*James and Lorie Jensen, et al., Plaintiffs*
*vs.*
*Minnesota Department of Human Services, et al., Defendants*
Case No. 09-cv-01775 (DWF/BRT)

# Public Exhibits

## TO THE DECLARATION OF ANGELA DUGAN, PSY.D., LP (filed under seal)

*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 ANGELA DUGAN, PSY.D., LP

# Exhibit 1

# RESTRAINT AND SECLUSION
## Forensic Services

Issue Date: October 1, 2019 Effective date: November 5, 2019 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:**
Forensic Mental Health Program

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

**DEFINITIONS:**
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".

Recovery position – a position in which a patient is placed to remove them from the prone/supine position to take pressure off their chest allowing for adequate breathing.

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.
- spit hood that may be placed over patient's head to prevent contamination and risk of infection in situations where the patient is actively spitting.

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; and
- 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.

**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 within 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 staff will complete the Individual Treatment Plan to identify triggers that may lead to agitation and effective calming strategies for the patient.

3. During the work week, from Monday through Friday, excluding holidays, a Comprehensive History and Physical is performed by a medical practitioner within 24 hours of admission and entered in its entirety in Avatar. If an admission occurs when a comprehensive exam cannot be performed within 24 hours, then an Intake Physical Assessment will be performed on an admitting patient within 24 hours by a licensed independent practitioner. A Comprehensive History and Physical will then be completed the next business day.

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. This form will be updated annually.

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. Nursing staff must ensure that the airway is unobstructed and the expansion of the patient's lungs is not restricted. If the patient is restrained in a prone/supine position they must be placed in a recovery position 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 Forensic Mental Health Program-North Campus 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, as ordered by the medical practitioner.

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.

2. The patient's family will be notified if the patient and family have agreed to be notified.

3. The FS Medical Director or designee must be notified when:

a) a patient remains in restraint or seclusion for more than twelve hours;

b) a patient experiences two or more separate events within 12 hours; and

c) a Jensen-class member patient is mechanically restrained or secluded.

4. The Forensic Medical Director or designee must be notified every 24 hours if a patient remains in restraint or seclusion for more than 12 hours, or experiences two or more separate events within 12 hours.

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.

**REVIEW:**
Annually

**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", October 2, 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

*James and Lorie Jensen, et al., Plaintiffs vs.*
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# DECLARATION OF ANGELA DUGAN, PSY.D., LP

# Exhibit 2

***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**:<br><br>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**:<br><br>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 ANGELA DUGAN, PSY.D., LP

# Exhibit 3

# EVENT REVIEWS AND ROOT CAUSE ANALYSIS
## Direct Care and Treatment

Issue Date: October 1, 2019 Effective Date: November 5, 2019 DCT Policy Number: 140-1005

**POLICY:**
Event reviews, including Root Cause Analysis (RCA), are conducted by Direct Care and Treatment (DCT) on events for systematic process improvement using information gathered during a review of an unusual or potentially preventable event. Given the complexity of healthcare, not all events are avoidable. DCT engages in event review to promote safety and learning.

**AUTHORITY:**
42 C.F.R. §482.13 Conditions of Participation: Patient's Rights
Minnesota Statutes, section 144.7065 (Facility Requirements to Report, Analyze, and Correct)
Minnesota Statutes, section 145.63 (Confidentiality of Records of Review Organization)
The Joint Commission Comprehensive Accreditation Manual for Hospitals – Sentinel Event Chapter
The Joint Commission Comprehensive Accreditation Manual for Behavioral Health Care – Sentinel Event Chapter

**APPLICABILITY:**
DCT-wide

**PURPOSE:**
To outline procedures for events meeting criteria for an event review or RCA and to provide staff guidance on completing them.

**DEFINITIONS:**
Adverse Healthcare Event (AHE) - one of 29 reportable events defined under Minnesota law that requires special reporting by hospitals to the Minnesota Department of Health (MDH).

Clients – see definition in DCT Policy 145-1000, "Office of Special Investigations".

Critical Incident/Event Review - review of the incident a timeline including the details of the incident, how the incident was reported, to whom the incident was reported, and any actions taken by the staff to ensure continued safety for clients.

Likelihood of Harm – the likelihood of the issue to cause harm to clients, staff, or visitors (low-harm could happen, but would be rare, moderate-harm could happen occasionally, or high-harm could happen at any time).

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

Patient Safety Registry - web-based reporting databases run by the MDH. Hospitals are required to report any of the 29 adverse healthcare events within 15 days after an eligible event occurs to this registry. DCT has assigned responsibility to the primary contact established at each site to verify that the information in the registry is accurate.

Root Cause Analysis (RCA) - a systematic process using information gathered during the investigation of an undesirable event or occurrence to determine the underlying reasons for deficiencies or failures. It is a protocol

for identifying the most basic or causal factor or factors that underlie variation in performance, including the occurrence of an adverse or sentinel event.

Scope of Harm – how widespread the problem is based on the surveyors' observations (limited-unique occurrence that is not representative of routine/regular practice, pattern-multiple occurrences with the potential to impact few/some clients, visitors, staff and/or settings, or widespread-multiple occurrences with potential to impact many/all clients, visitors, staff and/or settings).

Sentinel Event - an unexpected occurrence involving death or serious physical or psychological injury. Death, permanent harm, severe temporary harm, suicide of a client serviced or within 72 hours of discharge, abduction of client, rape, assault (leading to death or permanent loss of function, or homicide of a staff member, visitor, or vendor while on site at the facility).

Severe Temporary Harm - critical, potentially life-threatening harm lasting for a limited time with no permanent residual but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition (Joint Commission (JC) definition).

Undesirable Event - unusual or potentially preventable event with negative results or outcomes not otherwise defined by division incident reporting policies. These events, identified by leadership, are typically those that could benefit from review to determine whether they could have been anticipated, prepared for, or addressed more effectively.

**PROCEDURES:**

A. Throughout the review process if any findings or actions are determined that are client specific should be immediately directed to the treatment team for updates to the treatment plan and other necessary documents.

B. As soon as possible after an AHE/sentinel event or undesirable event occurs or becomes known, the program will report the event following their division specific incident reporting policy.

1. Community Based Services (CBS) Policy 215-2300, "Incident Reporting".

2. Minnesota Life Bridge (MLB) Policy 215-2301, "Incident Reporting".

3. Forensic Services (FS) Policy 410-3000, "Incident Reporting" and/or 410-3005, "Supplemental Incident Report".

4. Mental Health and Substance Abuse Treatment Services (MHSATS) Policy 410-4000, "Incident Reporting". Staff may choose to use the MHSATS Event Decision Tree (140-1005c) to determine additional reporting.

5. Minnesota Sex Offender Program (MSOP) Policy 410, "5300, "Incident Reports".

6. The incident report administrative reviewer is the first step in the event review process. All additional event reviews outlined in the policy supplement the initial incident report.

7. Staff may choose to use the Critical Event Review Documentation Checklist (140-1005i) as part of the incident report review process.

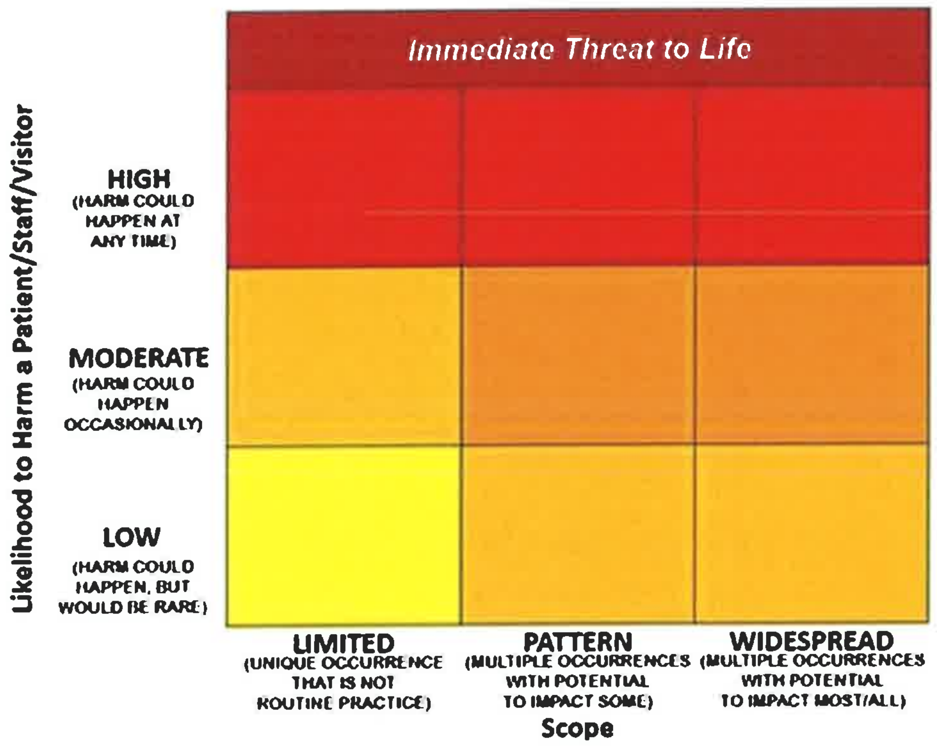
C. When an AHE/sentinel event or undesirable event occurs, the event will be reviewed by the Local Authority and/or Risk Manager or designee to determine the types of review required using the following as a framework to help decide about reporting to external and accrediting organizations.

1. Review of events will be conducted considering client and facility-based risk factors using likelihood and scope of harm to both the agency and client and severity to both. See DCT Likelihood to Harm a Patient/Staff/Visitor Chart (140-1005h). The Local Authority may ask staff to document their account of the event.

2. Events that are related to employee misconduct or related activity, will be referred to Human Resources (HR) for appropriate investigation. With that, review of the overall processes and clinical care concerns related to the event will continue to be reviewed using the below methodology. These reviews will include development of corrective action plans when appropriate or whenever possible to ensure and mitigate risk to client and staff safety.

3. Whenever possible, reviews and action plans should be streamlined into one action plan for tracking and monitoring.

4. The Survey Analysis for Evaluating Risk (SAFER) Matrix may be used for all reviews to determine risk level and the level of review.




5. Review Types
   a) Critical Incident Review
      (1) Minnesota Specialty Health Systems (MSHS) Policy 410-4030, "Critical Incidents".

      (2) MHSATS Policy 215-4065, "Post Incident Review" and/or 410-4030, "Critical Incidents".

(3) FS Policy 140-3000, "Incident Review".

(4) MSOP Policy 410-5310, "Incident Review".

(5) CBS Policy 215-2320, "Incident Review" and CBS Internal Review Conclusion and Evaluation (215-2500e).

(6) Minnesota Life Bridge (MLB) Policy 215-2321, "Incident Review".

(7) Additionally, the Local Authority or Risk Manager may advise completion of Critical Event Review and Action Guide (140-1005b). This review should begin immediately following the incident and completed within 72 hours of the incident. If possible, Immediate Corrective Action Plans will be conducted prior to the admission of a complex client or an unusual situation to proactively review and plan. Staff may use the Critical Event Review Documentation Checklist (140-1005i) to ensure a complete review.

(8) Events will be reviewed with facilities committees according to DCT Policy 110-1020 "Governance".

b) DCT facilities may conduct a DCT Clinical Review (140-1005g). These reviews are led by nursing, the Local Authority or clinical leadership team to enhance understanding of complex clients and treatment options. If possible, clinical reviews will be conducted prior to the admission of complex client to proactively review and plan. The review includes a review of:

(1) client history;

(2) actions taken with the client since admission;

(3) historical risk management approaches and treatment;

(4) a timeline of the incident;

(5) identification of problems or risks;

(6) review of policies; and

(7) development of needed action plans, follow-up from treatment team members, and client care needs.

(8) If during the clinical review processes issues are detected or found, these findings will be sent to the quality director and department leader for that service area for review and integration into the Quality Assurance Performance Improvement (QAPI) program.

c) Safety reviews will be completed using the DCT After Action Report (140-1005a) when:

(1) alternate methods of continuing essential services are needed;

(2) a business interruption exceeds four hours; and

(3) whenever life safety systems are compromised over four hours within a 24-hour period.

(4) The report is shared at the facility level and with DCT leadership to reduce risk across DCT.

d) Root Cause Analysis (RCA)

(1) An RCA will be initiated when an incident is reported to JC as a Sentinel Event or Patient Safety Registry.

(2) An RCA may be initiated when an adverse health event/sentinel event, unusual or potentially preventable event, or visitor/employee injury occurs or as requested by leadership staff, approved by the Chief Quality Officer (CQO)/designee. If the event does not meet the criteria for reporting to the JC or the Patient Safety Registry, the CQO/designee may advise the Local Authority on whether an RCA or other type of review is recommended. If an RCA is recommended, see DCT Root Cause Analysis Instructions (140-1005d), and subsequently the Framework for Root Cause Analysis and Corrective Actions (140-1005e).

(3) RCA's review processes related to systems, processes, and care models.

(4) Reviews should integrate findings and action plans from other reviews as appropriate.

(5) RCA's meeting the criteria above will be initiated within 72 hours, or as soon as possible.

(6) Whenever possible, all RCA's and subsequent action plans must have executive review prior to submission, finalization, and implementation.

(7) RCA's will be shared with facilities committees according to DCT Policy 110-1020 "Governance".

e) Deaths: Follow DCT Policy 230-1020, "Mortality Review", DCT Policy 310-1035, "Organ Donations", DCT Policy 230-1005, "Expected Death of a Client", and DCT Policy 230-1010, "Unexpected Death of a Client"; complete the Serious Injury Report, and refer to DCT Policy 310-1020, "Professional Performance Evaluation".

(1) Death Reviews review the interdisciplinary clinical care provided to an individual.

(2) If during the death review processes issues are detected or found, these findings will be sent to the Quality Director for that service area for review, integration into the RCA summary and follow-up.

f) Professional Performance Evaluation (PPE):

(1) PPE reviews the clinical care provided to an individual by medical staff; and

(2) during the peer review processes issues are detected or found, these findings will be sent to the quality director for that service area for review, integration into the RCA summary and follow-up.

g) In collaboration with the quality department, other reviews may be conducted. Examples include but are not limited to: Failure Measurement Evaluation Analysis (FMEA), Common Cause Analysis, Continuous Improvement Activities, and or Clinical Case Consults.

5. Reporting

a) Vulnerable Adult (VA)/Maltreatment/Maltreatment of Minors reporting policies.

(1) CBS Policy 215-2500, "Vulnerable Adult Reporting – Internal Review and Investigation" and/or 215-2510, "Maltreatment of Minors".

(2) FS Policy 215-3040, "Maltreatment Reporting – Adults" and/or 215-3041, "Maltreatment Reporting – Minors"

(3) MHSATS Policy 215-4080, "Vulnerable Adult Maltreatment Reporting" and/or 215-4380, "Maltreatment of Minors Reporting".

(4) MSOP Policy 210-5058, "Vulnerable Adults" and/or 210-5110, "Guardianship Initiation".

(5) Whenever possible, reports should include a summary of what immediate corrective actions were implemented following detection of the alleged events.

(6) Medication Errors severity rating E through I: See Definitions in DCT Policy 320-1070, "Medication Errors".

(7) DCT Executive Directors will consult with DCT CEO and CQO to determine notification to internal DHS stakeholders including DHS compliance and regulatory/licensing bodies.

b) Employee Injury: In the event an employee sustains an injury while on the job staff will follow the following policies:

(1) DHS policy on OSHA Injury Reporting Guidelines.

(2) DCT Policy 115-1060, "Prevention of Workplace Violence and Violence Against DCT Workers".

(3) DCT Policy 115-1065, "Critical Incident Stress Management".

(4) DCT Policy 120-1060, "Safety Program (AWAIR)".

(5) Employees can access job related injury forms and worker's compensations forms via the DHS Policy on Workers Compensation.

c) Visitor Injury: If an injury is sustained by a visitor while visiting a client, staff will follow their division specific incident reporting and visiting policies.

(1) CBS: Staff utilize the Flip Chart and provide first aid as directed, which includes calling 911 for emergency situations.

(2) FS Policy 420-3095, "Visiting".

(3) MHSATS Policy 415-4000, "Visitors".

(4) MSOP Policy 420-5100, "Visiting" and/or 310-5015, "Employee, Contractor and Visitor Emergency Health Care".

d) The Joint Commission (JC): Sentinel Event

(1) DCT programs accredited by the JC will report specific events identified as a sentinel event and will complete an RCA when the criteria is met.

(2) Submission of these events will be done by quality staff after consultation with the Local Authority.

(3) Tracking of sentinel events is done by the quality department.

e) Minnesota Department of Health: Adverse Health Event (AHE) Reporting

(1) Programs licensed as a hospital by MDH will report adverse health events to the AHE Patient Safety Portal and will complete an RCA when the criteria is met.

(2) Submission of these events will be done by quality staff after consultation with the Local Authority.

(3) Tracking of Adverse Health Events is done by the quality department.

f) Document Management

(1) The Local Authority will determine the location for filing all documents included in this policy.

(2) All documents completed and utilized as part of an event review should be kept together and be easily accessible by facility leadership in the event of regulatory review.

g) Tracking and Trending

(1) Event reviews and related issues may be tracked and trended by the Local Authority in conjunction with the quality department.

(2) Opportunities for improvement and education should be shared by facility leadership with team members following event reviews.

(3) At minimum, annual summaries of event findings and actions will be conducted and lessons learned will be shared with leadership. These summaries will include, but not be limited to:

(a) annual reports (see DCT Policy 140-1020 "Quality System");

(b) evaluation and enhancements to policies and training curriculum; and

(c) QAPI and client safety programming.

**REVIEW:**
Annually

**REFERENCES:**

Incident Review Process Flowchart
Joint Commission Connect
Survey Analysis for Evaluating Risk (SAFER) Matrix
Minnesota Statutes, chapter 145.64
DHS Policy on OSHA Injury Reporting Guidelines
DHS Policy on Worker's Compensation
DHS General Records and Retention Schedule
DCT Policy 110-1015, "Ombudsman"
DCT Policy 115-1060, "Prevention of Workplace Violence and Violence against DCT Workers"
DCT Policy 115-1065, "Critical Incident Stress Management"
DCT Policy 230-1020, "Mortality Review"
DCT Policy 120-1060, "Safety Program (AWAIR)"
DCT Policy 310-1020, "Professional Performance Evaluation"
DCT Policy 110-1020 "Governance"
DCT Policy 320-1070, "Medication Errors"
DCT Policy 140-1020, "Quality System"
CBS Policy 215-2300, "Incident Reporting"
CBS Policy 215-2310, "Incident Response Policy"
CBS Policy 215-2320, "Incident Review"
MLB Policy 215-2301, "Incident Reporting"
MLB Policy 215-2311, "Incident Response"
MLB Policy 215-2321, "Incident Review"
CBS Policy 215-2500, "Vulnerable Adult Reporting – Internal Review and Investigation"
CBS Policy 215-2510, "Maltreatment of Minors"
FS Policy 140-3000, "Incident Review"
FS Policy 215-3040, "Maltreatment Reporting – Adults"
FS Policy 215-3041, "Maltreatment Reporting – Minors"
FS Policy 410-3000, "Incident Reporting"
FS Policy 410-3005, "Supplemental Incident Report"
FS Policy 420-3095, "Visiting"
MHSATS Policy 215-4065, "Post Incident Review"
MHSATS Policy 410-4000, "Incident Reporting"
MHSATS Policy 410-4030, "Critical Incidents"
MHSATS Policy 415-4000, "Visitors"
MHSATS Policy 215-4380, "Maltreatment of Minors Reporting"
MHSATS Policy 215-4080, "Vulnerable Adult Maltreatment Reporting"
MSOP Policy 210-5058, "Vulnerable Adults"
MSOP Policy 210-5110, "Guardianship Initiation"
MSOP Policy 310-5015, "Employee, Contractor and Visitor Emergency Health Care"
MSOP Policy 410-5300, "Incident Reports"
MSOP Policy 410-5310, "Incident Review"
MSOP Policy 415-5080, "Use of Force and Restraints"
MSOP Policy 420-5100, "Visiting"

**ATTACHMENTS:**

DCT After Action Report (140-1005a)
Critical Event Review and Action Guide (140-1005b)
MHSATS Event Decision Tree (140-1005c)

DCT Root Cause Analysis Instructions (140-1005d)
Framework for Root Cause Analysis and Corrective Actions (140-1005e)
DCT Event Reviews and Root Cause Analysis Checklist (140-1005f)
DCT Clinical Review (140-1005g)
DCT Likelihood to Harm a Patient/Staff/Visitor Chart (140-1005h)
Critical Event Review Documentation Checklist (140-1005i)
CBS Internal Review Conclusion and Evaluation (215-2500e)
Serious Injury Report

**SUPERSESSION:**
DCT Policy 140-1005, "Event Reviews and Root Cause Analysis", May 1, 2018

/s/
Marshall E. Smith
Health Systems Chief Executive Officer
Direct Care and Treatment
Department of Human 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
# ANGELA DUGAN, PSY.D., LP

# **Exhibit 4**

# INCIDENT REVIEW
## Forensic Services

Issue Date: January 7, 2020 Effective Date: February 4, 2020 Policy Number: 140-3000

**POLICY:**
In order to protect the safety and well-being of patients and staff in Forensic Services (FS), incidents must be managed, documented, reported, reviewed and investigated in a timely manner utilizing a common approach.

**AUTHORITY:**
Minn. Stat. § 246.014, subd. (d) (Services)

**APPLICABILITY:**
FS, program-wide

**PURPOSE:**
To outline the process for conducting reviews of incidents occurring in FS programs.

**DEFINITIONS:**
None

**PROCEDURES:**
A. Types of Reviews

1. Post Event Debriefing – this review occurs immediately after an Incident Command System initiation for response to an incident per the Incident Command System policy.

2. Restraint and Seclusion Debriefing – a review conducted immediately after an episode of restraint and seclusion as per the Restraint and Seclusion policy.

3. Daily Event Review – a routine review by leadership of the last 24 hours of events that is led by an Executive Team member. On weekends and holidays events are reviewed the next business day.

4. Clinical Debriefing – a routine review by clinical program leadership of the events occurring since the last review date to ensure clinical needs are being addressed timely and necessary action plans are implemented. The Clinical Debriefing is led by the Medical Director or designee.

5. Expanded Support Team Review – as per the Positive Supports Rule policy.

6. High Level Review – a fact-finding meeting designed to identify strengths in current practice and opportunities for improvement related to a specific incident.

7. Internal Review – a review completed by the Executive Director/designee when there is alleged maltreatment as per Maltreatment Reporting - Adults & Maltreatment Reporting – Minors policy.

8. Employee Injury Review – a review by leadership when an event has led to two or more OSHA recordable staff injuries.

9. Critical Incident Review – as defined in the Event Reviews and Root Cause Analysis policy.

10. Root Cause Analysis – as defined in Event Reviews and Root Cause Analysis policy.

B. Determining the Need for Review

1. Staff are responsible for reporting incidents following the Incident Reporting policy.

2. Executive and leadership teams, in coordination with the Quality Department, are responsible for identification of incidents that require additional review.

C. Initiation of the Incident Review Process

1. The Quality Director, in conjunction with leadership, will assign facilitation of each incident to an appropriate staff from Quality, Safety or the program or department leadership team, and provide guidance on the type of review, required participants and due date for review documentation, in accordance with the Event Reviews and Root Cause Analysis policy.

2. The assigned quality staff will ensure that all actions identified at the review will be entered into the Corrective Action and Response Plan log.

3. Incidents appropriate for review may include, but are not limited to those involving:

   a) sentinel events as defined in the Event Reviews and Root Cause Analysis policy;

   b) medical events or injury (patient or staff);

   c) disruption of facility operations; and

   d) security concerns or breaches.

D. Once the type of review has been determined the review facilitator will:

1. work with program leadership and the Scheduling Department to schedule the review;

2. follow the guidance for reviews outlined in the Event Reviews and Root Cause Analysis policy or

3. ensure the following is covered as part of a High Level Review:

   a) participants' responsibility to bring forward system level opportunities that have been identified to enhance a blame free culture of learning;

   b) a summary of the incident from as many staff involved as possible;

   c) a review of related documentation that may include incident reports, videos, supplemental reports, physician orders, progress notes, etc.;

d) a discussion of what went well;

e) a discussion of areas for improvement;

f) a review of possible policy revisions; and

g) a review of training needs.

4. complete any documentation required in DCT Event Reviews and Root Cause Analysis policy, or if conducting a High Level Incident Review, create a summary that includes:

a) date of review;

b) participants of review;

c) summary of incident;

d) documents or other items used as part of the review (e.g., incident reports, videos, etc.); and

e) a summary of the review meeting including:

(1) information learned during the discussion that provides context to the incident and/or staff actions taken during the incident;

(2) information learned during the discussion about what went well;

(3) information learned during the discussion about contributing factors to the outcome of incident;

(4) any identified training and policy opportunities; and

(5) the review group's suggested corrective actions that might prevent a similar incident or outcome in the future, prioritization of those actions, and recommendations, if any, for responsibility and timelines for those actions; and

5. send the completed documentation to the Quality Director for review.

E. Corrective Action After a Review

1. Once corrective actions have been determined, the Quality Director will direct the assigned quality staff to update the Corrective Action and Response Plan log with details of the actions, responsible staff and deadlines.

2. The Quality Officer will also add any incident reviews and corrective actions to the Quality Assurance and Performance Improvement Committee (QAPI) agenda for review at the next and subsequent meetings until the actions are completed.

3. If a corrective action falls behind schedule, the QAPI committee or Quality Director may direct the Quality Officer to request the responsible staff present to the QAPI Committee so that appropriate support and actions to get back on track can be identified.

**REVIEW:**
Annually

**REFERENCES:**
DCT Policy 140-1005, "Event Reviews and Root Cause Analysis"
FS Policy 215-3040, "Maltreatment Reporting – Adults"
FS Policy 215-3041, "Maltreatment Reporting – Minors"
FS Policy 120-3005, "Incident Command System"
FS Policy 215-3020, "Restraint and Seclusion"
FS Policy 215-3005, "Positive Supports Rule"
FS Policy 410-3000, "Incident Reporting"

**ATTACHMENTS:**
None

**SUPERSESSION:**
FS Policy 140-3000, "Incident Review", February 5, 2019

/s/
Carol Olson
Executive Director - Forensic 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 ANGELA DUGAN, PSY.D., LP

# Exhibit 5

# POSITIVE SUPPORTS RULE
## Forensic Services

Issue Date: February 4, 2020 Effective date: March 3, 2020 Policy Number: 215-3005

**POLICY:**
Forensic Services (FS) will provide supports for patients with a developmental disability or related condition according to Minn. R. part 9544.0010 and Minn. Stat. § 246.014, subd. (d).

**AUTHORITY:**
Minn. Stat. § 246.014, subd. (d) (Services)
Minn. R. Ch. 9544 (Positive Support Strategies and Restrictive Interventions)

**APPLICABILITY:**
Forensic Mental Health Program

**PURPOSE:**
To identify and monitor patients with developmental disabilities or related condition and to implement positive support strategies and transition plans according to Minn. R. Ch. 9544.

**DEFINITIONS:**
Behavior Intervention Reporting Form – as defined in Minn. R. part 9544.0020, subp. 3, the form prescribed by the Commissioner to collect data according to the requirements in Minn. Stat. § 245.8251, subd. 2.

Behavior Support Team (BST) – as defined in FS Policy 215-3075, "Behavior Support Team".

Developmental disability or related condition – as defined in Minn. R. part 9525.0016, subp. 2, items A to E.

Emergency use of manual restraint – as defined in Minn. Stat. § 245D.02, subd. 8a.

Expanded support team – as defined in Minn. Stat. § 245D.02, subd. 8b.

External Program Review Committee – as defined in Minn. R. part 9544.0130.

Functional behavior assessment (FBA) – as defined in Minn. R. part 9544.0020, subp. 21.

Manual restraint – as defined in Minn. Stat. § 245D.02, subd. 15a.

Mechanical restraint – as defined in FS Policy 215-3020, "Restraint and Seclusion".

Mental health practitioner – as defined in FS Policy 215-3044, "Treatment Planning".

Mental health professional (MHP) – as defined in Minn. Stat. § 245.462, subd. 18, sections 1-6.

Person-centered planning – as defined in Minn. R. 9544.0020, subp. 38 and Minn. Stat. § 245D.07, subd. 1a, (b), (1-3).

Positive support strategies – as defined in Minn. R. part 9544.0020, subp. 41 and Minn. R. part 9544.0030 subp. 2 and 4.

Positive support transition plan (PSTP) – as defined in Minn. Stat. § 245D.02, subd. 23b.

Psychotropic medication – as defined in Minn. Stat. § 245D.02, subd. 27.

Restrictive intervention – means:

A. Prohibited procedures identified in Minn. Stat § 245D.06, subd. 5 and Minn. R. part 9544.0060;
   1. Prohibited procedures are only prohibited if used:
      a) as a substitute for adequate staffing,
      b) for a behavioral or therapeutic program to reduce or eliminate behavior,
      c) as punishment, or
      d) for staff convenience.
   2. Use of these procedures is therefore permitted during:
      a) incidents presenting imminent risk, of harm to the individual served or others and when less restrictive interventions have been ineffective to prevent harm to the individual or others, according to Restraint and Seclusion;

         or

      b) interventions associated to:
         (1) Use of Restraints for Transport Outside the Secure Perimeter; and/or
         (2) Liberty Levels;

         and

B. The emergency use of manual restraint.

Seclusion – as defined in FS Policy 215-3020, "Restraint and Seclusion".

**PROCEDURES:**

A. Identification/Tracking of Patients with Developmental Disabilities and Notice

   1. Upon admission or as referred, patients will be screened by an MHP identified by each unit to determine if the patient meets criteria for a developmental disability or a related condition when:

      a) the patient has an IQ of 70 or below, or

      b) a developmental disability or related condition diagnosis is suspected; or

      c) prior documentation reflects a diagnosis of a developmental disability or related condition.

   2. The MHP will outline their determination in an Avatar progress note titled "Positive Supports Rule Screening – Developmental Disability or Related Condition."

      a) The MHP must complete their screening within 14 calendar days from admission or referral.

      b) Timelines associated to screenings may be extended by the MHP's supervisor, though documentation in an Avatar progress note must be reflected by the original deadline noting:

         (1) rationale for the extension (e.g. collateral testing, additional observations, etc.); and

(2) estimated date for screening to be completed.

c) If a patient is admitted and has previously been identified as meeting the criteria for Positive Supports Rule (PSR), the MHP is responsible for reflecting that in an Avatar progress note within the required timelines.

3. Upon completion of the screening, and within one business day, the MHP who completes the screening will complete steps one and two of the PSR identification section of the PSR SharePoint site.

4. The patient's social worker will ensure that the patient (and correlated legal representative) receive the Positive Supports Rule: Notice and Rights, within five working days, and annually thereafter. In correlation to this Notice and Rights, copies of Minn. Stat. § 245D.04 and this policy will be provided to the patient (and legal representative, if applicable).

5. Guidelines according to the Positive Supports Rule and subsequently identified in this policy will apply to the patient being served on the date they are determined to meet criteria of having a developmental disability or related condition by the MHP.

B. Implementing Positive Support Strategies and Person-Centered Planning

1. Positive Support Strategies must:

a) be strengths-based;

b) be culturally and linguistically competent/responsive to needs;

c) have focus on individual preference and choice;

d) be developed from an individualized assessment;

e) teach skills and/or strategies that aide in their autonomy;

f) not include a restrictive intervention; and

g) be incorporated in writing to the Person Centered Master Treatment Plan (PCMTP).

2. Positive Support Strategies will be used to:

a) generate FBA, PCMTP, support plans, reinforcement plans, transition plans, Person-Centered Profiles/Descriptions (PCP/D), One-Page Profiles (OPP), Positive Supports Assessments (PSA), and PSTP.

b)


3. Principles of person-centered planning will be used to:

a) generate tools to support the individual in achieving their highest quality of life in their current setting using their identified strengths, interests, dreams, goals, and talents;

b) support the patient and the treatment team in identifying what is important to the patient and important for the patient as treatment goals are established;

c) ensure respect for each patient's history, dignity, and cultural background; and

d) safeguard the individual's self-determination that supports and provides:

(1) affirmation and protection of each patient's civil and legal rights; and

(2) opportunities for the development and exercise of functional and age-appropriate skills, decision-making and choice, personal advocacy and communication.

4. The treatment team will incorporate principles of Positive Support Strategies and person-centered planning in service delivery and must:

a) evaluate with the patient and/or guardian at least quarterly whether the services support the patient's preferences, daily needs and activities, and the accomplishment of the person's goals;

b) evaluate that any permitted action or procedure related to Emergency Use of Manual Restraints (EUMR), mechanical restraint, and/or seclusion is implemented only in a manner prescribed by the PSTP;

c) evaluate individual support plans such as reinforcement plans and ensure that plans contain essential elements which must include, but are not limited to:

(1) collaboration with patient;

(2) skill to build and/or replacement behaviors;

(3) an end date;

(4) no punitive elements; and

(5) target behaviors supported by baseline data.

d) Ensure that all changes are reflected in the PCMTP.

C. The Restraint and Seclusion documentation will be completed according to the Restraint and Seclusion policy. The completed documentation will be uploaded to the Incident Reporting section of the PSR SharePoint site within 72 hours of the incident.

D. Reporting and Reviews Related to Emergency Use of Manual Restraints (EUMR), mechanical restraint and/or seclusion requires the completion of:

1. Internal Review for Emergency Use of Manual Restraint Form

a) The BST will complete the Internal Review for Emergency Use of Manual Restraint. The review must be completed within five working days of the incident and uploaded to the Incident Tracking section of the PSR SharePoint site.

b) The internal review must consider whether:

(1) the patient's service and support strategies developed according to the Treatment Planning procedure need to be revised;

(2) related policies and procedures were followed;

(3) the policies and procedures were adequate;

(4) there is a need for additional staff training;

(5) the reported event is similar to past events with the patients, staff or the services involved; and

(6) there is a need for corrective action by the license holder to protect the health and welfare of patients.

c) One internal review may review and offer recommendations related to multiple incidents that occurred on the same calendar day.

2. Expanded Support Team Review (ESTR)

a) Upon receipt of the internal review, the treatment team will facilitate an expanded support team review meeting within five working days where staff will:

(1) invite the following individuals to the ESTR:

(a) the patient (if patient is not invited or does not attend, provide clinical justification in the ESTR progress note);

(b) the patient's family members who are active in treatment planning;

(c) the patient's legal representative, guardian, and advocate, if any;

(d) representatives of providers of the service areas relevant to the needs of the patients as described in the patient treatment plan;

(e) case manager; and

(f) a licensed health or mental health professional or other licensed, certified, or qualified professionals or consultants working with the patient and included in the team at the request of the patient or the patient's legal representative.

(2) discuss the incident and the internal review of the incident in its entirety, including who was involved, what interventions were used, what worked well or did not work well, and what strategies could be employed in the future.

(3) have the following documents available for review. Changes will be made as needed and identified based on the meeting discussion and team member's input.

(a) Person Centered Master Individualized Treatment Plan

(b) Individual Abuse Prevention Plan

(c) Positive Support Transition Plan or other support plans

(d) BMRC or any other restrictive interventions currently in place

(4) develop and inform the BST of a plan for completing any staff training or corrective action plan identified in the internal review, to be completed within 30 days, and include this information in the ESTR chart note and unit team meeting minutes;

(5) document the expanded support team review meeting in an Avatar progress note titled "Expanded Support Team Review" and include:

(a) the patient's input;

(b) whether the patient was invited to the meeting or in attendance, and if not, a clinical justification for this decision;

(c) the names of individuals invited as well as who participated; and

(d) a plan for completing any staff training or corrective action plan identified in the internal review.

(6) document the Expanded Support Team Review in the Incident Tracking section of the PSR SharePoint site.

b) An expanded support team review may review numerous incidents that occurred on the same calendar day.

3. Behavior Intervention Reporting Form (BIRF)

a) The area supervisor will ensure completion and submission of the Behavior Intervention Reporting Form within five working days of the expanded support team review.

b) The area supervisor will ensure that a copy of the internal review and expanded support team review are attached to the BIRF.

c) The area supervisor will print a copy of the BIRF prior to its submission and upload to the Incident Tracking section of the PSR SharePoint site.

d) The BST will maintain a copy of the BIRF.

E. Reporting Additional Incidents

1. The area supervisor must report the following incidents within 15 business days by completing a Behavior Intervention Reporting Form:

a) a medical emergency occurring as a result of the use of a restrictive intervention with a patient that leads to a call to 911 or seeking physician treatment or hospitalization for a patient;

b) a behavioral incident that results in a call to 911;

c) a mental health crisis occurring as a result of the use of a restrictive intervention that leads to a call to 911 or a provider of mental health crisis services;

d) use of medication to intervene in a behavioral situation. This does not include the use of a psychotropic medication prescribed to treat a medical symptom or a symptom of a mental illness or to treat a child with severe emotional disturbance;

e) an incident (target intervention) that the patient's positive support transition plan requires the program to report; or

f) use of a restrictive intervention as part of a positive support transition plan as required in the plan.

2. Maintain practices identified in procedure D. 3 c) and d).

F. Development of a Positive Support Transition Plan (PSTP)

1. Patient's expanded support team must develop a Positive Support Transition Plan for a patient who had three incidents of emergency use of manual restraint, mechanical restraint and/or seclusion within 90 days or four incidents of emergency use of manual restraint within 180 days.

2. Each treatment team will be responsible to track these incidents. The start date to begin tracking is:

a) the date in which the psychiatric practitioner identified the patient to meet criteria of a developmental disability or related condition, or

b) the date in which the last PSTP was discontinued.

3. Once the threshold related to EUMR incidents has been met, the area supervisor will ensure that a referral to the BST is completed.

4. In developing the PSTP, the Positive Support Transition Plan Review must be followed and must include the development of a functional behavioral assessment (FBA) which is conducted by a clinician from the BST or as assigned. The initial Positive Support Transition Plan must be completed and submitted within 30 days of the patient meeting the standard associated to EUMR by a BST clinician. Subsequent updates and reviews will be completed by the mental health practitioner assigned to the treatment team. If the behaviors have not reduced within six months, teams are asked to seek additional support from the BST.

5. If the patient has an active PSTP, all other support plans will be deactivated until the PSTP is discontinued.

6. If the patient has as existing FBA and has had a previous PSTP, the clinician from the BST and

the treatment team will discuss whether a full update or an addendum is appropriate for each document. Criteria for an update may include any but not all of the following:

a) changes to frequency of the PSTP review;

b) changes to target interventions;

c) changes to target behaviors;

d) addition of a prohibited procedure to the plan;

e) changes to quality indicators.

7. The PSTP will be discussed on a weekly basis at the patient's treatment team's Clinical Review meeting.

8. The PSTP will be reviewed by the Expanded Support Team on a quarterly basis, and submitted by the team's Mental Health practitioner to Department of Human Services (DHS) mailbox positivesupports@state.mn.us.

9. Updates to the PSTP must adhere to guidelines noted in the Positive Support Transition Plan Instructions manual, and will be completed by the Mental Health practitioner from the patient's treatment team. If further assistance is needed, a consultation referral can be completed and submitted to the BST.

10. The PSTP must be referenced in the PCMTP and Individual Abuse Prevention Plan.

11. A PSTP may be terminated according to guidelines noted in the Positive Support Transition Plan Instructions manual and through agreement by the expanded support team. Positive Support Transition Plans are to be phased out no later than 11 months after initiation, however some treatment teams may need to request an extension to continue supports. Instructions to do so can be found at the links below:

a) Request for the Authorization of the Emergency Use of Procedures

b) DHS Request prohibited procedure extension page

12. The clinical director will determine whether the PSTP is extended. A referral may be submitted to the BST for consultation as to whether the plan should be extended. This referral should be put in at least 30 days prior to the date of expiration.

13. If a patient is admitted with a completed PSTP and FBA, the team is responsible for updating the PSTP and FBA within the required timelines.

G. Compliance of PSR Process and Documents

1. The BST will audit the PSR SharePoint site on a scheduled basis to ensure accuracy in identification and tracking of individuals screened in under PSR, as well as incident tracking and reporting.

2. The BST will review plans created for patients screened in under PSR to ensure compliance with statute and FMHP policy.

3. The External Program Review Committee will review all documents related to PSR and provide feedback and recommendations, as well as determination on efficacy and compliance to PSR statute.

**REVIEW:**
Annually

**REFERENCES:**
Minn. Stat. § 245D (Home and Community-Based Services Standards)
Guidelines for Positive Supports in DHS-Licensed Settings, DHS 6810C (07-16)
FS Policy 215-3020, "Restraint and Seclusion"
FS Policy 215-3044 "Treatment Planning"
FS Policy 415-3020, "Use of Restraints for Transport Outside the Secure Perimeter"
FS Policy 215-3043, "Abuse Preventions Plans"
FS Policy 215-3042, "Liberty Level"

**ATTACHMENTS:**
Positive Supports Rule: Notice and Rights, 215-3005a, DHS 7150
Internal Review for Emergency Use of Manual Restraint, 215-3005b
Behavior Intervention Reporting Form, DHS 5148
Positive Support Transition Plan, DHS 6810
Positive Support Transition Plan Review, DHS 6810A
Positive Support Transition Plan Instructions, DHS 6810B

**SUPERSESSION:**
FS Policy 215-3005, "Positive Supports Rule", March 5, 2019

/s/
Carol Olson
Executive Director – Forensic 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 ANGELA DUGAN, PSY.D., LP

# Exhibit 6

# MALTREATMENT REPORTING - ADULTS

## Forensic Services

Issue Date: February 4, 2020 Effective Date: March 3, 2020 Policy Number: 215-3040

**POLICY:**
All Forensic Services (FS) patients are considered vulnerable adults. All mandated reporters (e.g. staff, contractors, consultants, students and volunteers) must report any suspected maltreatment including abuse, neglect or financial exploitation they have reason to believe has occurred to any patient.

FS observes zero tolerance for the maltreatment of any patient. Any staff member who has committed maltreatment will be disciplined pursuant to Department of Human Services (DHS) policies and the collective bargaining agreement. Where appropriate, Direct Care and Treatment (DCT) will refer matters of suspected abuse or neglect to the county attorney for criminal prosecution.

**AUTHORITY:**
Minn. Stat. § 246.014, subd. (d) (Services)
Minn. Stat. § 245A.65, subd. 1 (License holder requirements)
Minn. Stat. § 626.557 (Reporting of Maltreatment of Vulnerable Adults)
Minn. Stat. § 626.5572 (Definitions)

**APPLICABILITY:**
FS, program-wide

**PURPOSE:**
To provide guidance to staff on how to report maltreatment or suspected maltreatment of vulnerable adults, and establish an internal review of maltreatment allegations.

**DEFINITIONS:**
Abuse – as defined in Minn. Stat. § 626.5572, subd. 2.

Adverse Action – as defined in Minn. Stat. § 626.557, subd. 17(c).

Internal reporter – staff assigned to manage the internal review process for FS.

Local authority – as defined in DCT Policy 115-1065, "Critical Incident Stress Management".

Maltreatment – as defined in Minn. Stat. § 626.5572, subd. 15.

Mandated Reporter – a professional or professional's delegate while engaged in: social services, law enforcement, education, direct care, occupations governed by a health-related licensing board (Minn. Stat. § 214.01, subd. 2), employment in a licensed facility, medical examiner or coroner activities.

Minnesota Adult Abuse Reporting Center (MAARC) – the central system in Minnesota for reporting suspected maltreatment of vulnerable adults, formerly known as the common entry point.

Neglect – as defined in Minn. Stat. § 626.5572, subd. 17.

**PROCEDURES:**

A. Staff Training

1. The local authority will ensure that all new mandated reporters (e.g. staff, consultants, contractors, students and volunteers) receive orientation training within 72 hours of first providing direct contact services to vulnerable adults and annually thereafter.

2. The local authority will document training, monitor implementation by staff and ensure that the policy is accessible to staff.

B. The local authority will ensure:

1. posting of the abuse prevention plan specific to the program site where required;

2. posting of the patient notice "How to Report Suspected Maltreatment" on each living unit;

3. posting of the "How to Report Suspected Maltreatment for Staff" in each unit station or staff office area; and

4. provide information about reporting procedures during the admission process.

C. Reporting Suspected Maltreatment

1. Any mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury that is not reasonably explained will:

   a) immediately intervene to ensure the patient's immediate safety via any available resource or assistance required; and

   b) immediately (within 24 hours of initial knowledge that the incident occurred) report it by calling the MAARC at 1-844-880-1574 (available 24/7); or go to the website www.mn.gov/dhs/reportadultabuse,

   OR

   c) immediately report it by calling the Internal Reporting line at (507) 985-2827 who then must submit a report within 24 hours. If the internal reporter is involved in the alleged maltreatment, the Mandated Reporter may contact the FS Executive Director.

2. The report must have sufficient information to identify the patient, the person believed to be responsible for the suspected maltreatment (if known), the date and time of the incident (if known), the nature and extent of maltreatment and the name and address of the reporter (particularly if reported to the MAARC). The report should also include action taken to ensure the safety of the patient(s) upon recognition of concerns.

3. The Mandated Reporter may contact their immediate supervisor or On Duty Supervisor to assist with staffing or environmental changes necessary to protect the vulnerable adult, but they must still contact the MAARC or Internal Reporting line to comply with the law.

4. If there is suspicion of criminal activity and an immediate need for law enforcement to be involved, the Mandated Reporter may call the local law enforcement agency through Master Control at (507) 985-2121, 911, but the Mandated Reporter must still contact the MAARC or Internal Reporting line.

5. If the Mandated Reporter makes a report of suspected maltreatment to the Internal Reporting line, the internal reporter (or FS Executive Director, if applicable), will conduct a review of the concern. If maltreatment is determined, the Internal Reporter must report it to the MAARC within 24 hours from when the Mandated Reporter first became aware that an incident occurred.

6. If the Mandated Reporter has notified the MAARC directly, they may contact the Internal Reporting line for follow-up by the facility.

7. If the Mandated Reporter initially contacts the Internal Reporting line, they will receive a written notice within two working days stating whether the report was forwarded to the MAARC. The notice will:
   a) be given in a manner that protects the Mandated Reporter's confidentiality as much as possible;

   b) inform the Mandated Reporter that if they are not satisfied with the facility's decision whether to report externally, the Mandated Reporter may still report to the MAARC; and

   c) advise that the Mandated Reporter is protected against any retaliation if they decide to make a good faith report to the MAARC.

D. Internal Review
1. An internal review will be completed when the facility has reason to know that an internal or external report of alleged or suspected maltreatment of a patient has been made.

2. All internal reviews are to be completed within 30 calendar days of knowledge of the report.
   a) The internal reporter is responsible for completing the internal review and will submit to others as requested.

   b) If there is reason to believe the internal reporter was involved in the alleged or suspected maltreatment, the FS Executive Director/designee will be responsible to complete the internal review and submit to others as requested.

3. At a minimum, the internal review must include an evaluation of whether:
   a) related policies and procedures were followed;

   b) the policies and procedures were adequate;

   c) there is a need for additional staff training;

   d) the reported event is similar to past events with the vulnerable adult or the services provided; and

   e) there is a need for corrective action by the facility to protect the health and safety of vulnerable adults. When applicable, this may result in the administration of corrective action or progressive discipline for staff.

4. Documentation related to Maltreatment of Vulnerable Adults Investigation Records and Reports will be maintained according to the DHS Retention Schedule.

E. Immunity - Protection for Reporter: A person who makes a good faith report is immune from any civil or criminal liability that might otherwise result from making the report, or from participating in the investigation, or for failure to comply fully with the reporting obligation.

F. Retaliation Prohibited

1. The local authority/designee will not retaliate against any mandated reporter who reports in good faith suspected maltreatment, or against a vulnerable adult with respect to whom a report is made, because of the report.

2. Any retaliatory action received by a reporter of suspected maltreatment will be reported to the FS Executive Director.

3. In addition to remedies available for adverse employment consequences, any facility or person who retaliates against a good faith reporter is liable to that person for actual damages, punitive damages up to $10,000 and attorney fees.

4. If any adverse action is taken against a person making a report, or if any adverse action is taken against the person with respect to whom the report was made, and such action is taken within 90 days of the report, the action will be presumed to be retaliatory.

G. Failure to Report: A mandated reporter who negligently or intentionally fails to make a report is liable for damages caused by the failure.

H. Falsified Report: A person or facility who intentionally makes a false report will be liable in a civil suit for any actual damages suffered by the reported facility, person or persons and for punitive damages up to $10,000.00 and attorney fees.

I. Lead agencies (DHS-Licensing, Department of Health, or the local county social services agency) will have access to all vulnerable adult reports available regarding the alleged or suspected maltreatment.

**REVIEW:**
Annually

**REFERENCES:**
Minn. Stat. § 144.651 (Health Care Bill of Rights)
DCT Policy 145-1000, "Office of Special Investigations"

**ATTACHMENTS:**
How to Report Suspected Maltreatment, 215-3040a
How to Report Suspected Maltreatment for Staff, 215-3040b

**SUPERSESSION:**
FS Policy 215-3040, "Maltreatment Reporting-Adults", February 5, 2019

/s/
Carol Olson
Executive Director – Forensic Services