restraints will not be used for Jensen Class Members at any MHSATS facility.

2. conducts a face-to-face evaluation, if in the facility, within one hour of initiation of seclusion or restraint;

3. consults with an RN to provide renewal of an order when necessary for a maximum of:
   a) Seclusion - four additional hours for adult programs or one additional hour for CABHS;

   b) Restraint – four additional hours for adult programs or one additional hour for CABHS; and

   c) Restraint Chair – two additional hours or one additional hour for CABHS.

4. sees and evaluate the patient every 24 hours before writing a new order for seclusion and restraint used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others;

5. provides an order to discontinue the seclusion or restraint if seclusion or restraint ends prior to ordered time.

F. The RN in charge of the incident:
1. responds immediately to potentially dangerous patient situations;

2. arranges and ensures adequate staff members are present to maintain safety;

3. initiates seclusion or restraint as needed to protect the immediate physical safety of the patient, staff, or others when all other methods of intervention were ineffective;

4. consults with the Medical Practitioner and obtains order to authorize the application of seclusion or restraint as soon as possible, not to exceed one hour after initiation of the seclusion or restraint;

5. ensures all orders for seclusion or restraint are time-specific;

6. obtains an order for discontinuation of the seclusion or restraint if the event ends prior to the ordered end time;

7. ensures that manually restrained patients are positioned onto their side at the earliest possible time;

8. completes initial RN assessment on the Seclusion/Restraint Record (DHS 5614) at the time of initiation of seclusion or restraint;

9. completes the Therapeutic Observation Record (DHS 5688) every 15 minutes to include, but not limited to:
   a) respiratory status;
   b) circulatory status;
   c) behavior and mental health status;
   d) efforts made to assist patient meeting criteria for release; and
   e) patient progress towards criteria for release;

10. completes all required documentation accurately and in its entirety in the Seclusion/Restraint Record (DHS 5614).

11. For voluntary patients:
   a) obtains an order for the voluntary adult patient to be placed on an emergency hold order; and
   b) CABHS only: ensures the authorization for seclusion/restraint is signed by parent/guardian or obtain an emergency hold order.

12. assigns a staff person to provide one to one observation and documents the patient's behavior:
   a) every 15 minutes; and
   b) assists the patient to a safe area, in the event of fire, tornado, or other emergency.

13. conducts and documents a face-to-face evaluation of the patient within one hour of initiation of seclusion or restraint (if the Medical Practitioner is not within the facility):
   a) contact the Medical Practitioner as soon as possible, after conducting the face-to-face evaluation, to report results; and
   b) document the outcome of the medical practitioner's consultation.
   c) A trained physician assistant or RN may complete the evaluation, followed by consultation with the Medical Practitioner, only after normal business hours and if the Medical Practitioner is not in the facility;

14. (if applicable) ensures guardian is notified by a RN of the seclusion or restraint;

15. ends seclusion or restraint at the earliest possible time based on assessment and monitoring of the patient and evaluating criteria for release;

16. consults with Medical Practitioner prior to the issuance of a new order when continuation is needed for:
    a) seclusion or restraint beyond four hours in adult programs;

    b) CABHS only: seclusion, restraint, or restraint beyond one hour; and

    c) AMRTC and CBHH only: restraint chair beyond two hours;

17. reviews and updates the Person Centered Master Treatment Plan and Vulnerability Risk Reduction Plan (VRRP) (DHS 3519) as needed, following the incident, to address the behavior that necessitated seclusion or restraint;

18. ensures observations are conducted every 30 minutes, in addition to safety checks, for two hours following release from seclusion or restraint in adult programs, and documented in the Seclusion/Restraint Record (DHS 5614);

19. CABHS and CBHH only: completes the Behavioral Intervention Staff Debriefing (215-4090b) as soon as possible or by the end of that work shift, to allow staff involved to discuss what went well or what could be learned from the event, and improved upon for future events;

20. AMRTC only: completes the Post Incident Review (215-4065b) as soon as possible or by the end of that work shift, to allow staff involved to discuss what went well or what could be learned from the event and improved upon for future events; and complete the Post Incident Review Debriefing Form (215-4065a) within 24 hours.

G. Prior to placing a patient in seclusion:
1. check seclusion room prior to use for cleanliness, proper ventilation, temperature, and for items which could be used to inflict injury;

2. search patients entering seclusion according to MHSATS Policy 415-4005, "Searches – Clients";

3. check the patient for dangerous items, removing hairpieces or wigs if necessary;

4. instruct patient to change into scrubs if indicated:
    a) observe patient at all times while undressing; and

    b) make every effort to respect patient privacy.

H. Direct care staff monitoring a patient in seclusion:
1. observe the patient continuously during seclusion period;

2. place all items removed from patient in a container and return to patient upon release if permitted and follow procedures in MHSATS Policy 120-4000, "Contraband" if any contraband is found;

3. give patient toilet receptacles and supplies, bed linens (unless contraindicated) and fresh drinking water;

4. allow patient to use toilet articles in seclusion area upon request, after consultation with the RN or Medical Practitioner;

5. repeat and discuss release criteria upon request of patient and as often as necessary to facilitate

patient's release;

6. maintain cleanliness of seclusion room. Empty toilet receptacles as soon as possible and offer patient opportunity to wash hands;

7. Meals:
   a) provide meal at meal times or as soon as possible;

   b) give patient opportunity to wash or sanitize hands before meal;

   c) do not place tray on floor;

   d) dispose of leftover food immediately after patient is finished;

   e) remove all toilet articles from room during meals and return when patient is finished eating;

8. document observations and patient's behavior in Therapeutic Observation Record (DHS 5688) at least every 15 minutes;

9. assigned staff will engage with patient at a minimum of every 15 minutes to assist the patient in regaining emotional regulation and safety towards their release from seclusion;

10. clean and disinfect seclusion room thoroughly after use, following Infection Control Guidelines:
    a) sanitize mattresses; and

    b) stack against the wall to air dry.

I. Direct care staff monitoring patient in restraints:
1. monitor and attend to restrained patient continuously, on a one to one basis, with no physical barriers between the staff and the patient;

2. repeat and discuss release criteria upon request of patient and as often as necessary to facilitate patient's release;

3. document observations and patient's behavior on the Therapeutic Observation Record (DHS 5688) at least every 15 minutes;

4. assigned staff will engage with patient at a minimum of every 15 minutes to assist the client in regaining emotional regulation and safety towards their release from restraint;

5. note presence or absence of indicators for good circulation in hands and feet as indicated by warmth, color, motion and sensitivity on observation record and inform RN immediately of absence of any indicator;

6. take vital signs as directed by the RN;

7. ensure patient is in good body alignment with adequate respirations;

8. offer food at meal times, or as soon as possible, if clinically indicated;

9. provide water and offer bedpan/urinal as necessary; and,

10. the restraint chair will be cleaned and disinfected after use.

J. Quality Improvement Monitoring

1. An Incident Report will be completed after each seclusion or restraint event (see MHSATS Policy 410-4000, "Incident Reporting").

2. The Charge RN will ensure the completion, accuracy, and correction of any deficiencies noted by the end of the shift on the:

   a) AMRTC only: Seclusion/Restraint Audit (215-4090d); or

   b) CBHH/CABHS only: Seclusion/Restraint Audit (215-4090c).

3. The RN Supervisor/Administrator on Duty (AOD) reviews to provide feedback, additional training, and/or develop action plan, if needed:
   a) AMRTC: all Seclusion/Restraint Audits (215-4090d) within 24 hours and scans to the Nursing Quality Department. After business hours, the AOD reviews the Restraint/Seclusion Audit (215-4090d), provides the original to the RN Supervisor and scans to the Nursing Quality Department.

   b) CABHS and CBHH: Seclusion/Restraint Audit (215-4090c).

4. The RN Supervisor/AOD ensures data is entered into Avatar for each seclusion and restraint event upon completion of the seclusion/restraint audit for data analysis and performance improvement measures.

5. The RN Supervisor maintains the original copy of the seclusion or restraint audit (see DHS Retention Schedule).

6. Information obtained from seclusion or restraint events and facility comparisons are monitored through the quality assurance/process improvement processes in place to identify and respond to any emergent process or performance issues.

7. The seclusion and restraint episode is recorded as a major incident, documented in an Incident Report, and reported immediately to the Local Authority when:
   a) Moderate or serious injury occurring with 24 hours after a patient has been released from seclusion or restraint; or

   b) unexpected death occurring within one week of restraint or seclusion being used when associated directly or indirectly with a patient's death (additional reporting to External investigative agencies as mandated by applicable law and regulation (see DCT Policy 230-1010 "Unexpected Death of a Client").

K. Staff Training or Competencies

1. All staff who engage in direct patient contact will participate in training and competency demonstration prior to participating in a seclusion or restraint, and annually or as indicated, on the following topics:
   a) Effective and Safe Engagement (EASE) training, which includes:

(1) techniques to identify triggers of circumstances requiring use of seclusion or restraint;

(2) use of nonphysical intervention skills;

(3) choosing least restrictive interventions; and

(4) safe implementation of seclusion and application of restraints;

b) monitoring of a patient in seclusion or restraint, including measuring vital signs.

2. Identification of specific behavioral changes that indicate the seclusion or restraint is no longer needed.
   a) First aid is required at time of hire for all non-licensed nursing staff and ancillary staff, and every two years thereafter.

   b) Cardiopulmonary resuscitation (CPR) training is required every two years for all staff.

3. Training will be updated as appropriate to maintain a safe environment for patients and staff.

4. RNs and physician assistants who conduct one hour face-to-face evaluation will receive initial training and annual competency assessment.

REVIEWS:
Annually

REFERENCES:
Jensen Class Members
Lippincott's Seclusion for Assaultive and Violent Behavior
DHS Retention Schedule
DCT Policy 115-1065, "Critical Incident Stress Management"
DCT Policy 230-1010 "Unexpected Death of a Client"
MHSATS Policy 120-4000, "Contraband"
MHSATS Policy 415-4005, "Searches – Clients"
MHSATS Policy 410-4000, "Incident Reporting"
MHSATS Policy 120-4100, "Fire Response Plan"
MHSATS Policy 120-4110, "Adverse Weather"
MHSATS Policy 120-4120, "Evacuation"
MHSATS Policy 120-4130, "Shelter in Place"

ATTACHMENTS:
Therapeutic Observation Record (DHS 5688)
Seclusion/Restraint Record (DHS 5614)
Post Incident Review (215-4065b)
Post Incident Review Debriefing Form (215-4065a)
Procedural Modifications to Seclusion and Restraint (215-4090a)
Behavioral Intervention Staff Debriefing (215-4090b)
(CABHS/CBHH) Seclusion/Restraint Audit Form (215-4090c)
(AMRTC) Seclusion/Restraint Audit Form (215-4090d)
Infection Control Guidelines

SUPERSESSION:
MHSATS Policy 215-4090, "Seclusion and Restraint," September 12, 2017 and all Direct Care and Treatment, Mental Health and Substance Abuse Treatment Services policies, memos, or other communications whether verbal, written, or transmitted by electronic means regarding this topic.

/s/
Wade Brost, Executive Director
Mental Health and Substance Abuse Treatment Services

James and Lorie Jensen, et al., Plaintiffs
vs.
Minnesota Department of Human Services, et al., Defendants

Case No. 09-cv-01775 (DWF/BRT)

Declaration of KyleeAnn Stevens

Exhibit F

RESTRAINT AND SECLUSION

Forensic Services

Issue Date: September 4, 2018 Effective date: October 2, 2018 Policy Number: 215-3020

POLICY:
Forensic Services (FS) will have an identified process for the use of Restraint and Seclusion.

AUTHORITY:
Variance to Minnesota Rules, parts 9520.0500 to 9520.0690 (Rule 36) for MSH
Minn. Stat. § 245A.04, subd. 9 (Variances)
Minn. Stat. § 253B.03 (Rights of Patients)
Minn. R. part 9544 (Positive Supports Strategies and Restrictive Interventions)

APPLICABILITY:
Competency Restoration Program (CRP), Minnesota Security Hospital (MSH) and Transition Services (TS)

PURPOSE:
To define the requirements and staff responsibilities when restraint or seclusion is used.

DEFINITIONS:
Emergency Intervention – restraint or seclusion of a patient which is necessary to protect the patient or others from imminent risk of harm.

Family/Social Support – a person or people committed to the support of the individual receiving services, regardless of whether they are related or live in the same household.

Imminent Risk of Harm – a behavior that is likely to cause harm to self or others in the immediate future.

Jensen Class Member – all individuals who were subjected to the use of any aversive or deprivation procedures, including restraints or seclusion while a resident at the Minnesota Extended Treatment Options program at any time(s) from July 1, 1997 through May 1, 2011.

Medical Practitioner – as defined in DCT Policy- 320-1060, "Medication Administration".

Restraint – physical or mechanical limiting of the free and normal movement of body or limbs.

- Manual restraint – physical intervention intended to hold a patient immobile or limit a patient's voluntary movement by using body contact as the only source of physical restraint
- Mechanical restraint – use of devices, materials, or equipment attached or adjacent to the patient's body that limits a patient's voluntary movement or holds a patient immobile. See Restraint and Seclusion Intervention Data Form for list of current mechanical restraint devices approved by DHS Licensing Division.
- Restraint chair – Multi-point mechanical restraint system on which the patient sits upright and restricts movement of body and limbs. The facility considers the restraint chair the most intrusive restraint intervention.

Restraint does **not** include the following:

- braces.

- any devices or belts which are used to maintain posture or to keep a patient from falling, which does not require assistance to release.
- helmets.
- brief acute medical or surgical care, standard practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic or surgical procedures, IV arm boards and radiotherapy procedures.
- Use of Restraints for Transport Outside the Secure Perimeter.

Restraint and Seclusion Committee – a multidisciplinary committee that provides oversight for the restraint and seclusion processes that includes the use of restraint or seclusion, policies, training and documentation.

Seclusion – removing a person involuntarily to a room from which exit is prohibited by a staff person or a mechanism such as a lock, a device or an object positioned to hold the door closed or otherwise prevent the person from leaving the room; or otherwise involuntarily removing or separating a person from an area, activity, situation or social contact with others and blocking or preventing the person's return.

Spit Hood – a hood placed over patient's head to prevent contamination and risk of infection in situations where the patient is actively spitting.

PROCEDURES:

A. Staff Training

1. Staff must complete the required training regarding the use of restraint or seclusion. The training includes FS philosophy on use of restraint and seclusion and the different types of mechanical restraint used. All staff must demonstrate competency with their identified roles in the use of restraint or seclusion.

2. Staff will be trained on any new types of mechanical restraint equipment prior to use.

3. Training will be provided on the use of restraint or seclusion on an annual basis or when changes are made to the policy.

B. Upon Admission

1. Within 24 hours staff will complete the Individual Abuse Prevention Plan (IAPP) to identify vulnerabilities and measures to reduce the patient's risk of harming self or others.

2. Within 24 hours of admission staff will complete the Individual Treatment Plan to identify triggers that may lead to agitation and effective calming strategies for the patient.

3. Within 24 hours a primary care practitioner will complete a history and physical examination. The examination will identify a patient's pre-existing medical conditions or any physical disabilities and limitations that place them at greater risk during restraint or seclusion. This information is documented on the Physical Activity and Intervention Clearance Order.

4. Staff will complete the Patient and Family Restraint & Seclusion Notification form with the patient and guardian, if applicable. If the patient would like family to be notified if restrained or secluded, staff will complete the form with input from the family member.

C. Upon Initiation of Restraint or Seclusion

1. In the case of imminent risk of harm to self or others, any staff member may initiate the use of manual restraint.

2. Each use of restraint or seclusion must be assessed and authorized by a Registered Nurse (RN) or medical practitioner.

3. Consideration of patient safety, dignity and privacy will be of highest priority. The minimum amount of intervention will be utilized for the shortest period of time to meet safety concerns.

4. Any patient committed as Developmentally Disabled (DD)-only without a predatory offender designation or a Jensen Class Member requires approval from a medical practitioner before mechanical restraint or seclusion can be used. The FS Medical Director will review such incidents within two business days.

5. A spit hood may be used if a patient is actively spitting. Nursing will document the use.

6. If the patient is restrained in a prone/supine position, they must be placed on their side as soon as possible. Nursing staff must ensure that the airway is unobstructed and the expansion of the patient's lungs is not restricted.

7. When seclusion is ordered the patient and the room/area will be searched for contraband and potentially hazardous objects. When the restraint chair is ordered only the patient will be searched.

8. A mattress, blanket, pillow and clothes will be provided to all secluded patients unless clinically contraindicated after an assessment by a medical practitioner. Removal of the mattress, blanket, pillow or clothes requires an order. A tear proof gown will be provided if clothes are removed.

9. Additional items may be provided to a patient in seclusion to assist in working towards release criteria. Staff will document any additional items requested and provided or if a request for an item was denied.

10. At the initiation of the restraint or seclusion the patient will be made aware of the reason for the restraint or seclusion and the release criteria to discontinue the intervention. If the patient's behavior is clinically assessed as being unable to understand the verbal information (i.e., is yelling, pounding on the walls or demonstrating other behavior that is making it impossible to communicate) this information will be given to the patient as soon as he/she is assessed to be able to hear and understand it. Additional release criteria included in the medical practitioner's order will be provided to the patient after the order is received.

11. A patient may not be secluded in a room that does not have a toilet. At Community Competency Restoration Program a urinal or bedpan will be offered as needed in the seclusion room.

D. Orders for Restraint or Seclusion

1. The use of manual restraint, mechanical restraint, restraint chair or seclusion must have a medical practitioner order. The order must be obtained by the RN within 60 minutes of initiation

of the intervention. If the patient can be released prior to obtaining the order, the RN will inform the medical practitioner of the patient's behaviors which prompted release. The order will specify:

a) the reason for the intervention;

b) the release criteria;

c) the level and type of observation; and

d) the time limits.

(1) Manual and mechanical restraint orders will be time limited to the length of the intervention.

(2) Seclusion orders will be time limited to four hours for an adult patient and two hours for patients under age 18.

(3) Restraint chair orders will be time limited to two hours.

2. There must be a new medical practitioner's order for:

a) a change in the time limits for restraint or seclusion;

b) a change in the release criteria; or

c) a change in the level or type of observation

d) when release criteria is not met by the time the current order expires.

E. Monitoring of Patients in Restraint or Seclusion

1. Patients in restraint are on 1:1 observation without a barrier at all times to ensure their physical safety.

2. Patients in seclusion are on 1:1 observation with a barrier at all times to ensure their physical safety.

3. Nursing staff will provide the 1:1 observation the first 30 minutes. An assigned staff person will relieve the nursing staff after the first 30 minutes and provide 1:1 observation until the patient is released.

4. The RN will determine if nursing 1:1 observation can be discontinued after 30 minutes. If discontinued at 30 minutes, this will be documented on the Restraint and Seclusion - RN Assessment Form. If the RN assesses that it cannot be discontinued based on the patient's physical status, the RN must contact the medical practitioner regarding the physical assessment of the patient.

5. If the staff cannot maintain visual contact through the window during seclusion due to patient behavior, the medical practitioner must be contacted and may authorize the use of a camera to observe the patient.

6. If it is clinically appropriate, simultaneous video and audio equipment may be used for seclusion monitoring after the first hour.

7. The RN will assess the patient at the start of restraint or seclusion and every 15 minutes thereafter, and document their assessment on the Restraint and Seclusion - RN Assessment Form. This assessment includes the following as appropriate:

   a) signs of any injury associated with restraint or seclusion;

   b) nutrition/hydration;

   c) circulation and range of motion in the extremities;

   d) vital signs;

   e) hygiene and elimination;

   f) physical comfort;

   g) psychological status

   h) readiness for release from restraint or seclusion; and

   i) restraint chair requirements.

      (1) The RN will observe and document the condition of the patient's restrained limbs hourly, e.g. color, warmth, swelling, bruising; security of cuffs, straps, and waist restraint.

      (2) Range of Motion will be offered every two hours at a minimum and documented.

8. Meals will be provided.

9. If the water needs to be turned off in the seclusion room a medical practitioner order is required.

10. If access to fluids is restricted, fluid intake will be offered with meals, medications and as requested unless medically contraindicated.

11. The medical practitioner will complete an in-person evaluation:

   a) for an adult patient within four hours of the first intervention, and at least every eight hours thereafter until the patient meets release criteria.

   b) for a patient under age 18 within two hours of the first intervention, and at least every four hours thereafter until the patient meets release criteria.

c) for a patient in the restraint chair within four hours of the first intervention, and at least every two hours thereafter until the patient meets release criteria. Consult with the Medical Director if a patient remains in the restraint chair for eight consecutive hours.

d) for a patient that is released before the initial order expires within twenty four hours of the first intervention.

12. In the event of a fire, the staff person assigned to the 1:1 observation of the restraint or seclusion is responsible for the evacuation of the patient from the immediate area of danger.

F. Release from Restraint or Seclusion

1. The use of restraint or seclusion will end when the imminent risk of harm to self or others ends.

2. When the RN or medical practitioner has determined that release criteria is met, they will ensure adequate staff are available to facilitate the patient's release and the successful return to the milieu.

3. If a patient is sleeping they meet release criteria unless specified in the medical practitioner order.

4. When it is determined that a gradual release from the restraint chair is needed, the rationale and process will be documented in the medical practitioner order, e.g. gradual release of limbs from the chair restraints. When gradual release has been initiated the RN will provide 1:1 observation for continual assessment and documentation on the RN Assessment Form.

G. Notification

1. The patient's guardian must be notified of the restraint or seclusion. The patient's family will be notified if the patient and family have agreed to be notified.

2. The FS Medical Director or designee must be notified when a patient remains in restraint or seclusion for more than twelve hours or experiences two or more separate events within 12 hours. Thereafter, the FS Medical Director or designee is notified every 24 hours if either of the above issues continues.

H. Restraint and Seclusion Debriefing Process

1. Staff involved in the incident will debrief immediately following the incident. The debriefing will be led by the A-Team member or designee assigned to the unit where the incident occurred. The debriefing will be documented on the Restraint and Seclusion Debriefing form on the staff section.

2. The patient, a RN, staff involved in the event if available, treatment team members, guardian if available, and family, if appropriate will debrief within 24 hours of the incident. The outcome of the debriefing will be documented on the Restraint and Seclusion Debriefing form on the patient section.

3. If the patient chooses to not participate in the initial debriefing, the following must occur:

a) A staff person who is able to engage with the patient must attempt to meet with the patient within three days.

b) The staff will document the follow-up information received from the patient on the Restraint and Seclusion Debriefing form on the patient section.

c) If the treatment team determines the debriefing process will be counter-therapeutic, this must be documented.

d) Any treatment changes will be provided to the patient.

I. Documentation of Restraint and Seclusion

1. The Restraint and Seclusion - Intervention Data Form will be completed by assigned staff.

2. The Restraint and Seclusion - RN Assessment Form will be completed by the RN.

3. The Observation Data Form will be completed by the staff assigned to do the 1:1 observation if the intervention lasts 15 minutes or longer.

4. The Restraint and Seclusion Debriefing form will be completed by assigned staff.

5. An incident report will be completed by assigned staff.

J. Review of Restraint and Seclusion

1. The Unit Director, Program Director or RN Supervisor will complete a review of each restraint or seclusion within seven days from the incident. The review will ensure that all required documentation is completed.

2. The Restraint and Seclusion Committee will define restraint and seclusion incidents that meet outlier criteria and parameters for seeking clinical consultation.

3. The Restraint and Seclusion Committee will ensure a Restraint and Seclusion Audit occurs for each restraint or seclusion incident that meets the outlier determination to ensure that all required documentation is completed.

4. The Restraint and Seclusion Committee will provide patient names to a designated clinical expertise consultant to complete a clinical review.

5. The consultation will include a review of the treatment plan and supporting documents, debriefing and recommendations, if applicable. The outcome of the recommendations must be documented.

6. The Restraint and Seclusion Committee will review data to identify trends, evaluate efficacy and recommend improvement strategies to individual units or programs.

7. Aggregate data will be presented to the Leadership Team on a monthly basis. The Leadership Team will provide guidance to the Restraint and Seclusion Committee, individual units or programs to continue to help reduce the use of restraint and seclusion.

K. The restraint chair will be sanitized after each use. Assigned staff will inspect the restraint chair daily to ensure mechanical integrity and cleanliness. When necessary the restraint chair will be removed from service and it will be reported to the Program Director.

REFERENCES:
FS Policy 415-3020, "Use of Restraint for Transport Outside the Secure Perimeter"
FS Policy 215-3044, "Treatment Planning"
FS Policy 110-3000, "Program Description and Department Service Delivery Plan"
FS Policy 215-3005, "Positive Supports Rule"
FS Policy 215-3000, "Observation Levels"
FS Policy 410-3000, Incident Reporting
FS Policy 120-3015, "Fire Plan"
FS Policy 315-3025, "Medical Clearance for Physical Activity and Intervention"

ATTACHMENTS:
Restraint and Seclusion – Intervention Data Form, 215-3020a, DHS 7165A
Restraint and Seclusion – Intervention Data Form - Additional Documentation, 215-3020b, DHS 7165B
Restraint and Seclusion - RN Assessment Form, 215-3020c, DHS 7165C
Restraint and Seclusion – RN Assessment – Additional Documentation, 215-3020d, DHS 7165D
Restraint and Seclusion Debriefing Form, 215-3020e, DHS 7165E
Patient and Family Restraint & Seclusion Notification, 215-3020f, DHS 7165F
Restraint and Seclusion Data Entry Form, 215-3020g
Restraint and Seclusion Audit, 215-3020h
Observation Data Form, 215-3000a-DHS 7141

SUPERSESSION:
FS Policy 215-3020, "Restraint and Seclusion", April 3, 2018

All facility policies, procedures, memos, or other communications whether verbal, written or transmitted by electronic means regarding this topic.

/s/
Carol Olson
Executive Director – Forensic Services