3.5.12 Rule 40 Advisory Committee Meeting

Table of Contents

1. Agenda
2. Rule vs. Statute
3. Behavioral Safeguards Summary Sheet
4. Waiver Instructions G2 Section
5. National Consensus Statement on Mental Health Recovery brochure
6. Statutes and Rules That Relate to Restraint and Seclusion in Community Mental Health Services
7. Minn. R. 9530.6535
8. Rule 40 manual – excerpts
9. Oversight of Use of Controlled Procedures
10. Aversive and Deprivation Procedures: Determining What Procedures are Exempted, Controlled or Prohibited

Minnesota Department of **Human Services**

Rule 40 Advisory Committee
Lafayette Building, Room 3148
March 5, 2012 Agenda

I. Opening (9:00-9:20) — Gail Dekker

II. Walk through the Settlement (9:20-9:50) — Shamus O'Meara

III. Rules, Statutes and Other Questions — Suzanne Todnem

IV. Continuing Care Administration Transformation Initiatives and CMS Requirements — Charles Young

V. BREAK (1030:10:45)

VI. Other DHS Divisions and Other State Agencies Policies (10:45-11:50)
   A. Adult Mental Health—Larraine Pierce
   B. Alcohol and Drug Abuse—Bruce Biddlecomb
   C. Minnesota Department of Education—Barbara Case
   D. Minnesota Department of Health—Michelle Ness

VII. LUNCH (11:50-12:40)

VIII. Rule 40 and the DHS Licensing Division (12:40-1:15) — Dean Ritzman, Katherine Finlayson

IX. Measures (1:15-2:00)
   A. 2010 Data — Dean Ritzman
   B. Provider Survey: Presentation and Your Feedback

X. Positive Practices (2:00-2:30) — Tim Moore

XI. BREAK (2:30-2:45)

Continued on next page

XII. Discussion (2:45-3:00) Gail Dekker

A. What did you hear that you want more information about?
B. What current standard from any area you heard about today do you think might be valuable as you make recommendations for the future?

XIII. Small Group Proposal and Your Feedback (3:00-3:15) Gail Dekker

A. Possible Topics, discussion, decision
B. Which topic are you most interested in working on?

XIV. Closing (3:15-3:30) Gail Dekker

A. Next meeting is scheduled for Monday, April 2, 9:00-? In Lafayette 3148
B. A few agenda items we are planning on:
    1. Comparison of Minnesota with other States by Michael Mayer and Derrick Dufresne
    2. Information on resources you listed at the first meeting
    3. Small group work
    4. Do you have suggestions for the agenda?

C. Questions?
D. Thanks! and Adjourn

Rule vs. Statute

Rules

An administrative rule is a general statement adopted by an agency to make the law it enforces or administers more specific or to govern the agency's procedures which affect the public.

Department of Human Services rules are operating principles or orders created under authority granted by the Legislature. These administrative rules have the force and effect of law.[1] The Legislature granted the Department authority to "promulgate rules governing the use of aversive and deprivation procedures in all licensed facilities and licensed services serving person with developmental disabilities" in Minnesota Statute § 245.825.[2]

The Minnesota Administrative Procedure Act in Minnesota Statutes, chapter 14 fully describes and explains rulemaking.

Statutes

Statutes are laws that apply to all citizens and cover a variety of topics, including the following: the legislature, **the executive branch**, state departments, the judiciary and courts, tax policy, public safety and police authority, towns, cities, counties, commerce and trade, private property and private rights, civil injuries and remedies, and crimes against people and property and the penalties associated with them.[3] Emphasis added.

How do laws, statutes, and rules differ?[4]

Laws refer to all laws passed by the Legislature during a regular or special session. Statutes are a codification of the general and permanent laws, which are compiled and published every year as Minnesota Statutes or its supplement. By codifying laws into Minnesota Statutes, the laws are placed into context of statutes that are already on the books.

Sometimes, it is difficult to understand a law unless it is placed into the proper context in Minnesota Statutes. But remember that not all laws will become statutes. Some laws, such as ones passed for a specific town or city, and appropriations, aren't included in Minnesota Statutes.

Why are some laws not included in statutes? The main reason is that appropriation laws are applicable for only two years, whereas laws included in the statutes are intended to be permanent. Local laws do not apply to the whole state so they are not included in the statutes.

Administrative rules are not actually enacted by the Legislature. The Legislature gives the Department authority to make rules.

Do we need a rule?

Probably. A rule revision is necessary to comply with the Settlement Agreement approved by the Federal Court in *Jensen, et al. v. Minnesota Department of Human Services, et al.*, Court File No. 09-CV-1775 (DWF/FLN). For example, the Settlement Agreement eliminates the use of some restrictive procedures that are permitted in the current rule. Therefore, the Department would have to undertake rulemaking to eliminate restrictive procedures that are no longer permitted.

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[1] See http://www.house.leg.state.mn.us/leg/faqtoc.asp?subject=7
[2] Minn. Stat. § 245.825, subd. 1.
[3] See http://www.house.leg.state.mn.us/leg/faqtoc.asp?subject=7
[4] See http://www.house.leg.state.mn.us/leg/faqtoc.asp?subject=7

Furthermore, even if statutory options are utilized, the Department will likely use a rule to obtain the level of detail and specificity required under the terms of the settlement agreement and to provide procedural guidance to providers and others who will implement the statutes in the daily course of treating consumers.

Lastly, if the Department eliminates all use of all restrictive procedures, the Department will need statute or rule to establish a means to detect unauthorized use of restrictive procedures.[5] Rule will likely be the best vehicle to provide the necessary procedural specificity to satisfy federal requirements and stakeholders' interests.

[5] See CMS waiver application section G-2.

CMS Behavioral Safeguards Summary

Topic: The Centers for Medicare and Medicaid Services' (CMS) requirements surrounding Behavioral Safeguards pertaining to CAC, CADI, BI and DD waivers.

Reference: Appendix G-2 "Instructions: Version 3.5 HCBS Waiver Application"

Summary: CMS requires that for every waiver, Minnesota identifies whether the "use of restraints and/or restrictive interventions during provision of waiver services" is allowed.

If they are allowed, the State is asked to: "Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion)" and to "Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency." HCBS Waiver Application, Version 3.5.21.2008, Appendix G-2:1.

When permitted, types of permitted and prohibited restraints need to be identified. For each type of restraint allowed, the safeguards need to address:

1. Requirements concerning the use of alternative strategies to avoid the use of restraints and seclusion;
2. Methods for detecting the unauthorized use of or misapplication of restraints;
3. The protocols that must be followed when restraints or seclusion are employed (including the circumstances when their use is permitted and when they are not) and how their use is authorized;
4. The practices that must be employed in the administration of a restraint or seclusion to ensure the health and safety of individuals;
5. Required documentation (record keeping) concerning the use of restraints or seclusion; and,
6. The education and training requirements that provider agency personnel must meet who are involved in the administration of a restraint or seclusion.[6]

If they are not allowed, "the state must have a means to detect unauthorized use."

[6] Page 231 *Instructions: Version 3.5 HCBS Waiver Application*

STATUTES AND RULES THAT RELATE TO RESTRAINT AND SECLUSION IN COMMUNITY MENTAL HEALTH SERVICES

Most services for people with a mental illness are under State Statute 245. The pertinent sections begin at Section 245.461 and go through Section 245.90.
These sections include the

- Adult Mental Health Act,
- Community Support and Day Treatment Services,
- Children's Mental Health Act,
- Children's Mental Health Grants and
- Children's Mental Health Integrated Fund.

The Adult Mental Health Act is silent on Restraints and Seclusion. The Children's Mental Health does address restraints.

Minnesota Rules, parts 9520.500 to 9520.0690 contains original language for licensing of Residential Treatment Programs for Adults who have a Mental illness. This rule identified when restraints were acceptable. That rule is currently being rewritten. These programs are running under the variance to Minnesota Rules, parts 9520.0500 to 9520.0690 (Rule 36) for Intensive Residential Treatment Services (IRTS). The IRTs Programs are intended to be more intensive and more treatment oriented. The variance language does not allow restraint or seclusion. The variance includes language about Behavioral Emergency Procedures.

CHILDREN'S MENTAL HEALTH ACT:
MINNESOTA STATUTE 245.826
USE OF RESTRICTIVE TECHNIQUES AND PROCEDURES IN FACILITIES SERVING EMOTIONALLY DISTURBED CHILDREN.

When amending rules governing facilities serving emotionally disturbed children that are licensed under section 245A.09 and Minnesota Rules, parts 9545.0900 to 9545.1090, and 9545.1400 to 9545.1500, the commissioner of human services shall include provisions governing the use of restrictive techniques and procedures. No provision of these rules may encourage or require the use of restrictive techniques and procedures. The rules must prohibit: (1) the application of certain restrictive techniques or procedures in facilities, except as authorized in the child's case plan and monitored by the county caseworker responsible for the child; (2) the use of restrictive techniques or procedures that restrict the clients' normal access to nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, and necessary clothing; and (3) the use of corporal punishment. The rule may specify other restrictive techniques and procedures and the specific conditions under which permitted techniques and procedures are to be carried out.

History: *1990 c 542 s 6*

245.8261 RESTRICTIVE PROCEDURES PLANNING AND REPORTING.

Subdivision 1.**Scope.**

(a) This section applies to providers of the following mental health services for children:

(1) emergency services as defined in sections 245.4871, subdivision 14, and 245.4879;

(2) family community support services as defined in section 245.4871, subdivision 7;

(3) day treatment services as defined in section 245.4871, subdivision 10;

(4) therapeutic support of foster care as defined in section 245.4871, subdivision 34;

(5) professional home-based family treatment as defined in sections 245.4871, subdivision 31, and 245.4884, subdivision 3; and

(6) mental health crisis services as defined in sections 245.4871, subdivision 24a, and 245.488, subdivision 3.

(b) Providers of mental health services for children under paragraph (a) must meet the requirements of this section before using a restrictive procedure with a child.

Subd. 2.**Restrictive procedures plan.**

(a) A services provider under subdivision 1, paragraph (a), shall have on file and available for viewing a restrictive procedures plan for children in its program that must include at least the following:

(1) the list of restrictive procedures the provider intends to use;

(2) how the provider will monitor and control the use of restrictive procedures;

(3) a description of the training that staff who use restrictive procedures must complete prior to staff implementation of restrictive procedures;

(4) how the provider will document information needed to prepare the annual report required in subdivision 15; and

(5) how the provider will ensure that the child receives treatment for any injury caused by the use of a restrictive procedure.

(b) For purposes of this section, allowable restrictive procedures include those procedures allowed under subdivision 4, paragraph (a).

Subd. 3.**Definitions.**

(a) For the purposes of this section, the terms in this subdivision have the meanings given them.

(b) "Commissioner" means the commissioner of human services.

(c) "Child" means a person under 18 years of age.

(d) "Individual treatment plan" has the meaning given in section 245.4871, subdivision 21, as required for children's mental health services providers in section 245.4876, subdivision 3. The individual treatment plan must be based on a diagnostic assessment, which includes assessments and review of medical conditions and risks of psychological trauma that might be incurred by use of seclusion or restraint.

(e) "Mechanical restraints" means the use of devices to limit a child's movement or hold a child immobile. The term does not mean mechanical restraints used to:

(1) treat a child's medical needs;

(2) protect a child known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness; or

(3) position a child with physical disabilities in a manner specified in the child's plan of care.

(f) "Physical escort" means physical intervention or contact used as a behavior management technique to guide or carry a child to safety or away from an unsafe or potentially harmful and escalating situation.

(g) "Physical holding" means physical intervention intended to hold a child immobile or limit a child's movement by using body contact as the only source of physical restraint. The term does not mean physical contact:

(1) used to facilitate a child's response or completion of a task when the child does not resist or the child's resistance is minimal in intensity and duration; and

(2) necessary to conduct a medical examination or treatment.

(h) "Restrictive procedures" means application of an action, force, or condition that controls, constrains, or suppresses the action, behavior, intention, bodily placement, or bodily location of a child in a manner that is involuntary, unintended by that child, depriving, or aversive to that child.

(i) "Time out" means removing a child from an activity to a location where the child cannot participate or observe the activity and includes moving or ordering a child to an unlocked room.

(j) "Seclusion" involves the confining of a child alone in a room from which egress is beyond the child's control or prohibited by a mechanism such as a lock or by a device or object positioned to hold the door closed or otherwise prevent the child from leaving the room. The room used for seclusion must be well-lighted, well-ventilated, clean, have an observation window that allows staff to directly monitor the child in seclusion, fixtures that are tamperproof, electrical switches located immediately outside the door, and doors that open out and are unlocked or locked with keyless locks that have immediate release mechanisms.

Subd. 4.**Allowable procedures.**

(a) A provider may use one or more of the following restrictive procedures:

(1) physical escort;

(2) physical holding;

(3) seclusion; and

(4) the limited use of mechanical restraints only in emergency situations.

(b) A provider shall permit use of restrictive procedures only by a mental health professional under section 245.4871, subdivision 27, or by a mental health practitioner under section 245.4871, subdivision 26, who is acting under the clinical supervision of a mental health professional.

Subd. 5.**Parental consent and notification.**

Parental consent for use of seclusion and restraint procedures must be obtained when a child begins receiving services; the agreement must be reviewed at least quarterly. A provider shall notify the child's parent or guardian of the use of a restrictive procedure on the same day the procedure is used, unless the parent or guardian notifies the provider that the parent or guardian does not want to receive notification or the parent or guardian requests a different notification schedule.

Subd. 6.**Physical escort requirements.**

The physical escort of a child may be used to control a child who is being guided to a place where the child will be safe and to help de-escalate interactions between the child and others. A provider who uses physical escorting with a child shall meet the following requirements:

(1) staff shall be trained according to subdivision 11;

(2) staff shall document the use of physical escort and note the technique used, the time of day, and the names of the staff and child involved; and

(3) the use of physical escort shall be consistent with the child's treatment plan.

Subd. 7.**Physical holding or seclusion.**

Physical holding or seclusion may be used in emergency situations as a response to imminent serious risk of physical harm to the child or others and when less restrictive interventions are ineffective. A provider who uses physical holding or seclusion shall meet the following requirements:

(1) an immediate intervention must be necessary to protect the child or others from physical harm;

(2) the physical holding or seclusion used must be the least intrusive intervention that will effectively react to an emergency;

(3) the use of physical holding or seclusion must end when the threat of harm ends;

(4) the child must be constantly and directly observed by staff during the use of physical holding or seclusion;

(5) the use of physical holding or seclusion must be used under the supervision of a mental health professional;

(6) staff shall contact the mental health professional to inform the mental health professional about the use of physical holding or seclusion and to ask for permission to use physical holding or seclusion as soon as it may safely be done, but no later than 30 minutes after initiating the use of physical holding or seclusion;

(7) before staff uses physical holding or seclusion with a child, staff shall complete the training required in subdivision 11 regarding the use of physical holding or seclusion at the program;
(8) when the need for the use of physical holding or seclusion ends, the child must be assessed to determine if the child can safely be returned to the ongoing activities at the program;
(9) staff shall treat the child respectfully throughout the procedure;
(10) the staff person who implemented the use of physical holding or seclusion shall document its use immediately after the incident concludes and the documentation must include at least the following information:

(i) a detailed description of the incident which led to the use of physical holding or seclusion;
(ii) an explanation of why the procedure chosen needed to be used;
(iii) why less restrictive measures failed or were found to be inappropriate;
(iv) the time the physical hold or seclusion began and the time the child was released;
(v) documentation of the child's behavioral change and change in physical status for each 15-minute interval the procedure is used; and
(vi) the names of all staff involved in the use of the procedure and the names of all witnesses to the use of the procedure; and

(11) if seclusion is used, the room used for the seclusion must:

(i) be well-lighted, well-ventilated, and clean;
(ii) have an observation window which allows staff to directly monitor a child in seclusion;
(iii) have fixtures that are tamperproof, with electrical switches located immediately outside the door;
(iv) have doors that open out and are unlocked or are locked with keyless locks that have immediate release mechanisms; and
(v) have objects that may be used by a child to injure the child's self or others removed from the child and the seclusion room before the child is placed in seclusion.

Subd. 8.**Exempt techniques and procedures.**
(a) Use of the instructional techniques and intervention procedures listed in this subdivision is not subject to the restrictions established by this section. The child's individual treatment plan, as defined in section 245.4871, subdivision 21, and as required in section 245.4876, subdivision 3, must address the use of these exempt techniques and procedures. Exempt techniques and procedures include:

(1) corrective feedback or prompt to assist a child in performing a task or exhibiting a response;
(2) physical contact to facilitate a child's completion of a task or response that is directed at increasing adaptive behavior when the child does not resist or the child's resistance is minimal in intensity and duration;

(3) physical contact or a physical prompt to redirect a child's behavior when:

(i) the behavior does not pose a serious threat to the child or others;

(ii) the behavior is effectively redirected with less than 60 seconds of physical contact by staff; or

(iii) the physical contact is used to conduct a necessary medical examination or treatment; and

(4) manual or mechanical restraint to treat a child's medical needs or to protect a child known to be at risk of injury from an ongoing medical or psychological condition.

(b) The exemptions under this subdivision must not be used to circumvent the requirements for controlling the use of manual restraint. The exemptions under this subdivision are intended to allow providers the opportunity to deal effectively and naturally with instruction and treatment interventions.

Subd. 9.**Conditions on use of restrictive procedures.**

Restrictive procedures must not:

(1) be implemented with a child in a manner that constitutes sexual abuse, neglect, or physical abuse under section 626.556, the reporting of maltreatment of minors;

(2) restrict a child's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, or necessary clothing or to any protection required by state licensing standards and federal regulations governing the program;

(3) be used as punishment or for the convenience of staff; or

(4) deny the child visitation or contact with legal counsel and next of kin.

Subd. 10.**Prohibitions.**

(a) The following actions or procedures are prohibited:

(1) using corporal punishment such as hitting, pinching, slapping, or pushing;

(2) speaking to a child in a manner that ridicules, demeans, threatens, or is abusive;

(3) requiring a child to assume and maintain a specified physical position or posture, for example, requiring a child to stand with the hands over the child's head for long periods of time or to remain in a fixed position;

(4) use of restrictive procedures as a disciplinary consequence;

(5) totally or partially restricting a child's senses, except at a level of intrusiveness that does not exceed:

(i) placing a hand in front of a child's eyes as a visual screen; or

(ii) playing music through earphones worn by the child at a level of sound that does not cause discomfort;

(6) presenting an intense sound, light, noxious smell, taste, substance, or spray, including water mist;

(7) denying or restricting a child's access to equipment and devices such as walkers, wheelchairs, hearing aids, and communication boards that facilitate the child's functioning, except as provided under paragraph (b).

(b) When the temporary removal of the equipment or device is necessary to prevent injury to the child or others or serious damage to the equipment or device, the equipment or device shall be returned to the child as soon as possible.

Subd. 11.**Training for staff.**

(a) Staff who use restrictive procedures shall successfully complete training in the following skills and knowledge areas before using restrictive procedures with a child:

(1) the needs and behaviors of children;

(2) relationship-building;

(3) alternatives to restrictive procedures, including techniques to identify events and environmental factors that may trigger behavioral escalation;

(4) de-escalation methods;

(5) avoiding power struggles;

(6) documentation standards for the use of restrictive procedures;

(7) how to obtain emergency medical assistance;

(8) time limits for restrictive procedures;

(9) obtaining approval for use of restrictive procedures;

(10) the proper use of the restrictive procedures approved for the program, including simulated experiences of administering and receiving physical restraint;

(11) thresholds for employing and ceasing restrictive procedures;

(12) the physiological and psychological impact of physical holding and seclusion;

(13) how to monitor and respond to the child's physical signs of distress; and

(14) recognizing symptoms of and interventions with potential to cause positional asphyxia.

(b) Training under this subdivision must be repeated every two years.

Subd. 12.**Administrative review.**

The provider shall complete an administrative review of the use of each restrictive procedure within three working days after the use of the restrictive procedure. The administrative review shall be conducted by someone other than the person who decided to impose the restrictive procedure, or that person's immediate supervisor. The child or the child's representative shall have an opportunity to present evidence and argument to the reviewer about why the procedure was unwarranted. The record of the administrative review of the use of a restrictive procedure must state whether:

(1) the required documentation was recorded;

(2) the restrictive procedure was used in accordance with the treatment plan;

(3) the standards governing the use of restrictive procedures were met; and

(4) the staff who implemented the restrictive procedures were properly trained.

Subd. 13.**Review of patterns of use of restrictive procedures.**

At least quarterly, the treatment provider shall review the provider's patterns of the use of restrictive procedures. The review must be completed by the treatment provider or the program's advisory committee. The review shall consider:

(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 restrictive procedures;

(2) any injuries resulting from the use of restrictive procedures;

(3) actions needed to correct deficiencies in the program's implementation of restrictive procedures;

(4) an assessment of opportunities missed to avoid the use of restrictive procedures; and

(5) proposed actions to be taken to minimize the use of physical holding or seclusion.

Subd. 14.**Annual report.**

A provider using restrictive procedures shall annually submit a report to the commissioner stating the number and types of restrictive procedures performed. The report shall be submitted in a form and manner prescribed by the commissioner. Agencies with high use of restrictive procedures will be reviewed by the commissioner to determine needed changes in policies and procedures, including staff training.

History: *2008 c 234 s 1; 2009 c 86 art 1 s 40-42*

Licensing Residential Programs For Adults Who Are Mentally Ill
(Original language for restraint under the Rule 36)

9520.0510 DEFINITIONS

Subp. 25. **Restraint.** "Restraint" means any physical device that limits the free and normal movement of body and limbs.

Subp. 26. **Seclusion.**"Seclusion" means involuntary removal into a separate room which prevents social contact with other persons

9520.0630 POLICIES AND PROCEDURES GUARANTEEING RESIDENT RIGHTS.

Subpart 1.**Explanation of rights.**

A written statement of residents' rights and responsibilities shall be developed encompassing subparts 2 to 11. Program staff shall explain to each resident the resident's rights and responsibilities. A written statement of residents' rights and responsibilities shall be given to each resident, and to his or her responsible party if the resident has a legal guardian, on admission. A list of residents' rights and responsibilities shall be posted in a place accessible to the residents and shall be available to the department for review.

Subp. 2.**Grievance procedure.**

Upon admission each resident shall be informed of grievance procedures available to the resident, and a copy of the procedures shall be posted in a place accessible to the resident. The grievance procedures shall include the following:

A.an offer of assistance by the program staff in development and process of the grievance; and

B.a list of internal resources for use by the resident, such as the resident council or a grievance committee, and a list of community resources available to the resident, such as the health facilities complaint office in the Department of Health, the Licensing Division in the Department of Human Services, and the Department of Human Rights.

Subp. 3.**Resident council.**

Each program shall have a resident council through which residents have an opportunity to express their feelings and thoughts about the program and to affect policies and procedures of the program. Minutes of council meetings shall be recorded and made available to the program director.

Subp. 4.**Personal funds policy.**

Staff will not supervise the use of residents' personal funds or property, unless policies governing the supervision have been written and unless the resident has signed a consent form prior to the exercise of supervision indicating an awareness of and consent to procedures governing the use of the resident's personal funds. In order to encourage independent living skills, any restriction of a resident's personal funds must be documented in the individual treatment plan. Resident fund accounts shall be maintained separately from program fund accounts.

Subp. 5.**Resident compensation.**

A resident who performs labor other than labor of a housekeeping nature shall be compensated appropriately and in compliance with applicable state and federal labor laws, including minimum wage and minimum wage reduction provisions. Labor of a

housekeeping nature shall be limited to household chores which a person living in his or her own residence in the community would normally perform.

Subp. 6.**Physician appointments.**

A resident shall be allowed to see his or her physician at any reasonable time.

Subp. 7.**Photographs of residents.**

A resident shall not have his or her photograph taken for any purpose beyond identification unless he or she consents.

Subp. 8.**Telephone use.**

Residents shall have access within the facility to a telephone for incoming, local outgoing, and emergency calls. They shall have access within the facility to a pay phone or its equivalent for outgoing long distance calls. Any restriction on resident access to telephones shall be documented in the individual treatment plan.

Subp. 9.**Mail.**

Residents shall be allowed to receive and send uncensored mail. Any restrictions shall be documented in the individual treatment plan.

Subp. 10.**Restraints.**

The facility shall have a written policy that defines the uses of restraint, seclusion, and crisis medications as a treatment mode; the staff members who may authorize its use; and a mechanism for monitoring and controlling its use. Physical restraint and seclusion shall be used only when absolutely necessary to protect the resident from injury to self or to others. Restraint, seclusion, and medications shall not be used as punishment, for the convenience of staff, or as a substitute for a program.

Subp. 11.**Visitors.**

Residents shall be allowed to receive visitors at reasonable times. They shall be allowed to receive visits at any time from their personal physician, religious adviser, and attorney. The right to receive visitors other than those specified above may be subject to reasonable written visiting rules and hours established by the head of the facility for all residents. The head of the facility may impose limitations on visits to an individual resident only if he or she finds the limitations are necessary for the welfare of the resident and if the limitation and reasons are fully documented in the resident's individual treatment plan.

Statutory Authority: *MS s 245A.09*

History: *L 1984 c 654 art 5 s 58; 17 SR 1279*

Posted: *October 11, 2007*

***Variance to Minnesota Rules, parts 9520.0500 to 9520.0690 (Rule 36) for Intensive Residential Treatment Services (IRTS*)**

R36V.03 DEFINITIONS.

Subd. 33. **Restraint**. "Restraint" means physical or mechanical limiting of the free and normal movement of body or limbs.

Subd. 34. **Seclusion.** "Seclusion" means separating a recipient from others in a way that prevents social contact and prevents the recipient from leaving the situation if he or she chooses.

R36V.04 REQUIRED SERVICE COMPONENTS AND DOCUMENTATION.

Subd. 8. **Behavioral emergency procedures**. A license holder must have written procedures that staff must follow when responding to a recipient who exhibits behavior that is threatening to the safety of the recipient or others. Behavioral emergency procedures must not be used to enforce facility rules or for the convenience of staff. Behavioral emergency procedures must not be part of any recipient's treatment plan, or used at any time for any reason except in response to specific current behaviors that threaten the safety of the recipient or others. Behavioral emergency procedures may not include the use of seclusion or restraint. The procedures must include:

(a) A plan designed to prevent the recipient from hurting himself or herself, or others;

(b) Contact information for emergency resources that staff must consult or contact when a recipient's behavior cannot be controlled by the procedures established in the plan;

(c) The types of behavioral emergency procedures that staff may use;

(d) The circumstances in which behavioral emergency procedures may be used; and,

(e) The staff members authorized to implement the behavioral emergency procedures.

CHAPTER 1
INTRODUCTION

The Department of Human Services is committed to the use of positive approaches in the management of challenging behavior of persons with Developmental Disabilities. However, the Department recognizes that controlled procedures (i.e., the specific aversive and deprivation procedures regulated by Rule 40 and discussed in this manual) may be necessary supplements in circumstances where positive approaches alone have not been proven effective in reducing target behaviors.

The terms "aversive and deprivation" designate and describe a category of techniques and procedures applies under the general term behavior management or behavior intervention. Behavior management or behavior intervention is based on the principle that behavior followed by a positive and pleasurable experience will strengthen and increase while a behavior followed by a negative or unpleasant experience will weaken and decrease. Aversive and deprivation procedures combined with positive approaches have been effective in reducing and in some cases eliminating self-injurious, assaultive, and other challenging behavior that severely interferes with increased independence, integration, and quality of life of persons with mental retardation or a related condition.

Minnesota rules, parts 9525.2700 to 9525.2810 herein referred to as Rule 40 were promulgated On October 1, 1987, in order to govern the use of aversive and deprivation procedures for persons with developmental disabilities in services licensed by the Commissioner of the Department of Human Services. The intent of Rule 40 was not to promote the use of aversive and deprivation procedures, but rather to establish specific standards that must be met when other less restrictive alternatives have been attempted and proven unsuccessful. Rule 40 requires documentation that positive approaches by themselves have been attempted and proven unsuccessful prior to the implementation of an aversive or deprivation procedure and further requires the use of positive procedures in conjunction with any aversive or deprivation procedure.

Members of the Department of Human Services Regional Review committees, advocates, parents, as well as other expanded interdisciplinary team members found many of the individual program plans submitted to the Department for review to have two major flaws. The first flaw found was that the plans submitted were often not comprehensive (e.g., assessment information was limited to a single service environment, descriptions of past attempted interventions were not provided, goals to increase adaptive skills in service environments were not provided). The plans primarily concentrated on behavior reduction and not on increasing alternative, adaptive behaviors. Skill acquisition objectives and the resulting methodology appeared to be added to the plans so as to comply with Rule and often did not take into account the need to replace the undesired behaviors with more appropriate behavior.

The second major flaw found was that behavior reduction components often did not appear to be individualized. It appeared that a "cookbook" of treatments for behavior reduction (e.g., manual restraint, time out, and mechanical restraint) was being used in place of a comprehensive individualized program plan that was based on an analysis of the function(s) served by the challenging behavior. An effective behavioral support plan that is focused on decreasing challenging behavior and increasing alternative, adaptive responses will necessitate the identification of the variables maintaining the challenging behavior and the functions served by the behaviors (e.g., an individual's self-biting may result in the removal of task demands).

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This manual was developed to provide agencies and professionals a more comprehensive discussion and interpretation of issues related to Rule 40 and to assist in the development of comprehensive behavioral support plans that may include the use of a controlled procedure.

RULE 40

TRAINING MANUAL

MINNESOTA RULES

9525.2700 - 9525.2810

Developed by the
Minnesota Department Of Human Services
Division For Persons With Developmental Disabilities

FOR

Expanded interdisciplinary team members, QMRPs, review committees, parents, persons with mental retardation or a related condition, and consultants.

AUGUST 1993
Revised February 1996

CHAPTER 1

INTRODUCTION

The Department of Human Services is committed to the use of positive approaches in the management of challenging behavior of persons with mental retardation or related conditions. However, the Department recognizes that controlled procedures (i.e., the specific aversive and deprivation procedures regulated by Rule 40 and discussed in this manual) may be necessary supplements in circumstances where positive approaches alone have not been proven effective in reducing target behaviors.

The terms "aversive and deprivation" designate and describe a category of techniques and procedures applied under the general term behavior management or behavior intervention. Behavior management or behavior intervention is based on the principle that behavior followed by a positive and pleasurable experience will strengthen and increase while a behavior followed by a negative or unpleasant experience will weaken and decrease. Aversive and deprivation procedures combined with positive approaches have been effective in reducing and in some cases eliminating self-injurious, assaultive, and other challenging behavior that severely interferes with increased independence, integration, and quality of life of persons with mental retardation or a related condition.

Minnesota Rules, parts 9525.2700 to 9525.2810 herein referred to as Rule 40 were promulgated on October 1, 1987, in order to govern the use of aversive and deprivation procedures for persons with mental retardation or related conditions in services licensed by the Commissioner of the Department of Human Services. The intent of Rule 40 <u>was not</u> to promote the use of aversive and deprivation procedures, but rather to establish specific standards that must be met when other less restrictive alternatives have been attempted and proven unsuccessful. Rule 40 requires documentation that positive approaches by themselves have been attempted and proven unsuccessful prior to the implementation of an aversive or deprivation procedure and further requires the use of positive procedures in conjunction with any aversive or deprivation procedure.

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The second major flaw found was that behavior reduction components often did not appear to be individualized. It appeared that a "cookbook" of treatments for behavior reduction (e.g., manual restraint, time out, and mechanical restraint) was being used in place of a comprehensive individualized program plan that was based on an analysis of the function(s) served by the challenging behavior. An effective

behavioral support plan that is focused on decreasing challenging behavior and increasing alternative, adaptive responses will necessitate the identification of the variables maintaining the challenging behavior and the functions served by the behaviors (e.g., an individual's self-biting may result in the removal of task demands).

This manual was developed to provide agencies and professionals a more comprehensive discussion and interpretation of issues related to Rule 40 and to assist in the development of comprehensive behavioral support plans that may include the use of a controlled procedure.

CHAPTER 2

APPLICABILITY (9525.2700)

The following is a listing of those services licensed by the Commissioner of the Department of Human Services which are governed by Rule 40: (See Minnesota Rules, parts 9525.0215 to 9525.0355 [amended Rule 34]; parts 9525.1500 to 9525.1690 [Rule 38]; and parts 9525.2000 to 9525.2140 [Rule 42]).

License Holders and Licensed Services Governed By Rule 40	
✓	A residential program that provides 24-hour-a-day care, supervision, food, lodging, rehabilitation, training, education, habilitation, or treatment outside a person's own home which is administered by the commissioner to provide services for five or more persons whose primary diagnosis is mental retardation or related conditions.
✓	Home and community-based services that are provided in or outside of a person's own home when the service or care is provided in a service site requiring licensure by the commissioner.
✓	Adult and child foster care homes or services.
✓	A nonresidential program providing care, supervision, rehabilitation, training of a person provided outside the person's home and provided for fewer than 24 hours a day which includes developmental achievement services for children and day training and habilitation services provided to adults.
✓	Semi-independent living services for persons with mental retardation or related conditions that are provided in or outside of a person's own home.

Other services provided to individuals with mental retardation or related conditions are not governed by this rule. These services include:

Services NOT Governed by RULE 40

- Residential or nonresidential programs that are provided by a relative;
- Nonresidential programs provided by an unrelated individual to persons from a single related family;
- Residential or nonresidential programs that are provided to adults who do not abuse chemicals or who did not have a chemical dependency, a mental illness, mental retardation or a related condition, a functional impairment, or a physical handicap;
- Sheltered workshops or work activity programs that are certified by the Commissioner of Jobs and Training;
- Programs for children enrolled in kindergarten to the 12th grade and pre kindergarten special education programs that are operated by the Commissioner of Education or a legally constituted local school board, or private schools that have been approved under the rules of the Commissioner of Education. These programs are governed by the Minnesota Department of Education under Minnesota Rules 3525.2975, Subparts 1-11;
- Nonresidential programs for children that provide care/supervision for periods of < 3 hours/day while the child's parent or legal guardian is in the same building or present on property that is contiguous with the physical facility where the nonresidential program is provided;
- Nursing home/hospitals licensed by Commissioner of Health except as specified in Section 2;
- Board and lodge facilities licensed by the Commissioner of Health that provide services for more than five persons whose primary diagnosis is mental illness or mental retardation who have refused services in a residential program;
- Homes providing programs for persons placed there by a licensed agency for legal adoption, unless the adoption is not completed within two years;
- Programs licensed by the Commissioner of Corrections;
- Recreation programs for children or adults that operate fewer than 40 calendar days in a year;
- Programs not located in family or group family day care homes whose primary purpose is to provide activities outside of the regular school day for children age 5 and older, until such time as appropriate rules have been adopted by the commissioner;
- Head start nonresidential programs which operate for less than 31 days in each calendar year;
- Noncertified boarding care homes unless they provide services for five or more persons whose primary diagnosis is mental illness or mental retardation;
- Family day care for nonhandicapped children (cumulative total < than 30 days in 12 months;
- Residential care or program services for persons with mental illness, that are located in hospitals, until the commissioner adopts appropriate rules; and
- Specific therapies provided to committed patients residing at regional treatment centers.

CHAPTER 4

EXEMPTED ACTIONS AND PROCEDURES

(9525.2720)

This part of the rule serves to provide expanded interdisciplinary team members with examples of exempted behavior change and instructional procedures which are not controlled or regulated within Rule 40. Exempted actions identified in this part must be incorporated into a person's Individual Program Plan (IPP) with a complete methodology as required in Rule 185, but are not subject to Rule 40 requirements. Procedures exempted from Rule 40 requirements are listed and described in Table 2. An IPP that includes exempted actions and procedures must contain the following information:

	Required Information for Exempted Actions and Procedures
✓	Short-term objectives.
✓	A clear description of the treatment strategy or method.
✓	A description of the frequency of implementation.
✓	The staff identified as responsible for implementation.
✓	Starting and completion dates.
✓	Resources required (e.g., equipment, training, consultants).
✓	Monitoring responsibilities and frequency.
✓	Signatures of the client, legal representative, and case manager to ensure agreement.

Table 2. Exempted Procedures.

	EXEMPTED PROCEDURE	DESCRIPTION	EXAMPLES
✓	**Corrective Feedback**	This procedure involves providing immediate information (e.g., verbal comment, model of correct response to an individual who has responded incorrectly.	If Phyllis is asked to point at a symbol for "soda," but instead throws the symbol on the floor, the instructor may replace the symbol and say, "No, like this" and demonstrate to Phyllis the correct response of pointing to the symbol.
✓	**Physical Contact** (to assist a person in the participation of a task or activity)	This procedure is also referred to as manual guidance. This action consists of facilitating a person's completion of a task or response that is directed at increasing adaptive behavior and where the person offers little or no resistance.	If an individual is unsure of how to throw a ball, a staff person may place his or her hands on top of the hands of the person and guide the person in the appropriate motion to throw the ball.
✓	**Physical Contact or Physical Prompt** (to redirect a person's behavior)	Physical contact is used to deal effectively and naturally with intermittent and infrequently occurring situations where a person may need to be redirected. In these situtations, redirecting requires less than 60 seconds of physical contact by staff. These are situations which do not pose a threat to the person or others. Physical contact may also be used in an emergency situation when it is necessary to carry a person to safety if the person is in danger, as in the event of a fire. Physical contact may also be used to conduct necessary medical examinations and treatment.	A person may be engaged in hand waving behavior which interferes with engagement in other activities. When directed to choose a leisure activity, the person might continue to wave her hands. Staff may take the person's hands and place them on a leisure item.
✓	**Positive Reinforcement**	This consists of responding to a behavior by presenting a consequence (e.g., object, event, or situation) to the person which increases the likelihood of that person exhibiting that behavior again in the future. The consequence is usually considered enjoyable, rewarding, or satisfying. This type of intervention is encouraged and can be implemented alone or in combination with other procedures to develop new behaviors or increase the frequency of existing adaptive behaviors.	Even though laundry is not her favorite activity, Joan successfully loaded the washing machine with the first of two loads of laundry. As a result, her group home staff provided Joan with an opportunity to choose a desired activity or interaction. Joan choses to play a card game with the staff person. Following the completion of the desired activity, the group home staff requested Joan to continue doing her laundry. Joan willingly continued the laundry task. The opportunity and participation in a favorite activity served as positive reinforcer for Joan.
✓	**Temporary Interruption**	This action, also known as contingent observation, consists of interrupting instruction or an ongoing activity, due to the person exhibiting challenging behavior, by removing the person to a location where the person can observe the ongoing activity and see others receiving positive reinforcement for appropriate behavior. The person's return to normal activities is contingent upon the person demonstrating more appropriate behavior.	If Steve is throwing utensils during a cooking activity and does not respond to verbal redirection, he may be directed to another location in the room; putting some distance between Steve and others participating in the activity and the materials being used. Steve would be required to remain apart from the group until he exhibited an identified adaptive behavior, such as complying with a simple task demand.
✓	**Temporary Withdrawal or Withholding of Goods, Services, or Activities**	This action is used as a consequence to a person's inappropriate use of goods, services, or activities. It is important to remember that temporary withdrawal or withholding are intended to occur for only brief time periods lasting no more than several minutes, just until the person's behavior is redirected and normal activities can be resumed.	Examples of situations in which goods are withdrawn and withheld might include briefly delaying the return of a person's beverage at mealtime after the person has thrown the beverage on the floor or temporarily removing an object from the person's possession when it is being used to injure one's self or others.
✓	**Response Cost Procedures**	These procedures consist of a planned removal of objects (e.g., tokens, money) which are used to gain access to desired objects or activities and/or rewards (i.e., objects or activities which have been awarded or earned as part of a reinforcement program). It is important that the removal of objects or other rewards does not interfere with a person's access to necessary goods, services, and activities.	At the beginning of each hour, Kathleen is provided four tokens. If she engages in any identified challenging behavior, staff remove one of her tokens. If she still has any tokens at the end of each hour she is given her choice of preferred objects or activities. The action of taking a token as a consequence of challenging behavior is considered a response cost procedure.
✓	**Medical Mechanical Restraint**	This action is taken to protect a person known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness, or to position a person with physical disabilities in a manner specified in the person's individual program plan (IPP). Medical mechanical restraints must be prescribed by certified professionals (e.g., physicians, occupational therapists, physical therapists, etc.). Mechanical restraint is also allowed while providing medical services such as physical examinations. Mechanical restraint may also be temporarily prescribed by a physician for individuals with specific medical conditions that will not improve without the use of the restraint.	Jeff has just had eye surgery and mittens have been ordered by the physician to be used for two days to prevent scratching his eyes so as to promote healing. In some situations helmets are prescribed to protect an individual from frequent falls due to lack of coordination or seizures.

CHAPTER 5

PROHIBITIONS (9525.2730)

The first part of this chapter describes procedures and actions which are **prohibited**. This section describes actions which **cannot be used** to manage or control challenging behaviors. These procedures and actions are considered abusive and harmful or potentially harmful to an individual. "Implementation of these actions **or** of permitted procedures which include any actions viewed as abusive or neglectful treatment of minors and vulnerable adults as defined in Minnesota Statutes (section 626.556 and 626.557) can result in criminal prosecution, loss of license, and/or fines." Examples of such procedures include: Corporal punishment, presentation of noxious stimuli and denial of access to goods, services and activities which are normally available. Actions and procedures which are prohibited within Rule 40 are described in Table 3. Room time out can be included as part of an IPP, however, as seen in Table 3, **the emergency use of room time out is prohibited** for all license holders.

Table 3. Prohibited Procedures.

PROHIBITED PROCEDURES	
Abuse or Neglect	Any action or procedure delivered or implemented in an abusive or neglectful manner, such as hitting, pinching, or slapping, and speaking to a person in a manner that ridicules, demeans, threatens, or is abusive. Also refers to any requirement for a person to assume and maintain a specified physical position or posture as an aversive procedure. An example of such a procedure would be requiring a person to stand with his hands over his head for long periods of time or to remain in a fixed position.
Restriction from Normal Access to Goods and Services	Any procedure implemented in a manner that restricts a person's normal access to goods and services such as nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, or necessary clothing (Minnesota Statues, section 245.825); or to any protection required by state licensing standard and federal regulations governing the program. Also includes denying or restricting a person's access to equipment and devices such as hearing aids and communication boards that facilitate the person's functioning. If temporary removal of the equipment or device is necessary to prevent injury to the person or others, the equipment or device must be returned to the person as soon as possible.
Denied Access to Legal Representative and Relatives	Any procedure implemented in a manner that denies the person ordinary access to legal counsel and next of kin (Minnesota Statutes, section 245.825). Contact with relatives should not be considered a privilege to be earned but rather as the person's right.
Seclusion	Placing a person alone in a room which he or she is not free to leave for a certain amount of time due to a lock or device positioned to hold the door closed. Release from the placement would be noncontingent on the person's behavior.
Sensory Restriction	Totally or partially restricting a person's senses at a level that exceeds placing a hand in front of a person's eyes as a visual screen or playing music through earphones worn by the person at a level of sound which causes the person discomfort.
Intense Aversive Stimuli	Presenting intense sounds, lights, or other stimuli as aversive stimuli. Additionally, refers to the presentation or application of noxious smells, tastes, and substances (e.g., water mist, lemon juice, or hot pepper sauce) as aversive stimuli.
Emergency Use of Room Time Out	Placing a person in a room that he or she is not free to leave for a certain amount of time. The Federal Register states that a person may only be placed in room time out when the time out procedure has been incorporated into the person's individual program plan as a systematic intervention for the management of challenging behavior.
Emergency Use of Shock	The application of electrical current to the skin of a person as a consequence to the emission of challenging behavior. Emergency use of faradic shock is strictly prohibited.

CHAPTER 6

PROCEDURES PERMITTED AND CONTROLLED (9525.2740)

This section of the manual provides additional information about the aversive and deprivation procedures that are regulated by Rule 40. However, prior to the implementation of any permitted or controlled procedure, specific activities and tasks must be completed. For example, comprehensive assessment information and informed consent from the person's legal representative must be obtained.

Aversive or deprivation procedures permitted and regulated in Rule 40 are planned applications of aversive stimuli or planned delay or withdrawal of goods or services which are contingent on the occurrence of a target behavior identified in the IPP for reduction or elimination. Typically, an aversive procedure is unpleasant and penalizes or confines and is designed to reduce the probability that a behavior will occur again in the future. Because these procedures are aversive, they have specific guidelines of implementation. When positive approaches have been tried unsuccessfully or the behavior is such that emergency use of controlled procedures has been necessary (e.g., extremely aggressive behavior, severe self-injurious behavior), the rule recognizes that there may be a need to implement specified aversive or deprivation procedures in combination with or as an adjunct to positive procedures. It is important to remember that the rule requires that these procedures be implemented in the least restrictive and most respectful manner possible. **The rule does not intend to imply that these controlled procedures should be used, but strives to encourage the use of positive approaches as alternatives to controlled procedures.**

Procedures permitted and controlled include:

	Controlled Procedures
✓	Exclusionary Time Out
✓	Room Time Out
✓	Manual Restraint
✓	Mechanical Restraint
✓	Positive Practice Overcorrection
✓	Restitutional Overcorrection
✓	Partial Restriction of a Person's Vision and Hearing
✓	Deprivation

Prior to implementing a controlled procedure certain criteria must be met. These criteria include:

Controlled Procedure Criteria	
✓	Implementation of the controlled procedure is based on a need that is identified in the ISP;
✓	The use of the controlled procedure is supported with documentation describing how positive approaches and less intrusive procedures have been attempted;
✓	The controlled procedure is proposed, approved, and implemented as part of the person's IPP by the Expanded Interdisciplinary Team (EIDT) and the Internal Review Committee (IRC);
✓	The controlled procedure is written into a total comprehensive methodology and specified in the person's IPP;
✓	The controlled procedure represents the lowest level of intrusiveness required to influence the target behavior;
✓	The controlled procedure is not excessively intrusive in relation to the target behavior;
✓	Informed consent has been obtained for the use of the controlled procedure; and
✓	The controlled procedure is implemented and monitored by staff members who have been trained to implement the procedure.

Time Out

"Time out" or "time out from positive reinforcement" involves removing a person from the opportunity to gain positive reinforcement and is employed when a person demonstrates a target behavior identified in the IPP. Return of the person to ongoing activities is contingent on the person stopping or bringing under control the behavior that precipitated the time out. If release from the time out is time-based (e.g., Jerry must be calm--not exhibiting screaming or hitting behaviors for 5 minutes), a rationale must be provided for the use of the time-based criteria, as well as, historical information which supports the amount of time indicated. Time out periods are usually brief, lasting only several minutes.

When implementing a time out procedure, the following standards must be met and documented:

Time Out Standards	
✓	If the client is resistive to moving to another location or environment and physical assistance is required to escort the client to the location of time out, procedures and methodology for manual restraint must also be included in the behavior management plan.
✓	Time out procedures must not exceed 60 minutes.
✓	When possible the time out must be implemented in person's own room or other area commonly used as living space rather than in a room designated as a time out room.
	The IPP must include the following information:
✓	• Description of how the person is to be monitored while in time out (i.e., staff's position for visual monitoring, duration of procedure, etc.);
✓	• Must explain that return to an activity will be contingent on the person bringing under control the behavior that precipitated the time out procedure;
✓	• Must state that staff will attempt to return the person to an ongoing activity at least every 30 minutes during the time out procedure; and
✓	• Must include positive procedures.

There are two types of time out that are considered to be controlled procedures, **exclusionary time out and room time out.** Exclusionary time out consists of the removal of a person demonstrating a target behavior to an environment where the person cannot observe the ongoing activity but which is not a designated "time out room."

It must not be assumed that because a person is placed in his or her bedroom for a time out that the time out is exclusionary. Under some circumstances placing a person in his or her own bedroom can constitute room time out. For instance, if personal items (e.g., books, games, a stereo, puzzles) or items normally present are removed so that little or no stimulation is present, and the individual is prevented from leaving the room, the procedure may be considered room time out. Time out implemented in an individual's bedroom may also be considered room time out if he or she is prevented from leaving the room and the individual does not have the cognitive capacity to understand that return to ongoing reinforcing activities is contingent upon the cessation of the target behaviors and/or the individual does not have the physical capacity to return to ongoing activities without assistance. For example, an individual could remain in his or her bedroom for hours waiting for some cue that he or she can join ongoing activities or for someone to assist him or her into a wheelchair. In these cases, the individual would not have the capacity to return to ongoing activities without assistance.

The second type of time out is known as room time out. Room time out, also commonly known as separation, involves removing a person from an ongoing activity to an unlocked room. The person may be prevented from leaving a time out room by staff members blocking the door way of the room or by providing additional support to a closed door. The door cannot be locked by mechanical devices (e.g., latch locks, dead bolts) or blocked with objects positioned to hold the door closed. In addition, devices to hold the individual immobile, either partially or completely, cannot be used while room time out is being implemented. For example, a person may not have velcro straps placed around his or her lower legs while a room time out procedure is being implemented.

The following standards must be met and documented when a room time procedure is implemented:

Room Time Out Standards and Required IPP Documentation	
Standard	**Documentation**
✓ **Room Dimensions**	Regulation requires that the room measure 36 square feet and be large enough to allow the person to stand, to stretch his or her arms, and to lie down.
✓ **Safety of Room**	Documentation of safety features within the room (e.g., carpeting, cushioned walls, protected light fixtures, etc.)
✓ **Condition of Room**	It must be documented that the room is well lit, well ventilated, and clean.
✓ **Visual Monitoring/ Supervision**	Methods used to monitor or supervise the individual during the implementation of the room time out procedure. For example: "Bob will be observed through an observation window located within the unlocked door."
✓ **Duration of Time Out** (must not exceed one hour.)	Duration of time out procedure. Documentation that attempts have been made at least every 30 minutes to return the individual to ongoing and reinforcing activities while implementing the time out procedure.
✓ **Documentation of Room Time Out Procedure**	Description of how each use of the room time out procedure will be documented. This documentation should include the frequency of use of the procedure and the duration of each room time out occurrence.
✓ **Time Out (in excess of 30 minutes)**	Documentation that the individual was given access to water to drink and a bathroom. Documentation of attempts to return individual to ongoing activities.
✓ **Release Criteria**	Statements within procedures that specify or identify: •That release from room time out is contingent on the individual bringing under control the behavior that precipitated the time out. •That the individual will be returned to ongoing activities as soon as the behavior that precipitated the time out abates or stops. •The adaptive behavior that triggers release. •That when an amount of time that the person must remain in time out is specified, a rationale must be given for this time.

Manual Restraint

Physical or manual restraint consists of intervention intended to hold a person immobile or limit a person's movement by using body contact as the only source of physical restraint. This procedure is commonly referred to as "holding." Any procedure which requires staff to manually escort a resistive individual must also be considered manual restraint. Situations where the person is not resistive to manual guidance or has an unsteady gait requiring physical assistance from another person should not be considered manual restraint. A complete methodology for manual restraint includes an exact description of the type of hold or contact as well as a description of actions taken or steps completed prior to implementing a manual restraint (e.g., client will be redirected, aggression will be blocked, attempts to interrupt the behavior or distract the person will be made, staff will talk to person, staff will not talk to person). In some instances, immediate manual restraint may be necessary to implement due to the imminent injury to the person or others or due to the intensity or form of the challenging behavior displayed by the person.

Manual Restraint Standards and Required IPP Documentation

	Standard	Documentation
✓	Assess Medical Condition of Individual	Obtain primary physician's report indicating whether 1. The individual has any medical condition that may cause the target behavior 2. The individual has any medical condition that should be considered when implementing manual restraint. 3. Medical contraindications for the use of manual restraint.
✓	Opportunity for Motion Criteria	Procedures specifying and documenting that an individual is given the opportunity for release from the manual restraint and the opportunity for motion and exercise for at least 10 minutes out of every 60 minutes that manual restraint is used.
	Documentation of Procedure	Procedures and documentation of the following: 1. Efforts are made to lessen or discontinue the restraint at least every 15 minutes unless contraindicated. 2. The time each effort to lessen or discontinue the restraint was made. 3. The individual's response to the effort to lessen or discontinue the restraint.

Mechanical Restraint

This procedure involves the use of devices such as mittens, straps, helmets, braces, restraint chairs, or papoose boards to 1) limit a person's movement, 2) hold a person immobile, or 3) limit a person's access to specific body parts (e.g., eyes, ears) as an intervention precipitated by a person's behavior. Mechanical restraint is often used with individuals are extremely aggressive toward others or who engage in self-injurious behaviors such as head-banging, gouging, or other actions resulting in tissue damage, which may be life threatening or which have caused or could cause serious medical problems.

The required standards and documentation that must be addressed when mechanical restraint is used are summarized below.

Mechanical Restraint Standards and Required IPP Documentation When Restraint Restricts:

- Three or More Limbs
- Movement From One Location to Another

	Standard	Documentation
✓	Assess Medical Condition of Individual	Obtain primary physician's report indicating whether 1. The individual has any medical condition that may cause the target behavior 2. The individual has any medical condition that should be considered when implementing mechanical restraint. 3. Medical contraindications for the use of mechanical restraint.
✓	Monitoring the Individual	Procedures and documentation that staff continuously visually monitor the individual while the mechanical restraint procedure is implemented.
✓	Opportunity for Release Criteria	Procedures specifying and documenting that an individual is given the opportunity for release from the mechanical restraint and the opportunity for motion and exercise for at least 10 minutes out of every 60 minutes that the restraints are used.
	Documentation of the Procedure	Procedures and documentation of the following:
✓		1. Efforts are made to lessen or discontinue the restraint at least every 15 minutes.
✓		2. The time each effort to lessen or discontinue the restraint was made.
✓		3. The individual's response to the effort to lessen or discontinue the restraint.

Mechanical Restraint Standards and Required IPP Documentation When Restraint Does Not Limit Movement (e.g., helmet):	
✓ Assess Medical Condition of Individual	Obtain primary physician's report indicating whether 1. The individual has any medical condition that may cause the target behavior 2. The individual has any medical condition that should be considered when implementing mechanical restraint. 3. Medical contraindications for the use of mechanical restraint.
✓ Monitoring the Condition of the Individual	Staff must monitor the condition of the person every 30 minutes and document that these observations were made.
✓ Opportunity for Release from Restraint	Procedures specifying and documenting that an individual is given the opportunity for release from the mechanical restraint and the opportunity for motion and exercise for at least 10 minutes out of every 60 minutes that the restraints are used.

Deprivation Procedure

This procedure consists removing a positive reinforcer after an individual demonstrates a target behavior. The removal of the positive reinforcer is intended to result in a decrease in the frequency, duration, or intensity of the target behavior. Often, the positive reinforcer that is removed consists of goods, services, or activities that the individual normally receives. The removal is often in the form of a delay or postponement of the positive reinforcer.

Data regarding the use of deprivation, response cost and time out have yielded findings that the length of time of delay or removal or the type of good service or activity being removed is not as important a criteria as the impact that the delay or removal has or is expected to have on the person (Carr, Robinson, & Palumbo, 1990). For example, removing a radio during sleep time for three hours will not have the same level of intrusiveness for many people as removing a radio for two minutes during a preferred broadcast (e.g., a Twins baseball game). Another example would be to delay telephone use for two minutes after a set time during the week which has historically been the time the person makes telephone calls. In this case, this delay of two minutes would be perceived as intrusive due to historical use. Another consideration that must be addressed is the person's ability to understand time concepts. Some individuals may not understand that an item removed will be returned in a very short time. Instead, this individual may believe that the item will not ever be returned.

Positive Practice Overcorrection

This procedure requires a person to demonstrate or practice correct forms of a behavior at a rate or for a length of time that exceeds the typical frequency or duration of that behavior. This practicing of correct forms of the behavior enables the person to learn or practice correct forms of a desired behavior which is incompatible with an identified target behavior. For example, if a person aggresses toward another person during a greeting situation, staff may require the person to "shake hands" with that person, walk to another person and shake that person's hand, and repeat this behavior two more times with various people in the environment in order to learn the appropriate touch behavior associated with greetings.

Restitution Overcorrection

This procedure requires a person to clean, repair, or correct an area or situation damaged or disrupted as a result of the person's behavior to a point where the area or situation is not only restored but so that it exceeds its original condition. For example, Joe exhibits challenging behavior which includes tipping over furniture and waste baskets. As a consequence to this behavior, Joe is required to pick up the furniture and waste baskets that he tipped over and also straighten all the furniture and empty all the wastebaskets in his residence.

Partially Restricting an Individual's Sense of Hearing or Vision

This procedure consists of using devices in the environment to alter a person's sense of hearing and vision. Sensory deprivation cannot exceed a level of intrusiveness equivalent to placement of a hand in front of a person's eyes as a visual screen or provision of alternative auditory feedback, such as music through earphones worn by the person at a level of sound which does not cause discomfort. In instances where a person exhibits self-injurious behavior directed at the face and head, a helmet is often used. If this is the case, the individual program plan should specifically address the issue of how the person's helmet may restrict the person's sense of hearing or vision. The application of blindfolds to totally block vision or earphones to totally block hearing are prohibited.

CHAPTER 9

EMERGENCY USE OF CONTROLLED PROCEDURES

(9525.2770)

This section discusses emergency use of controlled procedures and specifies which procedures may be implemented on an emergency basis without first meeting the requirements in parts 9525.2750, 9525.2760, and 9525.2780. Documentation of the implementation of such procedures is also discussed. Emergency use of controlled procedures has often been a confusing and misunderstood area of Rule 40. As a result of this confusion, compliance related to correctly implementing controlled procedures on an emergency basis has been inconsistent. Consequently, license holders and case managers should review this section of the manual carefully.

The following controlled procedures can be implemented on an emergency basis:

Controlled Procedures Permitted for Emergency Use
✓ Exclusionary Time Out*
✓ Manual Restraint
✓ Mechanical Restraint
✓ Positive Practice Overcorrection
✓ Restitutional Overcorrection
✓ Partial Restriction of Person's Hearing or Vision
✓ Deprivation Procedures (as defined in 9525.2710, Subp. 12)
*PLEASE NOTE THAT THE IMPLEMENTATION OF ROOM TIME OUT IS NOT PERMITTED FOR ANY LICENSE HOLDER.

Emergency use implies that the requirements for implementing a controlled procedure (i.e., obtaining assessment information, reviewing the individual service plan, complying with content standards, reviewing the IPP, documenting and complying with all the standards of informed consent, etc.) have not been met. If such is true then the following four conditions must be met prior to implementing a controlled procedure on an emergency basis:

Criteria for the Emergency Use of a Controlled Procedure	
✓	Immediate intervention is needed to protect the person or others from physical injury or to prevent severe property damage that is an immediate threat to the physical safety of the person or others.
✓	Provisions for the use of the controlled procedure have not been written into the Individual Program Plan. (If there are provisions for use of the procedure within the IPP then it would not be considered emergency use).
✓	The least restrictive procedure possible is implemented to diffuse the emergency situation.
✓	An expanded interdisciplinary team meeting must be conducted within 30 calendar days from the date that the controlled procedure was implemented on an emergency basis, if it is determined that the behavior should be identified in the individual program plan for reduction or elimination.

In addition, emergency use of controlled procedures is only allowed when license holders have a written policy that specifically states the following:

Required Elements of Written Policy of License Holders on Emergency Use of Controlled Procedures	
✓	What procedures may not be implemented on an emergency basis (e.g., faradic shock, room time out) by that license holder.
✓	The internal agency procedures that must be followed throughout and following the implementation of any emergency use of a controlled procedure.
✓	How the license holder will monitor the emergency use of any controlled procedure.
✓	The type and amount of training a staff member will receive prior to being authorized to implement a controlled procedure under emergency conditions.
✓	A statement that the standards in part 9525.2750, subpart 1 concerning staff training and standards for use of mechanical and manual restraint must be met when those controlled procedures are used on an emergency basis.

Any facility staff member who implements an emergency procedure must submit a written report within three calendar days to a designated staff member who must be a QMRP. This report must include the following information:

Required Elements of an Emergency Use of Controlled Procedure Report	
✓	A detailed description of the incident leading to the use of the controlled procedure.
✓	The controlled procedure that was used.
✓	The time implementation of the procedure began and the time the procedure was terminated.
✓	The behavioral outcome that resulted.
✓	Why the procedure implemented was judged to be necessary to prevent injury or serious property damage.
✓	An assessment of the likelihood that the behavior that necessitated the use of the controlled procedure will occur again.

The designated facility staff member (QMRP) who reviews the emergency use report must submit a copy of the report to the case manager and expanded interdisciplinary team (EIDT) within 7 calendar day of the emergency use of a controlled procedure. **If the emergency use involved manual restraint, mechanical restraint, or the use of exclusionary time out exceeding 15 minutes at one time or a cumulative total of 30 minutes or more within 24 hours, the QMRP must also send a copy of the report to the internal review committee. It is recommended (but not required) a copy also be sent to the advisory committee.**

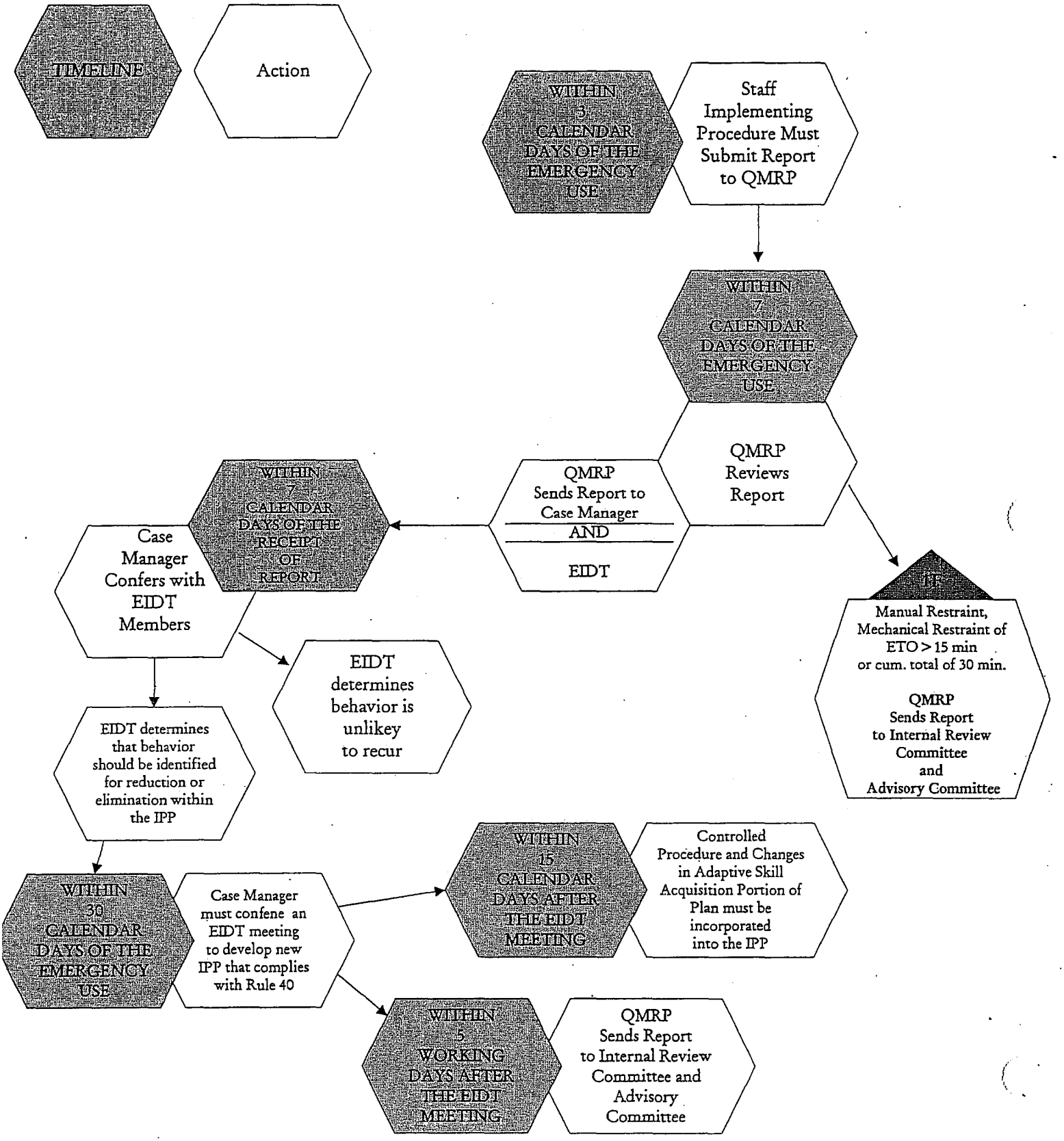
Additionally, within seven calendar days after receiving the report on the use of a controlled procedure on an emergency basis, the case manager must confer with members of the EIDT to discuss the following:

Points of Discussion Between the Case Manager and Members of the EIDT Following the Use of a Controlled Procedure on an Emergency Basis	
✓	The incident that occurred that necessitated the use of the controlled procedure.
✓	Define the target behavior for reduction or elimination in observable and measurable terms.
✓	Identify the antecedent or event that gave rise to the target behavior.
✓	Identify the perceived function that the target behavior served for the individual.
✓	Determine what modifications should be made to the existing individual program plan so as to reduce the need for the use of a controlled procedure.
Documentation of Attempts to Use Less Restrictive Alternatives	
✓	All attempts to use less restrictive alternatives that failed and why they failed.
✓	A rationale for not attempting the use of other less restrictive alternatives.

A copy of the report and a summary of the expanded interdisciplinary team's decisions following the discussion of the report, including any changes made to the adaptive skill acquisition portion of the individual program plan must be included in the person's permanent file. If it is determined that the behavior should be targeted within the IPP for reduction or elimination, an expanded interdisciplinary team meeting must be conducted within 30 calendar days after the emergency use of the controlled procedure.

The following displays the reporting process in the form of a flow chart that includes timelines and actions that must be taken. This figure may assist service providers with the timelines and responsibilities that are associated with the emergency use of a controlled procedure.

EMERGENCY USE OF A CONTROLLED PROCEDURE



APPENDIX B

PHYSICIAN'S REPORT

Date

Dear Doctor _____:

Our agency (_____) is considering the use of an intervention to reduce or eliminate behavior problems demonstrated by _____, who is a patient of yours. The problematic behaviors include:_____

_____

_____.

We are proposing to implement the following procedure:_____

_____

_____

_____.

✓Please indicate whether you are aware of any medical condition (excluding the diagnosis of mental retardation) that may be responsible for _____'s behavior problem(s).

☐ Yes, _____ has a medical condition that may be responsible for the demonstration of the identified behavior problems. The medical condition that may be responsible for the behavior problems is _____

_____

_____.

Known treatment for this condition consists of:_____

_____

_____.

☐ No, _____ does not have a medical condition that may be responsible for the demonstration of the identified behavior problems.

✓Please indicate whether any medical condition should be considered when developing a behavioral intervention (e.g., the person experiences respiratory problems and manual restraint may make it difficult for the person to breathe).

❑ Yes, _____ has a medical condition that should be considered when developing implementing behavioral interventions. The medical condition of concern is

_____

_____.

Greatest concern arises if the following behavioral procedures were implemented:_____

_____

_____

❑ No, _____ does not have a medical condition that should be considered when developing and implementing behavioral intervention.

✓Please indicate if you believe that the use of manual or mechanical restraint with _____ is medically contraindicated.

❑ Yes, the implementation of manual or mechanical restraint with my patient would be medically contraindicated for the following reasons:_____

_____

_____.

❑ No, the implementation of manual or mechanical restraint with my patient would not be medically contraindicated.

_____

Primary physician's signature Date

APPENDIX C

INFORMED CONSENT

FOR AVERSIVE AND DEPRIVATION PROCEDURE(S)

Client's Name:_____ Date Consent Obtained:_____

1. Description of target behavior(s):

2. Baseline measurement of target behavior.

3. Description of proposed controlled procedure:

4. Rationale for the use of this controlled procedure:

5. Description of potential benefits/expected treatment outcomes as a result of implementing this controlled procedure. Include within the description the extent that the target behavior is expected to change as the result of implementing the procedure(s).

6. Description of any discomforts, risks, and other side effects from the use of the controlled procedure:

7. Previous treatment attempts/alternative procedures considered. For each procedure listed, please include the following information:
   1) Dates (start and end dates) when the procedure was implemented.
   2) The type of procedure (include positive procedures, controlled procedures, and medications prescribed), and
   3) Possible reasons the listed procedures were not effective in reducing or eliminating the target behavior.

8. Description of attempts to modify environment(s):

9. Potential effects of not implementing the procedure:

10. Criteria for continuing, modifying, and terminating the controlled procedure:

11. You will be given a copy of this consent form. If you have any further questions or concerns regarding the information of the proposed procedures or seek additional information related to 9525.2700 - 9525.2810 which govern the proposed procedure, the following persons can be contacted:

Name:_____ Name_____

Address:_____ Address:_____

_____ _____

Phone Number:_____ Phone Number:_____

I understand that I have the right to refuse consent for use of the controlled procedure(s) described in this form and in the Individual Program Plan.

I understand that I have the right to withdraw my consent at any time. If I withdraw my consent, the procedure(s) described herein with be discontinued.

I understand that my consent automatically expires 90 days from the date on which I give informed consent. In addition, I understand that my informed consent must be re-obtained at that time in order for the use of the controlled procedure to continue after the initial 90 day period ends.

I understand that no substantial changes in the procedure(s) described above will be implemented without my informed consent of the new plan being obtained.

_____ ____/____/____
Signature of Client (if own guardian)

_____ ____/____/____
Legal Representative or Guardian

_____ ____/____/____
Legal Representative or Guardian

The date when my informed consent will expire (termination of the procedure) or be re-obtained is ____/____/____.

REVISED 2/96

APPENDIX D

EMERGENCY USE OF CONTROLLED PROCEDURE REPORT FORM

Client:_____ Date of Incident:_____

Person(s) preparing report:_____ Date of Report:_____

QMRP(designated staff person):_____

1. Description of incident (Events leading up to the use of the controlled procedure on an emergency basis). Use back of page, if necessary:

2. Describe the behavior that necessitated the use of a controlled procedure on an emergency basis:

3. Procedure Used: _____

4. Time procedure was implemented: Started at __ __: __ __ Ended at: __ __: __ __'

   Total time that procedure was implemented _____ (e.g., # minutes)

5. Behavioral outcome (following the use of the procedure):

6. Reasons it was thought necessary to implement the emergency use of the controlled procedure:

7. Less restrictive alternatives attempted prior to implementing the controlled procedure. If no less restrictive alternative was attempted, please explain why (e.g., "person was endanger of seriously hurting themselves").

8. Comment on the likelihood that the behavior necessitating the emergency use of the controlled procedure will occur again:

APPENDIX E

CONTROLLED PROCEDURES QUARTERLY REPORT FORM

Current Quarter: _____ (Month), 19_____ through _____ (Month), 19_____

I. GENERAL INFORMATION:

Please place check (✓) box (☐) to indicate provider submitting this quarterly report.

Client's Name _____ MA ID# _____

County of Financial Responsibility _____ Host County _____

QMRP's Name _____ Telephone _____

Case Manager's Name _____ Telephone _____

Service Settings	Address	Implementation of a Controlled Procedure?	*Date Implemented
☐ Residence Name _____	_____	( ) Yes ( ) No	____/____/____
☐ Day Program Name _____	_____	( ) Yes ( ) No	____/____/____
☐ Other Provider Name _____	_____	( ) Yes ( ) No	____/____/____

II. PROCEDURE DESCRIPTION (Check all that apply below)

( ) *Manual Restraint*
Reason for Use:
( ) Injury to Self
( ) Injury to Others
( ) Property Destruction
( ) Other_____

( ) *Mechanical Restraint*
Reason for Use:
( ) Injury to Self
( ) Injury to Others
( ) Property Destruction
( ) Other_____

( ) *Exclusionary Time Out*
Reason for Use:
( ) Injury to Self
( ) Injury to Others
( ) Property Destruction
( )
Other_____

( ) *Room Time Out*
Reason for Use:
( ) Injury to Self
( ) Injury to Others
( ) Property Destruction
( )
Other_____

( ) *Other:*_____
Reason for Use:
( ) Injury to Self
( ) Injury to Others
( ) Property Destruction
( ) Other_____

III. RULE 40 PROGRAM STATUS

Residence	DP &T	Other	
( )	( )	( )	New program, just started.
( )	( )	( )	Currently Implemented, No planned changes.
( )	( )	( )	Program revised, but still implemented.
( )	( )	( )	On hold, not implemented.
( )	( )	( )	Program planned for discontination.
( )	( )	( )	Discontinued
( )	( )	( )	Other (describe)_____

IV. PSYCHOTROPIC MEDICATIONS

Currently Prescribed Medications	Dose
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

* It is recognized that original implementation dates may be difficult to retrieve when a procedure has been implemented for numerous years. In these cases, please indicate the earliest Month and Year of implementation that can be verified in the individual's personal file.

V. EVALU ION OF TARGET BEHAVIORS TO BE DECREASE

Please record the information regarding the behavior rate (frequency, duration, or interval) for each target behavior in the appropriate cells of the table provided below. Also indicate the intensity of behavior that occurred most of the time in the current and previous quarter. Suggested Intensity Measures: (A. Slight B. Moderate C. Substantial D. Severe) (Instructions for this section can be found in the Rule 40 Manual)

(OPTIONAL)

Rule 40 Manual 77

	Target Behavior #1		Target Behavior #2		Target Behavior #3		Target Behavior #4	
Specific Measurement	Behavior Rate	Intensity	Behavior Rate	Intensity	Behavior Rate	Intensity	Behavior Rate	Intensity
Current Quarter								
Previous Quarter								

Frequency and Duration of the Implementation of Controlled Procedures			
	Procedure	Frequency	Duration
Current Quarter	TO-Excl.		
	TO-Room		
	Man Restr.		
	Mech Restr		
Previous Quarter	TO-Excl.		
	TO-Room		
	Man Restr.		
	Mech Restr		

Other Significant changes that have influenced the targeted behaviors in the current quarter (Refer to instructions in Rule 40 Manual for examples):

Exceptions to the above information (Refer to instructions in Rule 40 Manual for examples):

VI. EVALUATION OF ADAPTIVE BEHAVIORS TO BE INCREASED. Please see the manual insert for further instructions and examples.

	Adaptive Behavior #1	Adaptive Behavior #2	Adaptive Behavior #3	Adaptive Behavior #4
	Specific Measurement	Specific Measurement	Specific Measurement	Specific Measurement
Current Quarter				
Previous Quarter				

Other significant changes that have influenced adaptive behaviors within this quarter (Refer to instructions in Rule 40 Manual for examples):

VII. (OPTIONAL) OTHER SIGNIFICANT OUTCOMES IN THE PERSON'S LIFE (Refer to instructions in Rule 40 Manual for examples):

APPENDIX F

RULE 40 INDIVIDUAL PROGRAM PLAN REQUIREMENTS CHECKLIST

Minnesota Rules 9525.2700 to 9525.2810 (with reference to Rule 185)

General Information

Client's Name _____ Case Manager _____
County of Financial Responsibility _____
Host County _____
Residential Location _____
Day Training and Habilitation Location _____
Controlled Procedure Type(s) (Please specify all used: _____
_____

Assessment Information

Yes	No	N/A		
( )	( )		1.	Physical description of the person.
( )	( )		2.	Psychological description of the person.
			3.	Documentation that the person's primary medical physician was consulted and has provided a report indicating if a relationship exists between the target behavior(s) and medical conditions that the person has. Specifically:
( )	( )	( )		• Dr. specified whether medical conditions exist which could result in the demonstration of the target behavior.
( )	( )	( )		• Dr. specified whether there are medical conditions that should be considered when developing a behavioral intervention.
( )	( )	( )		• Dr. specified whether the implementation of the proposed controlled procedure is medically contraindicated.
( )	( )	( )	4.	Baseline of target behavior
( )	( )	( )	5.	Baseline of adaptive behavior
			6.	Environmental Assessment
( )	( )	( )		• A summary of elements in the environment (Physical and social) that could be influencing the target behavior(s) or of attempts made to change elements in environments.
( )	( )	( )		• An analysis of residential environment
( )	( )	( )		• An analysis of day training and habilitation environment
( )	( )	( )		• An analysis of placement and services (comment whether a change is warranted).
			7.	Communication Assessment (Functional Assessment of Behavior). The extent to which the target behavior:
( )	( )	( )		• Represents an attempt by the person to communicate with others
( )	( )	( )		• Serves as a means to control the person's environment
( )	( )	( )		• Recommendations for changes in the IPP or environment that are designed to enhance more adaptive communication skills (e.g., symbols, signs, spoken language)
			8.	Documented description of treatment approaches that have been tried.
( )	( )	( )		• Summary of previous interventions used;
( )	( )	( )		• Factors believed to have interfered with the effectiveness of those interventions tried.

Review of the Service Plan

Yes	No	N/A	
( )	( )	( )	Documentation that assessment needs have been identified in the ISP and that the ISP has been reviewed. Statement and signature from case manager is sufficient

IPP Content Standards

Yes	No	N/A		
			1.	Behavioral objectives
( )	( )	( )	•	Behavior objective to increase alternative functional adaptive behavior to replace target behavior(s)
( )	( )	( )	•	Behavior objective to decrease or eliminate target behavior(s)
			•	Time frames for expected change in behaviors, including projected starting and completion dates for each objective
( )	( )	( )		• Adaptive Behavior(s)
( )	( )	( )		• Target Behavior(s)
( )	( )	( )	•	Measurable behavioral criteria that will be used to determine whether the procedure has resulted in the achievement of short-term objectives.
			2.	Methodology
( )	( )	( )	•	Description of strategies to increase functional adaptive behavior(s)
( )	( )	( )	•	Description of controlled procedure
( )	( )	( )	•	Method of implementation for teaching adaptive behavior
( )	( )	( )	•	Method of implementation of controlled procedure
( )	( )	( )	•	Place(s) procedures will be implemented;
( )	( )	( )	•	Conditions for implementation identified;
			3.	Monitoring and Training
( )	( )	( )	•	Description of how implementation of procedure will be monitored.
( )	( )	( )	•	Who monitors implementation of the procedure.
( )	( )	( )	•	How frequently implementation of procedure is monitored.
( )	( )	( )	•	Description of how staff will be trained to implement procedure/staff training requirements.
( )	( )	( )	4.	Description of discomforts, risks, and side effects which are reasonable to expect when implementing procedure
			5.	Data Collection
( )	( )	( )	•	Description of method of data collection.
( )	( )	( )	•	Description of type of data to be collected.
( )	( )	( )	•	Method to be used for monitoring expected or unexpected side effects of procedure.
			6.	Generalization plan
( )	( )	( )	•	Description of what is being done to teach a functionally equivalent behavior to replace the targeted behavior;
( )	( )	( )	•	Description of what is being done to implement interventions that teach functionally equivalent behaviors across settings, persons, materials; and
( )	( )	( )	•	Description of what is being done to fade or eliminate the need for or use the controlled procedure.
( )	( )	( )	7.	Coordination of services across license holders
( )	( )	( )	8.	Plan for involvement of family and social contacts
( )	( )	( )	9.	Termination date of procedure

Monitoring

Yes	No	N/A		
( )	( )	( )	1.	Monitoring by case manager (quarterly for reauthorization and progress reports to the advisory committee; and more often as necessary
( )	( )	( )	2.	Monitoring of staff training and competency by the expanded interdisciplinary team

Documentation of Informed Consent

Yes	No	N/A		
( )	( )	( )	1.	IPP has been reviewed and signed by legal guardian/legal representative
( )	( )	( )	2.	A baseline measurement of the target behavior.
( )	( )	( )	3.	A detailed description of the proposed controlled procedure.
( )	( )	( )	4.	Documentation of benefits of procedure, including the extent to which the target behavior is expected to change as a result of implementing the controlled procedure.
( )	( )	( )	5.	A description of discomforts, risks, or other side effects that are reasonable to expect.
( )	( )	( )	6.	Expected effect of not implementing procedure
( )	( )	( )	7.	Offer to answer questions including names, addresses, and telephone numbers of contact people.
( )	( )	( )	8.	An explanation that the person or the individual authorized to give consent has the right to refuse consent.
( )	( )	( )	9.	An explanation that consent is time-limited (automatically expiring 90 days after the date on which consent was given), that consent must be reobtained after 90 days for procedure to be continued, and that consent may be withdrawn at any time.
( )	( )	( )	10.	An explanation that consent must be re-obtained if substantial changes in the procedure(s) are proposed.
( )	( )	( )	11.	Signature of guardian or legal representative on the Rule 40 Informed Consent Form

Review and Authorization

Yes	No	N/A		
( )	( )	( )	1.	Expanded Interdisciplinary Team
( )	( )	( )	2.	Internal Review Committee

Review of Administration of Rule 40

Yes	No	N/A	
( )	( )	( )	Advisory Committee

Standards for Controlled Procedures

Yes	No	N/A		**Exclusionary Time Out**
( )	( )	( )	1.	Continuously monitored.
( )	( )	( )	2.	Provisions present for staff to attempt to return the person to an activity at least every 30 minutes.
			3.	Time out in excess of 30 minutes, there must be:
( )	( )	( )		• Access to water and a bathroom.
( )	( )	( )	4.	Documentation of duration of time out.
( )	( )	( )	5.	Return to positive reinforcement is contingent on the person's bringing under control the behavior that precipitated the time out.
( )	( )	( )	6.	Rationale given for release criteria other than the cessation of the target behavior.

Yes	No	N/A	Room Time Out
( )	( )	( )	1. Continuously monitored.
( )	( )	( )	2. Room is safe.
( )	( )	( )	3. Observation window/mechanism.
( )	( )	( )	4. Proper size.
( )	( )	( )	5. Lighted, ventilated, clean.
( )	( )	( )	6. Documentation of duration of time out.
( )	( )	( )	7. Attempts made to return person to ongoing activities at least every 30 minutes.
			8. Time out in excess of 30 minutes, there must be:
( )	( )	( )	• Access to water and a bathroom.
( )	( )	( )	9. Return to activities is contingent on the display of a targeted adaptive behavior and the cessation of the target behavior.
( )	( )	( )	10. Rationale given for release criteria other than the cessation of the target behavior.

Yes	No	N/A	Manual Restraint
( )	( )	( )	1. Physician's report on any contraindications for use of the procedures.
( )	( )	( )	2. Opportunity for motion or exercise every hour for at least 10 minutes.
( )	( )	( )	3. Efforts made to lessen or discontinue restraint every 15 minutes unless contraindicated.
( )	( )	( )	4. Documentation of person's response to attempts at lessening or discontinuing restraint.

Yes	No	N/A	Mechanical Restraint
( )	( )	( )	1. Physician consulted and provides a report on any contraindications for use of the procedures.
			2. If three or more limbs, or the person is immobile, there must be:
( )	( )	( )	• Opportunity for motion or exercise every hour for 10 minutes.
( )	( )	( )	• Efforts made to lessen or discontinue restraints every 15 minutes.
( )	( )	( )	• A staff person who remains with person, making checks of restraint at least every 30 minutes.
( )	( )	( )	• Documentation of checks must be made and kept in person's records.
			3. If person's mobility is not restricted by restraint (two or less limbs):
( )	( )	( )	• Opportunity for motion or exercise every hour for 10 minutes.
( )	( )	( )	• Efforts made to lessen or discontinue restraints every 15 minutes.
( )	( )	( )	• A staff person who remains with person, making checks of restraint at least every 30 minutes.
( )	( )	( )	• Documentation of checks must be made and kept in person's records.

OVERSIGHT OF USE OF CONTROLLED PROCEDURES

Summary of Rule 40 Requirements

Minnesota Rules, parts 9525.2700 – 9525.2810 (Rule 40) sets specific standards for the development, review, approval and monitoring of plans proposing the use of controlled procedures, in addition to implementation and staff training requirements.

Expanded IDT: Plans proposed for use in any 245B licensed program require the review and approval by the person's expanded interdisciplinary team. The expanded interdisciplinary (IDT) membership must meet specified criteria. [9525.2750, subp. 1a.]

Internal Review Committee: Plans proposed for use in any 245B licensed residential services (ICF/MR certified and non-certified), residential-based habilitation services, or day training and habilitation program require the review and approval by the program's internal review committee. [9525.2750, subp. 2.]

Before approving a plan, the committee shall determine if each plan as submitted meets the requirements of parts 9525.2700 to 9525.2810 and all other applicable requirements governing behavior management established by federal regulations or by order of a court. The internal review committee membership must meet specified criteria.

Rule 40 Coordinator: Plans proposing the use of the following procedures must be submitted to the DHS-DSD rule 40 coordinator for manual restraint; mechanical restraint; use of a time out procedure for 15 minutes or more at one time or for a cumulative total of 30 minutes or more in one day; or faradic shock. The duties of the rule 40 coordinator, who has replaced the regional review committee, are as follows:

- review the reports on use of time out, mechanical restraint, and manual restraint required by parts 9525.2750 and 9525.2770 and act on those reports according to procedures established by the commissioner;
- confer as necessary if a case manager requests the authorization required in part 9525.2740, subpart 2; and
- act as directed by the commissioner to monitor and facilitate compliance with parts 9525.2700 to 9525.2810 and make recommendations to the commissioner; provide technical assistance in achieving compliance; and review, monitor, and report to the commissioner on statewide use of aversive and deprivation procedures in relationship to the use of less intrusive alternatives and to the use of psychotropic medication. [9525.2750, subp. 4 and 9525.2790, subp. 3.]

Quarterly Reporting: The license holder must submit quarterly data on forms prescribed by the commissioner on the use and effectiveness of plans that incorporate the use of manual restraint; mechanical restraint; use of a time out procedure for 15 minutes or more at one time or for a cumulative total of 30 minutes or more in one day; or faradic shock. [9525.2750, subp. 2a.]

Summary of 245B Requirements

Minnesota Statutes, chapter 245B, sets standards for the delivery of services provided to persons with developmental disabilities which relate to Rule 40 requirements.

Individual Program Plan: Rule 40 refers to the use of controlled procedures as being part of the "Individual Program Plan" (IPP). The documentation required of the license holder in 245B meets the individual program plan required in section 256B.092 or successor provisions. *[256B.092, subd. 1b, (5) states that the ISP must identify a need for an IPP, and subd. 1e, (a), identifies licensed providers responsibilities for the IPP when required in the ISP]*

The IPP in terms of the 245B documentation requirements includes, but is not be limited to, the consumer's identified outcomes, assessments, methods developed to support the consumer or to achieve outcomes, the risk management plan, health service needs and medication administration procedures (meaning any order for medical treatment, not just prescription medications) for the individual consumer, evaluation of services and progress toward outcomes and recommendations, written reports summarizing progress or reporting on the status of the consumer. [245B.03, subd. 2, (h)]

Outcome-based services must be developed, reviewed, approved and evaluated as follows: The license holder must provide outcome-based services in response to the consumer's identified needs as specified in the individual service plan; services must be based on the needs and preferences of the consumer and the consumer's personal goals; and be consistent with the principles of least restrictive environment, self-determination, and with additional specified criteria. "Outcome" means the behavior, action, or status attained by the consumer that can be observed, measured, and can be determined reliable and valid. Outcomes are the equivalent of the long-range goals and short-term goals referenced in section 256B.092, and any rules promulgated under that section. [245B.06, subd. 1]

The license holder must ensure consumer protections are met as follows:

- Ensure the exercise and protection of consumer rights. [245B.04]
- Lock doors only to protect the safety of consumers and not as a substitute for staff supervision or interactions with consumers. [245B.05, subd. 1]
- Report all incidents as defined under 245B.02, subd. 10, including deaths and serious injuries, to the required parties. [245B.05, subd. 7]
- Develop, document and implement a risk management plan. [245B.06, subd. 2]
- Provide sufficient supervision of consumers by staff to ensure the health, safety, and protection of rights of each consumer and to be able to implement each consumer's individual service plan. [245B.06, subd. 7]
- Provide for adequate supervision of direct care staff to ensure implementation of the individual service plan. [245B.07, subd. 4, (d)]
- Cannot use psychotropic medication or aversive and deprivation procedures, as a substitute for adequate staffing, as punishment, or for staff convenience. [245B.06, subd. 10]
- Must ensure staff are qualified and competent through training, experience, and education to meet the consumer's needs and additional requirements as written in the individual service plan. [245B.07, subd. 4, (a), subd. 5, 6, and 7]
- Designate a coordinator who must provide supervision, support, and evaluation of activities that include:
  (1) oversight of the license holder's responsibilities designated in the individual service plan;
  (2) instruction and assistance to staff implementing the individual service plan areas;
  (3) evaluation of the effectiveness of service delivery, methodologies, and progress on consumer outcomes based on the condition set for objective change; and
  (4) review of incident and emergency reports, identification of incident patterns, and implementation of corrective action as necessary to reduce occurrences.
  The coordinator is responsible for taking the action necessary to facilitate the accomplishment of the outcomes for each consumer as specified in the consumer's individual service plan. [245B.07, subd. 4, (b) and (c)]
- Develop and implement program policies and procedures to ensure protection of consumer health and safety, consumer rights and privacy, and that promote continuity and quality of consumer supports. [245B.07, subd. 8]

AVERSIVE AND DEPRIVATION PROCEDURES
Determining What Procedures are Exempted, Controlled or Prohibited

Use this table as a reference to determine which actions and procedures under Minnesota Rules, parts 9525.2700 to 9525.2810 (Rule 40) are exempted, which are permitted and controlled, and which are prohibited.

9525.2720 EXEMPTED ACTIONS AND PROCEDURES.	9525.2740 PROCEDURES PERMITTED AND CONTROLLED.	9525.2730 PROCEDURES AND ACTIONS RESTRICTED OR PROHIBITED.
Use of the instructional techniques and intervention procedures identified below is not subject to the restrictions established by parts 9525.2700 to 9525.2810. However, the person's IPP must address the use of the following exempted actions and procedures. [All consumer specific documentation required in 245B meets the IPP requirements identified in 256B.092. Refer to 245B.03, subd. 2, (h).] The supports and methods must include the following: 1. information about: physical and social environments, the equipment and materials required, and techniques that are consistent with the consumer's communication mode and learning style specified as the license holder's responsibility in the individual service plan; 2. the projected starting date for service supports and the criteria for identifying when the desired outcome has been achieved and when the service supports need to be reviewed; and 3. the names of the staff, staff position, or contractors responsible for implementing each outcome.	Controlled procedures are permitted when the procedures are implemented in compliance with parts 9525.2700 to 9525.2810. Behaviors "Adaptive behavior" means a behavior that increases a person's capability for functioning independently in activities of daily living. "Target behavior" means a behavior identified in a person's IPP as the object of efforts intended to reduce or eliminate the behavior. Reinforcement "Positive reinforcement" means the presentation of an object, event, or situation following a behavior that increases the probability of the behavior recurring. Typically, the object, event, or situation presented is enjoyable, rewarding, or satisfying. Procedures "Controlled procedure" means an aversive or deprivation procedure that is permitted by parts 9525.2700 to 9525.2810 and is implemented under the standards established by those parts. Controlled procedures are listed in part 9525.2740. "Aversive procedure" means the planned application of an aversive stimulus (1) contingent upon the occurrence of a behavior identified in the IPP for reduction or elimination; or (2) in an	How aversive or deprivation procedures are implemented is RESTRICTED. Certain actions or procedures are PROHIBITED. An aversive or deprivation procedure must not: ▪ be implemented with a child in a manner that constitutes sexual abuse, neglect, or physical abuse as defined in Minnesota Statutes, section 626.556, which governs the reporting of maltreatment of minors; or ▪ be implemented with an adult in a manner that constitutes abuse or neglect as defined in Minnesota Statutes, section 626.557, which governs the reporting of maltreatment of vulnerable adults. Refer to definition of abuse under Minnesota Statutes, section 626.5772, subdivision 2.

AVERSIVE AND DEPRIVATION PROCEDURES
Determining What Procedures are Exempted, Controlled or Prohibited

9525.2720 EXEMPTED ACTIONS AND PROCEDURES.	9525.2740 PROCEDURES PERMITTED AND CONTROLLED.	9525.2730 PROCEDURES AND ACTIONS RESTRICTED OR PROHIBITED.
	emergency situation governed by part 9525.2770. "Aversive stimulus" means an object, event, or situation that is presented immediately following a target behavior in an attempt to suppress that behavior. Typically, an aversive stimulus is unpleasant and penalizes or confines. "Deprivation procedure" means the removal of a positive reinforcer following a response resulting in, or intended to result in, a decrease in the frequency, duration, or intensity of that response. Often times the positive reinforcer available is goods, services, or activities to which the person is normally entitled. The removal is often in the form of a delay or postponement of the positive reinforcer.	
Description of Procedures		
Corrective feedback or prompts Corrective feedback or prompts to assist a person in performing a task or exhibiting a response. **Physical contact to increase adaptive behavior [vs. redirecting behavior]** Physical contact to facilitate a person's completion of a task or response and directed at increasing adaptive behavior when the person does not resist or the person's resistance is minimal in intensity and duration, as determined by the expanded IDT.	**Positive practice overcorrection** "Positive practice overcorrection" means a procedure that requires a person to demonstrate or practice a behavior at a rate or for a length of time that exceeds the typical frequency or duration of that behavior. The behaviors identified for positive practice are typically appropriate adaptive behaviors or are incompatible with a behavior identified for reduction or elimination in a person's IPP. **Restitutional overcorrection** "Restitutional overcorrection" means a procedure that requires a person to clean, repair, or correct	**Emotional abuse** Speaking to a person in a manner that ridicules, demeans, threatens, or is abusive is PROHIBITED.

AVERSIVE AND DEPRIVATION PROCEDURES
Determining What Procedures are Exempted, Controlled or Prohibited

9525.2720 EXEMPTED ACTIONS AND PROCEDURES.	9525.2740 PROCEDURES PERMITTED AND CONTROLLED.	9525.2730 PROCEDURES AND ACTIONS RESTRICTED OR PROHIBITED.
Positive reinforcement procedures Positive reinforcement procedures alone or in combination with either of the above procedures to develop new behaviors or increase the frequency of existing behaviors.	an area or situation damaged or disrupted as a result of the person's behavior to a point where the area or situation is not only restored to but exceeds its original condition.	
Temporary interruptions Temporary interruptions in instruction or ongoing activity in which a person is removed from an activity to a location where the person can observe the ongoing activity and see others receiving positive reinforcement for appropriate behavior. Return of the person to normal activities is contingent upon the person's demonstrating more appropriate behavior. This procedure is often referred to as contingent observation.	**Time out** "Time out" or "time out from positive reinforcement" means removing a person from the opportunity to gain positive reinforcement and is employed when a person demonstrates a behavior identified in the IPP for reduction or elimination. Return of the person to normal activities from the time out situation is contingent upon the person's demonstrating more appropriate behavior. Time out periods are usually brief, lasting only several minutes. Time out procedures governed by parts 9525.2700 to 9525.2810 are: • "exclusionary time out," which means removing a person from an ongoing activity to a location where the person cannot observe the ongoing activity; and • "room time out," which means removing a person from an ongoing activity to an unlocked room. The person may be prevented from leaving a time out room by staff members but not by mechanical restraint or by the use of devices or objects positioned to hold the door closed.	**Seclusion** is PROHIBITED. "Seclusion" means the placement of a person alone in a room from which egress is: • noncontingent on the person's behavior; or • prohibited by a mechanism such as a lock or by a device or object positioned to hold the door closed or otherwise prevent the person from leaving the room. **Emergency room time out** Room time out in emergency situations is PROHIBITED.

AVERSIVE AND DEPRIVATION PROCEDURES
Determining What Procedures are Exempted, Controlled or Prohibited

9525.2720 EXEMPTED ACTIONS AND PROCEDURES.	9525.2740 PROCEDURES PERMITTED AND CONTROLLED.	9525.2730 PROCEDURES AND ACTIONS RESTRICTED OR PROHIBITED.
Temporary withdrawal or withholding Temporary withdrawal or withholding of goods, services, or activities to which a person would otherwise have access as a natural consequence of the person's inappropriate use of the goods, services, or activities. Examples of situations in which the exemption would apply are briefly delaying the return of a person's beverage at mealtime after the person has thrown the beverage across the kitchen or temporarily removing an object the person is using to hit another individual. Temporary withdrawal or withholding is meant to be a brief period lasting no more than several minutes until the person's behavior is redirected and normal activities can be resumed. **Token fines or response cost procedures** Token fines or response cost procedures such as removing objects or other rewards received by a person as part of a positive reinforcement program. Token fines or response cost procedures are typically implemented after the occurrence of a behavior identified in the IPP for reduction or elimination. Removing the object or other reward must not interfere with a person's access to the goods, services, and activities protected by part 9525.2730.	**Deprivation** "Deprivation procedure" means the removal of a positive reinforcer following a response resulting in, or intended to result in, a decrease in the frequency, duration, or intensity of that response. Often times the positive reinforcer available is goods, services, or activities to which the person is normally entitled. The removal is often in the form of a delay or postponement of the positive reinforcer.	**Restricting access to basic necessities** Restricting a person's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, or necessary clothing as mandated by Minnesota Statutes, section 245.825, or to any protection required by state licensing standards and federal regulations governing the program is RESTRICTED. **Denying access to next of kin** Denying the person ordinary access to legal counsel and next of kin as mandated by Minnesota Statutes, section 245.825 is RESTRICTED. **Denying or restricting access to equipment and devices** Denying or restricting a person's access to equipment and devices such as walkers, wheelchairs, hearing aids, and communication boards that facilitate the person's functioning is PROHIBITED. When the temporary removal of the equipment or device is necessary to prevent injury to the person or others or serious damage to the equipment or device, the equipment or device must be returned to the person as soon as possible.

AVERSIVE AND DEPRIVATION PROCEDURES
Determining What Procedures are Exempted, Controlled or Prohibited

9525.2720 EXEMPTED ACTIONS AND PROCEDURES.	9525.2740 PROCEDURES PERMITTED AND CONTROLLED.	9525.2730 PROCEDURES AND ACTIONS RESTRICTED OR PROHIBITED.
Physical contact or a physical prompt to redirect behavior Physical contact or a physical prompt to redirect a person's behavior when: (1) the behavior does not pose a serious threat to the person or others; • For example, taking a person's hands and placing them on an object to redirect the person from another behavior, such as hand waving. (2) the physical contact is used to escort or carry a person to safety when the person is in danger; • For example, assisting a person during an emergency evacuation of a building. (3) the behavior is effectively redirected with less than 60 seconds of physical contact by staff; or • For example; touching a person's hand to redirect or prevent self-injurious behavior. (4) the physical contact is used to conduct a necessary medical examination or treatment. <u>This exemption may not be used to circumvent the requirements for controlling the use of manual restraint</u>. It is included to allow caregivers the opportunity to deal effectively and naturally with intermittent and infrequently occurring situations by using physical contact. • Physical contact is used to provide physical guidance. • Physical contact IS NOT used to hold a person immobile or to limit the person's	**Manual restraint** "Manual restraint" means physical intervention intended to hold a person immobile or limit a person's movement by using body contact as the only source of physical restraint. The term does not mean physical contact used to: (1) facilitate a person's completion of a task or response when the person does not resist or the person's resistance is minimal in intensity and duration; (2) escort or carry a person to safety when the person is in danger; or (3) conduct necessary medical examinations or treatments.	**Corporal punishment** Using corporal punishment such as hitting, pinching, or slapping is PROHIBITED. **Physical positions or posture** Requiring a person to assume and maintain a specified physical position or posture as an aversive procedure is PROHIBITED.

AVERSIVE AND DEPRIVATION PROCEDURES
Determining What Procedures are Exempted, Controlled or Prohibited

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movement. Cont'd next page **Manual restraint used due to medical needs** Manual restraint to treat a person's medical needs, to protect a person known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness, or to position a person with physical disabilities in a manner specified in the person's IPP is exempt. • This exemption applies only to manual restraint used for medical, protective or therapeutic purposes; any use of manual restraint to prevent self-injury constitutes use of a controlled procedure and plan for its use must be developed, reviewed and approved subject to the requirements of Rule 40.		
Mechanical restraint used due to medical needs Mechanical restraint used to treat a person's medical needs, to protect a person known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness, or to position a person with physical disabilities in a manner	**Mechanical restraint** "Mechanical restraint" means the use of devices such as mittens, straps, restraint chairs, or papoose boards to limit a person's movement or hold a person immobile as an intervention precipitated by a person's behavior.	

AVERSIVE AND DEPRIVATION PROCEDURES
Determining What Procedures are Exempted, Controlled or Prohibited

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specified in the person's IPP is exempt. • This exemption applies only to mechanical restraint used for medical, protective or therapeutic purposes; any use of mechanical restraint to prevent self-injury constitutes use of a controlled procedure and plan for its use must be developed, reviewed and approved subject to the requirements of Rule 40. • Medical mechanical restraint must be ordered by a licensed professional. • A physician's order alone for use of medical mechanical restraint does not meet the criteria of being an exempted procedure if the restraint is used to prevent injury from self-injurious behavior.	The term does not apply to mechanical restraint used: • to treat a person's medical needs, • to protect a person known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness, or • to position a person with physical disabilities in a manner specified in the person's IPP. **Mechanical restraint used due to self-injurious behavior** The term *does apply to, and parts 9525.2700 to 9525.2810 do govern*, mechanical restraint when it is used to prevent injury with *persons who engage in behaviors*, such as head-banging, gouging, or other actions resulting in tissue damage, that have caused or could cause medical problems resulting from the self-injury. [Emphasis added.] Contrast this use to mechanical restraints used due to medical needs in column to right.	

AVERSIVE AND DEPRIVATION PROCEDURES
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	Partially restricting senses Partially restricting a person's senses at a level of intrusiveness that does not exceed placing a hand in front of a person's eyes as a visual screen or playing music through earphones worn by the person at a level of sound that does not cause discomfort.	**Restricting senses** Totally or partially restricting a person's senses is PROHIBITED. **Aversive stimulus** Using a noxious smell, taste, substance, or spray, including water mist, as an aversive stimulus is PROHIBITED. **Faradic shock** Using faradic shock on an emergency basis is PROHIBITED.
	Authorization for procedures not specified as exempted, restricted, prohibited, or controlled If an expanded interdisciplinary team prepares a plan proposing the use of an aversive or deprivation procedure that is not specifically exempted by part 9525.2720, or specifically prohibited or restricted by part 9525.2730, or specifically permitted and controlled by subpart 1, the case manager must request authorization for the use of that procedure from the DHS-Disability Services Division (DSD) Rule 40 policy staff (formerly the responsibility of the regional review committee which was deactivated by legislative amendment in 1995) If a procedure is authorized by the DHS-DSD Rule 40 policy staff, use of the procedure is subject to the controls established in parts 9525.2700 to 9525.2810 (Rule 40).	