101. STATEMENT OF BASIS; PURPOSE; APPLICABILITY; ADHERENCE

101.1. BASIS

The authority of the Department of Institutions to promulgate and adopt these rules and regulations is set forth in Article 10 of Chapter 27, C.R.S. 1973 as amended.

101.2. PURPOSE

The purpose of these rules and regulations is to facilitate the implementation and enforcement of C.R.S. 27-10, Care and Treatment of the Mentally Ill.

The intent of these rules and regulations is:

A. To secure for each patient who may be mentally ill such care and treatment as will be suited to the needs of the patient and to ensure that such care and treatment are skillfully and humanely administered with full respect for the patient's dignity and personal integrity;

B. To deprive a person of his/her liberty for the purposes of treatment and care only when less restrictive alternatives are unavailable and only when his/her safety or the safety of others is endangered;

C. To provide the fullest possible measure of privacy, dignity and other rights to persons undergoing care and treatment for mental illness;

D. To encourage the use of voluntary rather than coercive measures to secure treatment and care for mental illness.

The purpose of the 1991 revision of the rules for the Care and Treatment of the Mentally Ill is to make the regulations easier to locate within the document, easier to read and to understand; to incorporate policy statements formerly contained in the Division of Mental Health's Procedures Manual; and to add several changes recommended to the Department of Institutions by the Mental Health Advisory Board for Service Standards and Regulations.

101.3. APPLICABILITY

These regulations govern the evaluation and treatment of involuntarily detained mentally ill patients in facilities designated by the Department of Institutions as seventy-two (72) hour treatment and evaluation facilities, short-term or long-term treatment facilities pursuant to the Act for the Care and Treatment of the Mentally Ill, C.R.S., 27-10-101 et seq. Patients may be treated on an outpatient basis pursuant to section 106 herein.

101.4. ADHERENCE

All designated facilities shall be appropriately licensed by the Department of Health or Social Services and shall strictly adhere to all standards, regulations, and statutory requirements applicable to that facility, including but not limited to the Act for the Care and Treatment of the Mentally Ill, C.R.S. 27-10-101, et seq. Any designation may be denied, revoked or not renewed by the Executive Director of the Colorado Department of Institutions if the facility is found not to be in compliance pursuant to C.R.S. 24-4-104 and 105.

102. DEFINITIONS

102.1. Assessment

The process of collecting and evaluating information about a client for the purpose of developing a profile on which to base service planning and referral. The assessment process is both initial and ongoing.

102.2. Case Management

Activities that are intended to ensure that clients receive the services they need, that services are coordinated, and that services are appropriate to the changing needs and stated desires of clients over time. The goals of case management are: (1) to bring about positive changes in clients' status, (2) to assist clients in reaching their highest potential, and (3) to achieve the best possible quality of life for clients and their families in the community. Goals are developed collaboratively between case managers and clients. Case management activities are community-based, and are delivered either in the designated facility or in the client's environment by a designated person or team. Activities include but are not limited to service planning, linkage, referral, monitoring/follow-up, advocacy, and crisis management.

102.3. Client

An individual who is receiving mental health services pursuant to C.R.S. 27-10-101 et seq.; Also known as patient.

102.4. Department: The Colorado Department of Institutions.

102.5. Designated Facility

A facility designated under these regulations by the Executive Director of the Department of Institutions, as (1) a seventy-two (72) hour treatment and evaluation facility, pursuant to C.R.S. 27-10-105 and 106, or (2) a short-term treatment facility pursuant to C.R.S. 27-10-107, or (3) a long-term treatment facility pursuant to C.R.S. 27-10-109, or (4) any combination of the above designations.

102.6. Discharge: The termination of services by the designated facility.

102.7. Division: The Colorado Division of Mental Health.

102.8. Drug: A substance intended for use in the diagnosis, care, mitigation, treatment, or prevention of disease or other conditions. See C.R.S. 12-22-102(11).

102.8.5. Gravely Disabled:

(a) Gravely disabled means a condition in which a person, as a a result of mental illness:

(I) Is in danger of serious physical harm due to his inability or failure to provide himself the essential human needs of food, clothing, shelter, and medical care; or

(II) Lacks judgment in the management of his resources and in the conduct of his social relations to the extent that his health or safety is significantly endangered and lacks the capacity to understand that this is so.

(b) A person who, because of care provided by a family member or by an individual with a similar relationship to the person, is not in danger of serious physical harm or is not significantly endangered in accordance with paragraph (a) of this subsection 102.8.5., may be deemed gravely disabled if there is notice given that the support given by the family member or other individual who has a similar

relationship to the person is to be terminated and the mentally ill individual:

(I) Is diagnosed by a professional person as suffering from any one of the following: chronic schizophrenia; a chronic major affective disorder; a chronic delusional disorder; or other chronic mental disorder with psychotic features; and

(II) Has been certified, pursuant to this article, for treatment of such disorder or has been admitted as an inpatient to a treatment facility for treatment of such disorder at least twice during the last thirty-six months with a period of at least thirty days between certifications or admissions; and

(III) Is exhibiting a deteriorating course leading toward danger to self or others or toward the condition described in paragraph (a) of this subsection 102.8.5. with symptoms and behavior which are substantially similar to those which preceded and were associated with his hospital admissions or certifications for treatment; and

(IV) Is not receiving treatment which is essential for his health or safety.

(c) A person of any age may be gravely disabled, but such term shall not include mentally retarded persons by reason of their retardation alone.

(d) For purposes of paragraph (b) of this subsection 102.8.5, an individual with a relationship to a person which is similar to that of a family member shall not include an employee or agent of a boarding home or treatment facility.

102.9. Investigational Drugs: Drugs approved by the Federal Drug Administration for investigational use. These are drugs which have not been approved for sale in interstate commerce by the Federal Food and Drug Administration because their toxicity and efficacy have not yet been sufficiently evaluated. They are drugs which are presently in the clinical stages of evaluation.

102.10. Involuntary Medication: The administration of medication by the order of a licensed physician without the patient's consent.

102.11. Legal Guardian: A person appointed by a court of competent jurisdiction pursuant to the provisions ofC.R.S.15-14-201 et seq. or 15-14-301 et seq., or a person assuming such status under other provisions of law. A legal guardian has such powers as are provided by statute or court order. The term “legal guardian” or “guardian” shall not include one appointed as guardian ad litem.

102.12. Medication: A drug as defined by C.R.S. 12-22-102(11) and these regulations, 102.5.

102.13. Mentally Ill Person: A person with a substantial disorder of the cognitive, volitional, or emotional processes that grossly impairs judgment or capacity to recognize reality or to control behavior.

102.14. Order:

102.14.A. A prescription order is any order, other than a chart order, authorizing the dispensing of drugs or devices, written or transmitted by other means of communication by a practitioner, and includes the name or identification of the patient, the date, and sufficient information for compounding, dispensing, and labeling; or

102.14.B. A Chart order is an order for inpatient drugs or medications entered on a patient's chart or medical record, to be dispensed by a pharmacist, or pharmacy intern under the direct

supervision of a pharmacist, which is to be administered by an authorized person only during the patient's stay in a hospital facility.

102.14.C. An order contains the name of the patient and the medicine ordered, and such directions as the practitioner may prescribe concerning strength, dosage, frequency and route of administration. See C.R.S. 12-22-102(22-5).

102.15. Patient and/or Client: An individual who is receiving mental health services pursuant to C.R.S. 27-10-101 et seq.

102.16. Patient Representative: A person designated by a mental health facility to process complaints or grievances, including representing patients who are minor patients pursuant to C.R.S. 27-10-103(3.3).

102.17. Physical Restraint: The restraint of a patient using devices, including but not limited to restraint sheets, camisoles, belts attached to cuffs, leather armlets and restraint chairs.

102.18. Placement Facility:

102.18.A. A public or private facility that has a written agreement with a designated facility to provide care to any person undergoing mental health evaluation or treatment by a designated facility, pursuant to the provisions of Section 103.

102.18.B. A placement facility may be a general hospital, psychiatric hospital, community clinic and emergency clinic, convalescent center, nursing care facility, intermediate health care facility or residential facility, or community mental health center or clinic under contract with the Department or a public or private facility licensed by the Department of Social Services as a residential child care facility.

102.19. Practitioner: A person authorized by law to prescribe any drug or device, acting within the scope of such authority. See C.R.S. 12-22-102(27).

102.20. Professional Person: A person licensed to practice medicine or psychology in Colorado.

102.21. Registered Professional Nurse: A nurse who is currently licensed as a Registered Professional Nurse by the State of Colorado. A Registered Professional Nurse may be authorized to initiate a seventy-two (72) hour involuntary detention for evaluation if the nurse meets at least one of the following criteria:

102.21.A. Has a master's or more advanced degree in psychiatric/mental health nursing from an accredited college or university, or,

102.21.B. Is certified as a clinical specialist in psychiatric/mental health nursing by the American Nurses' Association, or,

102.21.C. Has at least one (1) year full-time post-baccalaureate supervised, clinical psychiatric nursing experience which has included the development of specific skills in mental health assessment and crisis intervention, and who is currently employed either: (a) on a psychiatric unit of a hospital designated by the Department of Institutions for the care and treatment of the mentally ill, or (b) at a community mental health center or state hospital.

102.22. Seclusion: The confinement of a patient alone in a locked room.

102.23. Special Designations: Designation of a facility that is not a licensed hospital, residential child care facility, or community mental health center/clinic, as a seventy-two (72) hour treatment and

evaluation facility or a short-term and long-term treatment facility, by the Executive Director of the Department or his/her designee. The special designation shall be determined upon an individual facility basis and upon a showing that the use of the specially designated facility will be particularly beneficial to patients. Special designations may or may not entail a waiver as provided in Section 113 hereof.

102.24. Specific Therapy: Therapy that requires a special procedure for consent, including electro-therapy treatment (electro-convulsive therapy), behavior modifications using physically painful, aversive, or noxious stimuli, or the use of investigational drugs. A therapy that entails a substantial risk is also considered to be a specific therapy.

103. FACILITY DESIGNATIONS AND USE

103.1. CRITERIA FOR APPLICATION

A. Facilities which may routinely apply for designation are: (a) a general hospital or a psychiatric hospital licensed by the Colorado Department of Health, or (b) a community mental health center or clinic under contract with the Colorado Department of Institutions, or (c) a residential child care facility licensed by the Colorado Department of Social Services.

B. Facilities which do not meet the above criteria may apply for a special designation. The Executive Director of the Department or his/her designee, may approve a special designation on a case by case basis, upon a showing that the use of the specially designated facility will be particularly beneficial to patients. Special designations may or may not entail a waiver as provided in Section 113.

C. Facilities shall have a professional person, either employed or under contract, to be responsible for the evaluation and treatment administered to each patient. Staff privileges shall be an acceptable form of contractual arrangement. The professional person may delegate any part of his/her duties, except as limited by statute or these regulations, but he/she shall remain responsible at all times for the quality of the mental health treatment administered to the patient. Facilities shall have a single identifiable organization responsible for their operation.

A facility meeting the criteria in Section 103.1. may apply to the Department of Institutions for any or all of the following designations: (1) seventy-two (72) hour treatment and evaluation, or (2) short-term treatment; or (3) long-term treatment.

103.2. TYPES OF DESIGNATIONS

A. Seventy-two (72) Hour Treatment and Evaluation

A.1. Facilities

Facilities which are designated by the Department of Institutions as seventy-two (72) hour treatment and evaluation facilities may detain on an involuntary basis persons placed on a seventy-two (72) hour hold for the purpose of evaluation and treatment. Evaluation shall be completed as soon as possible after admission.

Except in emergency circumstances affecting the facility's ability to provide evaluation and treatment services, a facility seeking to exclude Saturdays, Sundays and holidays must supply in its application for designation or redesignation:

A.2.1. Documentation to establish that it does not have evaluation services available on these days due to the limited availability of a professional person; and

A.2.2. Assurance that in no case shall the period of detention for purposes of evaluatior exceed a total of eighty-four (84) hours from the time the person is taken into custody.

B. Short-term or Long-term Treatment Facilities

Facilities that are designated by the Department as short-term treatment facilities may involuntarily detain persons for short-term or extended short-term care and treatment. Facilities that are designated by the Department as long-term treatment facilities may involuntarily detain persons for long-term care and treatment or extended long-term treatment. Every patient receiving treatment for mental illness by a designated short-term or long-term facility shall, no later than twenty-four (24) hours after admission to treatment, be placed under the care of a professional person employed by or under contract with the designated facility. Staff privileges shall be an acceptable form of contractual arrangement.

103.3. DESIGNATION PROCEDURE

A. Application

A.1. Facilities applying for designation shall make application to the Department in the form specified by the Department.

A.2. The Department shall acknowledge in writing receipt of the application and shall state what additional information or documents, if any, are required to be forwarded to the Department for review prior to an on-site evaluation. The dates of the on-site evaluation shall be mutually determined.

A.3. If, after initial inspection and review of a facility, the Department finds:

A.3.1. That the facility is in substantial compliance with these rules and regulations, and the areas of non-compliance do not adversely affect the health, safety, or welfare of a patient;

A.3.2. That full compliance may be achieved within a reasonable period of time; and

A.3.3. That the facility has a reasonable plan or schedule in writing for achieving full compliance, the Department may grant provisional approval for a period not to exceed ninety (90) days. A second provisional approval for a period not to exceed ninety (90) days may be granted, if necessary, to achieve full compliance. The applicant shall be advised in writing within sixty (60) days of the initial on-site evaluation of the decision of the Department approving or disapproving the facility, and in cases of disapproval, the reasons for disapproval. If the Department disapproves a facility following the initial on-site evaluation, the facility may request a hearing as provided in Section 103.3.F.

B. Designation

B.1. A facility that is found to be in compliance with these rules and regulations upon initial review will be approved by the Department as a designated facility for the provision of seventy-two (72) hour treatment and evaluation services and/or short-term and/or long-term treatment, effective for a one (1) year period.

B.2. Approval, including provisional approval, shall be evidenced by placing the approved facility on a list of approved centers, clinics, hospitals, residential child care facilities, or other facilities and by issuing the facility a certificate of approval.

C. Redesignation

Redesignation will be considered on a yearly basis and shall be based on an on-site evaluation of the facility by the Department staff. The criteria shall be the same as for designation. The dates of the on-site evaluation shall be mutually determined.

D. Change in Designation

If a facility wishes to make a change in its designation status or wishes to drop designation, it shall notify the Department in writing thirty (30) days in advance of the desired effective date and outline its plan for obtaining care elsewhere for involuntary patients once the facility is no longer designated.

E. Termination of Designation

Designations shall be rescinded for any facility whose license or contract as listed in 103.1.A. (a), (b) or (c) is terminated or revoked.

The designation of any facility that has not provided mental health services for three (3) months shall be reviewed.

F. Hearing

Following any revocation, suspension, limitation or modification of an approval of the designation or the denial of an application for a new designation without a hearing, the applicant facility, within sixty (60) days after the giving of notice of such action, may request a hearing before the Department. Pursuant to C.R.S. 27-1-102(2)(a), the Executive Director of the Department hereby delegates to the Director of the Division the power to conduct such hearings on behalf of the Department. The hearing shall be conducted as provided in C.R.S. 24-4-105, and the action of the Division after any hearing shall be subject to judicial review as provided in C.R.S. 24-4-106.

103.4. PLACEMENT FACILITIES

A. Designated facilities may provide mental health services directly or through the use of placement facilities. In either case, the designated facility is responsible for assuring a humane psychological and physical environment for each patient. Whenever a placement facility is used, the designated facility shall be responsible for the care provided by the placement facility.

B. Whenever a designated facility uses a placement facility, it shall establish a contract which includes:

B.1. Adequate provision for inservice training of placement facility staff according to a plan approved and monitored by the designated facility;

B.2. Direct care supervision by professional persons employed by or under contract with the designated facility;

B.3. Necessary availability and necessary supervision of placement facility staff; and

B.4. Adherence to these regulations.

C. All agreements between designated facilities and placement facilities and all supplemental agreements and amendments shall be reduced to writing and forwarded to the Department no later than 10 days prior to the effective date of the agreement or amendment.

D. A placement facility may be used by any designated seventy-two (72) hour treatment and evaluation facility or any designated short-term or long-term treatment facility, at its discretion under the provisions of these regulations, in order to provide care to any person undergoing mental health evaluation or treatment. Designated facilities shall not place patients in a placement facility unless

all of the applicable provisions of these regulations are met and placement in such facility is required in order to meet the clinical needs of the patient. When a placement facility is required, the least restrictive facility possible and available must be used, consistent with the clinical needs of the patient.

E. A placement facility shall not provide services outside of the limitations of its licensing body.

F. Nothing contained in these regulations shall be construed to limit in any way the ability and duty of a designated facility to treat or evaluate persons in the least restrictive setting possible, and unrestricted community placement and outpatient evaluation and treatment shall be the preferred alternative whenever possible consistent with the patient's needs and safety subject to available resources.

103.5. EDUCATION

Appropriate educational programs shall be available for all school age children who are residents of the designated facility in excess of fourteen (14) days. These educational programs may be provided by either the local school district or by the designated facility. If provided by the designated facility, the educational program shall be approved by the Department of Education.

103.6. USE OF JAILS

A jail may be used as a last resort in a county of under 75,000 population, when detaining a patient pursuant to the emergency provisions under C.R.S. 27-10-105., et seq. if an appropriate designated facility is not reasonably available. In a county of over 75,000 population it shall be presumed that an appropriate designated facility is available and a jail shall not be used. The burden of proof for any exception to this requirement lies with the designated facility and the patient's clinical record must contain adequate documentation to support the use of a jail on the basis of non-availability of an appropriate designated facility.

A. No person detained pursuant to C.R.S. 27-10-105 shall be held in a jail for a period exceeding twenty-four (24) hours, excluding Saturdays, Sundays and holidays.

B. The seventy-two (72) hour evaluation and treatment period shall begin when the person is taken into custody.

C. All persons detained pursuant to C.R.S. 27-10-105 shall be segregated from persons charged with or convicted of penal offenses.

D. It is the responsibility of the peace officer, professional person, licensed clinical social worker or nurse who takes the patient into custody and places the patient in jail to contact the nearest responsible designated facility within four (4) hours of the initial detention.

E. It is the responsibility of the nearest designated facility to examine the person detained pursuant to C.R.S. 27-10-105 within twelve (12) hours of the initial detention, to determine if the person is receiving appropriate care and to plan an appropriate disposition. Such disposition shall be made within twenty-four (24) hours of the initial detention, excluding Saturdays, Sundays and holidays, and shall include one of the following alternatives:

E.1. Terminate the seventy-two (72) hour emergency procedure and release the patient from jail whenever the patient does not appear to be an imminent danger to self or others or gravely disabled as a result of mental illness and does not consent to treatment; or

E.2. Transfer the patient to a designated facility to receive treatment and evaluation whenever the patient:

E.2.1. Appears to be an imminent danger to self or others or gravely disabled as a result of mental illness and does not consent to voluntary treatment or reasonable grounds exist to believe the patient will not remain in voluntary treatment; or

E.2.2. Consents to treatment on a voluntary basis.

F. The person being detained pursuant to C.R.S. 27-10-105 shall be examined every twelve (12) hours, for as long as he/she remains in jail, by a peace officer, nurse, physician or appropriate staff from the nearest designated facility to ensure that the person is receiving appropriate care. In addition to being examined every twelve (12) hours, the person shall be observed every thirty (30) minutes to ensure that the person's safety is not threatened.

G. Each designated facility, in a region where appropriate facilities for evaluation are not available, shall establish written policies, procedures and agreements with the jails, for its mental health service area, to assure that a patient detained in jail receives appropriate care consistent with his/her mental condition.

H. A detailed description of the reasons the patient has been detained in jail for a seventy-two (72) hour evaluation and treatment shall be documented in the patient's clinical record and reported to the Division.

104. ENFORCEMENT; WAIVERS; QUALITY ASSURANCE

104.1. ENFORCEMENT

The Department shall, at least annually, evaluate all designated facilities for compliance with the rules and regulations concerning the care and treatment of the mentally ill. Evaluation of placement facilities may also be conducted at the discretion of the Department, but such evaluation will be limited to those services which are provided pursuant to a contract with a designated facility. The Department shall investigate all complaints related to these regulations concerning designated facilities and placement facilities, and all complaints concerning the voluntary hospitalization of minors pursuant to C.R.S. 27-10-103.

104.2. NON-COMPLIANCE PROCEDURE; PROVISIONAL APPROVAL; HEARING

A. If the Department finds, after evaluation or pursuant to a complaint, that a designated facility is not in compliance with these regulations, the Department shall first, within forty-five (45) days of the review, notify the designated facility in writing of the specific items found to have been out of compliance.

B. The designated facility shall have thirty (30) days from the receipt of the notice of noncompliance in which to submit written data and/or a plan and schedule for achieving full compliance, with respect to the matter(s) not in compliance.

C. The Department, after reviewing the designated facility's written reply, may take action as follows:

C.1. Approve the proposed plan and schedule for achieving full compliance; or

C.2. Approve a modified plan and schedule for achieving full compliance; or

C.3. Revoke, suspend, annul, limit or modify the designation of the facility.

C.3.1. Notify any entity from which the designated facility received reimbursement for mental health services of a noncompliance.

D. In cases where the Department approves a proposed or modified plan and schedule for achieving full compliance, the Department shall grant provisional approval for a period not to exceed ninety (90) days. At the end of the provisional approval period, the Department may take action as follows:

D.1. Designate the facility, if full compliance is achieved; or

D.2. Extend the provisional approval period for an additional ninety (90) days, if necessary to achieve full compliance; or

D.3. Revoke the designation.

E. In cases where the Department grants a second provisional approval period for the facility to achieve full compliance, such approval shall not exceed ninety (90) days. At the end of the second provisional approval period, the Department may take action as follows:

E.1. Designate the facility, if full compliance is achieved; or

E.2. Revoke the designation.

F. Not withstanding any of the foregoing provisions, if the Department has reasonable grounds to believe and finds that the designated facility has been guilty of deliberate and willful violations of these rules and regulations, or that the public health, safety, and welfare imperatively requires emergency action and incorporates such findings in its report, the Department may summarily suspend the approval pending proceedings for suspension or revocation which shall be promptly instituted and determined, as provided in C.R.S 24-4-105, et seq.

G. Following any revocation, suspension, annulment, limitation or modification of a designation or the denial of an application for a new designation without a hearing, the applicant agency, within sixty (60) days after the giving of notice of such action, may request a hearing before the Department. Pursuant to C.R.S. 27-1-102(2)(a), the Executive Director of the Department hereby delegates to the Director of the Division the power to conduct such hearings on behalf of the Department. The hearing shall be conducted as provided in C.R.S. 24-4-105, and the action of the Division after any hearing shall be subject to judicial review as provided in C.R.S. 24-4-106.

104.3. WAIVER

Although it is the policy of the Department that each designated facility comply in all respects with these rules and regulations, a waiver of the specific requirements of the rule and regulations may be granted by the Department in accordance with Section 113.

104.4. GRIEVANCE; PATIENT REPRESENTATIVE

A. Each designated facility shall develop policies and procedures for patient grievances which include provisions for forwarding unresolved complaints pursuant to C.R.S. 27-10-101, et seq. or these regulations to the Director of the Division of Mental Health for resolution.

B. A notice shall be posted within the designated facility at locations available to patients. The notice shall include the name, location, responsibilities of the patient representative and where a copy of the grievance procedure may be obtained.

104.5. CONFLICT OF INTEREST

Each designated facility shall establish policies regarding conflicts of interest which shall include the circumstances under which any current patient may be transferred to the private practice of an employee of the facility.

104.6. QUALITY ASSURANCE

A. Each designated facility shall be reviewed annually by the Department for compliance with the rules and regulations concerning the Care and Treatment of the Mentally Ill.

B. Each designated facility shall adopt and implement a quality assurance program.

C. A review process, including senior staff, shall be established to determine the appropriateness and effectiveness of treatment. The process shall include review of selected case records at least every three (3) months.

D. A physician shall review the medical status of each patient at least every six (6) months for those involuntary patients in treatment for six (6) months or longer. There shall be documented follow-up of identified medical problems.

E. At least every six (6) months, a professional person shall review the records of each involuntary patient who has been in treatment six (6) months or longer and document this review in the patient's record.

F. Each designated facility shall establish policies and procedures for reviewing all deaths and other critical incidents involving patients of the facility.

104.7. STAFF TRAINING AND DEVELOPMENT

All staff who participate in the provision of care and treatment for patients admitted under C.R.S. 27-10-101, et seq. shall receive training on an annual basis regarding the provisions and requirements of Article X, Title 27 and these rules and regulations.

105. PATIENT RIGHTS

105.1 ADVISEMENT OF PATIENT RIGHTS

A. All patients receiving evaluation, care or treatment under any provision of Article X, Title 27 shall be advised of the following rights in writing on admission. Every patient receiving evaluation or treatment shall be furnished by the designated facility with a written copy of his/her rights and a list of such rights (translated into Spanish or any other appropriate language) shall be posted prominently in all designated and placement facilities. Rights A.1. through A.5. may be denied for good cause only by the professional person providing treatment. Each denial of a patient's right shall be made on a case by case basis and the rationale for denying the right shall be documented in the patient's chart. Rights A.6. through A.15. can not be denied unless otherwise stated below. Restricted rights shall be evaluated for therapeutic necessity on an ongoing basis, and the rationale for continuing the restriction shall be documented at least every 7 days.

A.1. The patient has the right to receive and send sealed correspondence. No incoming or outgoing correspondence shall be opened, delayed, held or censored by the personnel of the facility;

A.2. To have access to letter writing materials, including postage, and to have staff members of the facility assist him/her if unable to write, prepare and mail correspondence;

A.3. To have ready access to telephones, both to make and receive calls in privacy;

A.4. To have frequent and convenient opportunities to meet with visitors. The facility may not deny visits at any time to the patient by his/her attorney, clergyman or physician;

A.5. To wear his/her own clothes, keep and use his/her own personal possessions and keep and be allowed to spend a reasonable sum of his/her own money;

A.6. To refuse to take medications, unless the patient is at imminent danger to self or others or the court has ordered medications;

A.7. To not be fingerprinted unless required by law;

A.8. To refuse to be photographed except for hospital identification purposes;

A.9. For patients under certification for care and treatment, to receive twenty-four (24) hour notice before being transferred to another designated facility ‘unless an emergency exists; the right to protest any transfer to the court; and the right to have the transferring facility notify someone chosen by the patient about the transfer;

A.10. To confidentiality of treatment records except as required by law;

A.11. To accept treatment voluntarily, unless reasonable grounds exist to believe the patient will not remain a voluntary patient;

A.12. To receive medical and psychiatric care and treatment in the least restrictive treatment setting possible, suited to meet the patient's individual needs and subject to available resources;

A.13. To have the opportunity to register and to vote, with staff assistance, if requested, in accordance with Section 105.3.;

A.14. To request to see medical records, to see the records at reasonable times, and to be given written reasons if the request is denied;

A.15. To retain and consult with an attorney at any time.

105.1.B. The patient shall be given the name and telephone number of the facility's patient representative to contact should the patient have a question or complaint or wish to file a grievance. This shall be noted in the chart.

105.2. DISCRIMINATION

No person who has received evaluation or treatment under any provision of Article X, Title 27 shall be discriminated against because of such status. For the purposes of this section, “discrimination” means giving any undue weight to the fact of hospitalization or outpatient care and treatment unrelated to a person's present capacity to meet standards applicable to all persons.

105.3. VOTING

A. Every patient who is eighteen (18) years or older shall be given the opportunity to exercise his/her right to vote in primary and general elections.

B. The staff of the designated facility shall assist each patient in obtaining voter registration forms, and applications for absentee ballots, and in complying with any other prerequisite for voting.

105.4. EMPLOYMENT OF PATIENTS AND COMPENSATION

A. Work, including all labor, employment or jobs involving facility operation and maintenance or used as labor-saving devices which are of an economic benefit to the facility, shall be treated as work and

shall be compensated according to applicable minimum wage or certified wage rates.

B. Maintaining a minimum standard of cleanliness and personal hygiene and personal housekeeping, such as making one's bed or cleaning one's area shall not be treated as work and shall not be compensated.

C. Patients shall not be forced in any way to perform work.

D. Training programs must comply with all applicable federal and state laws.

E. All work assignments, together with a specific consent form, and the hourly compensation received, shall be noted in the patient's record.

F. Privileges or release from a designated facility shall not be conditioned upon the performance of work.

106. CERTIFICATION ON OUTPATIENT BASIS

106.1 CERTIFICATION FOR TREATMENT ON AN OUTPATIENT BASIS

A person who has been treated involuntarily under a short-term or long-term certification at a 24-hour residential program designated or approved by the department for mental health treatment may be certified on an outpatient basis if the following conditions are met:

A. A professional person who has evaluated the person and who is on the staff of the designated facility which has been treating the person, determines that the person continues to meet the requirements for certification and that certification on an outpatient basis is the appropriate disposition suited to the person's individual needs;

B. The designated facility that will hold the certification on an outpatient basis has documentation of the results of a recent physical examination;

C. Arrangements have been made for the person to have access to:

C.1. Case management;

C.2. Medical screening and medication management;

C.3. Essential food, clothing, shelter; and

C.4. Medical care and emergency dental care.

D. A service plan that meets the requirements of 106.2., below, has been approved by the designated facility that will hold the certification.

106.2. SERVICE PLAN FOR OUTPATIENT TREATMENT UNDER A CERTIFICATION

A. The service plan shall include:

A.1. A plan for clinical treatment services, including specific treatment goals; measurable objectives; and a description of specific services to be provided through the designated facility for meeting the treatment goals and objectives.

A.2. A plan for accessing medical and emergency dental service; and

A.3. A plan for accessing other needed goods and services, such as food, clothing and shelter.

The continued availability of essential food, clothing and shelter to the patient shall be a condition of outpatient treatment.

b. The plan shall note the minimum treatment and services, which shall include essential food, clothing and shelter, that must be accepted by the patient in order for the patient to continue to be treated on an outpatient basis.

C. The plan shall indicate the necessary level of functioning to be maintained by the patient in order to terminate the certification.

D. The service plan shall be developed by the patient, the treating professional person, the designated facility, the family as appropriate, and the case manager if case management is provided by someone other than the treating professional person.

E. The patient shall sign the service plan and a copy shall be offered to the patient and to others who participated in the development of the service plan. If the participants are unable to reach agreement on the plan, the treating professional person shall make the final determination and the areas of disagreement shall be noted in the plan. If the patient does not sign the plan, the reason shall be noted.

106.3. ASSURANCE OF ADEQUACY AND AVAILABILITY OF SERVICES

A. The Division shall monitor the designated facility's capability to provide clinical treatment services, medical screening, medication management, case management and other support services as appropriate.

b. The treating professional person shall state in the service plan that services specific to the individual service plan are available to the patient.

c. The case manager, who may be the treating professional person, shall be responsible for monitoring the implementation of the service plan. The case manager shall immediately report to the treating professional person and to the director (or designee) of the designated facility any instances of:

C.1. the unavailability to the patient of any services in the service plan, and/or

C.2. the fact that the patient is not obtaining essential food, clothing, or shelter.

D. The need for certification shall be reviewed at least monthly by the treating professional person.

E. The service plan, including the plan for clinical treatment services, shall be reviewed, and revised if appropriate, at least monthly by the treating professional person, the patient and the case manager, if case management is provided by someone other than the treating professional person. This review shall be documented.

F. The patient shall be given the name and telephone number of the facility's patient representative to contact should the patient have a question or complaint or wish to file a grievance. This shall be noted in the chart.

106.4. ENFORCEMENT

A. If a patient substantially fails to comply with the requirements specified in the service plan, the professional person, or staff of the designated facility that holds the certification, shall make reasonable efforts, including outreach, to obtain the patient's compliance. As part of these efforts, reasonable attempts shall be made to advise the patient that he/she may be picked up and taken into custody for appraisal of the person's need for continued certification and ability to receive

treatment on an outpatient basis.

B. If the medical director or the treating professional person reasonably believes that there is a significant risk of deterioration in the patient's condition, and the reasonable efforts to obtain the patient's compliance as required in 106.4.A. have been unsuccessful, the medical director or the treating professional person shall make arrangements consistent with continuity of care regulations to have the patient transported to a designated facility or the emergency room of a hospital. Modifications, if needed, should then be made in the service plan, based on the current needs of the patient.

   If the safety of the patient or the public requires transportation by the sheriff, the medical director or treating professional person may petition the court pursuant to these rules and regulations.

C. The Patient shall not be physically forced to take prescribed medication during this appraisal process.

D. The patient shall not be detained at the designated facility and/or emergency room for more than four hours for the appraisal. After this appraisal, if the patient is not detained, the facility holding the certification or the treating professional person shall arrange transportation for the patient to return to the patient's residence or other reasonable location, if the patient so desires.

E. Nothing in this Section 106. shall limit the actions that a professional person or a designated facility may take in an emergency situation as described in Section 107.5.A.

106.5. CERTIFICATION ON AN OUTPATIENT BASIS BY A PROFESSIONAL PERSON IN PRIVATE PRACTICE

A. A patient under the care of a professional person in private practice may be certified for involuntary treatment on an outpatient basis to a designated facility which has accepted the certification.

B. The designated facility is responsible for ensuring that all documentation required under these regulations is recorded.

C. If the patient wishes to discontinue treatment with the treating professional person, and is unable to identify another professional person and designated facility willing to accept the transfer of certification, the designated facility and the professional person shall work together in reviewing the merit of terminating the patient-professional person relationship. If this review indicates such action is appropriate, the designated facility, with assistance From the professional person, shall make reasonable efforts to assist the person in finding another professional person to provide treatment. In all cases the designated facility retains the responsiblity for the continuation of treatment under the certification.

C. Sections 106.1. to 106.4., above, are also applicable for certifications under section 106.5.

107. MEDICAL CARE; MEDICATION

107.1. MEDICAL CARE

A. <u>Seventy-Two (72) Hour Treatment & Evaluation Facilities</u>

The designated facility shall ensure the availability of emergency medical care to meet the individual needs of each patient. The designated facility shall have and adhere to a written plan for providing emergency medical care to include at least:

A.1. A qualified physician responsible for the completion of physical examinations within twenty-four (24) hours of admission, when indicated.

A.2. The availability of a physician or emergency medical facility on a twenty-four (24) hour, seven (7) day week basis.

A.3. Whenever indicated, a patient shall be referred to an appropriate specialist for either further assessment or treatment.

B. Short-term and Long-term Treatment Facilities

The designated facility shall ensure the availability of medical care and emergency dental care to meet the individual needs of each patient. The designated facility shall have and adhere to a written plan for providing medical and emergency dental care to include at least:

B.1. A qualified physician responsible for the completion of physical examinations within twenty-four (24) hours of admission.

B.2. Subsequent physical examinations shall be completed annually.

B.3. Ongoing appraisal of the general health of each patient, including immunizations in accordance with state law and need for corrective devises such as glasses, hearing aids, prosthesis, etc.

B.4. Availability of a physician or emergency medical facility on a twenty-four (24) hour, seven (7) day week basis.

B.5. Whenever indicated, a patient shall be referred to an appropriate specialist for either further assessment or treatment.

C. Medical Cost Issue

The obligation to ensure availability of emergency medical services shall not be construed as the obligation to pay for such services.

107.2. PRESCRIBING, HANDLING, DISPENSING MEDICATION

A. Prescribing Medication

A.1. In all instances where prescription medications are to be ordered as part of a treatment program, the following information shall be provided to the patient and his/her custodian or legal guardian:

A.1.a. The name of the medication being prescribed.

A.1.b. The usual uses of the medication.

A.1.c. The reasons for ordering the medication for this patient.

A.1.d. A description of the benefits expected.

A.1.e. The common side effects, if any.

A.1.f. The major risks, if any.

A.1.g. The probable consequences of not taking the medication.

A.2. The facility shall have policy and procedures for documenting that the required information was given to the patient, custodian, or guardian before the patient took the medication. When information is given to the patient, the documentation shall include an assessment regarding

whether the patient understood.

A.3. The physician shall make a reasonable attempt to obtain voluntary acceptance of prescription medication.

A.4. The attending physician shall be available to answer inquiries regarding the medication.

A.5. The patient shall be informed that he/she may withdraw agreement to take the medication at any time.

A.6. If after all of the above have occurred and the patient refuses to accept medication, then appropriate treatment alternatives, if any, shall be presented to the patient by the physician.

A.7. No patient shall be threatened with or experience adverse consequences by staff action solely because of a failure to accept prescription medication voluntarily. This rule is not meant to affect any privilege the professional person or designated facility may have in terminating services.

A.8. If an emergency condition exists and the patient refuses medication, the physician shall follow the procedures outlined in Section 107.5.

B. Handling and Dispensing Medication

B.1. All medication shall be administered on the written order of a physician. See also 107.2.B.2.d. below.

B.2. The designated facility shall have procedures about the following:

B.2.a. Documentation and administration of medication, medication errors, and drug reactions.

B.2.b. Notification of a physician in case of medication errors and/or drug reactions.

B.2.c. Discontinuing and disposing of medication.

B.2.d. Acceptance of verbal medication orders, confirmed by written orders.

B.3. The designated facility shall maintain records of all prescription medications dispensed to patients including:

B.3.a. The name of the patient.

B.3.b The name and dosage of medication.

B.3.c. The reason for ordering the medication.

B.3.d. The time and date the medication was administered.

B.3.e. The name and position of the person who administered the medication.

B.3.f. The name of the prescribing physician.

C. Staff

C.1. Only persons authorized by law and the policies and procedures of the designated facility shall administer medication. The law includes the Medical Practice Act C.R.S. 12-36-101, et seq., the Nurse Practice Act C.R.S. 12-38-101, et seq., and the Psychiatric Technician's Act C.R.S. 12-42-101 et seq.

C.2. All direct-care staff shall be trained in the recognition of common side effects of medication.

Drugs that entail a substantial risk and drugs that are experimental require a special procedure for consent. See Section 109., specific therapies on p 51.

107.3. USE OF FDA APPROVED DRUG IN A NON-FDA APPROVED MANNER

Drugs that entail a substantial risk and drugs that are experimental require a special procedure for consent. See section 110, specific therapies and informed consent on page 60. For other drugs the regulations in section 107.2., Prescribing, Handling, Dispensing Medications, pages 37–40, shall be followed.

107.4. USE OF INVESTIGATIONAL DRUGS

The use of investigational drugs requires a special procedure for consent. See section 110., specific therapies and informed consent.

107.5. INVOLUNTARY MEDICATION

Involuntary Medication is the administration of medication by the order of a licensed physician without the patient's consent. Its use is not limited to a type of facility.

A. Emergency Conditions

A.1. Patients who are detained pursuant to C.R.S. 27-10-105, 106, 107, 108 and 109 and are refusing medication may be administered prescription medication over their objection under an emergency condition. The order for medications shall be for only twenty-four (24) hours. There shall be an evaluation of the patient at least every twenty-four 24-hours to determine if the emergency condition continues to exist.

A.2. An emergency condition exists if:

A.2.a. The patient is determined to be in imminent danger of hurting herself/himself or others as evidenced by symptoms which have in the past reliably predicted imminent dangerousness in the particular patient or by a recent overt act, including, but not limited to, a credible threat of bodily harm, an assault on another person, or self destructive behavior.

A.2.b. The patient's life is in imminent danger due to toxicity arising from the patient's use or abuse of another medication, drug, or other substance.

A.2.c. The patient's life is in imminent danger because of a severely debilitated condition.

B. In the continuation of an emergency, if the attending physician is of the opinion that medication is indicated beyond seventy-two (72) hours, then within that seventy-two (72) hours:

B.1. The designated facility shall request a court hearing for an order to administer the medication; and

B.2. A documented concurring consultation with another physician to include an examination of the patient and a review of the patient's medical record shall be obtained. If a consultation is not obtained within seventy-two (72) hours, then medication shall be discontinued until such concurring consultation is obtained and documented.

B.3. In no case shall a patient who has refused medication be administered medication for a

period exceeding ten (10) days without an order from a court of competent jurisdiction.

B.4. The patient shall be promptly notified of the right to contact an attorney and/or a court of competent jurisdiction. If the patient desires to exercise this right, the designated facility shall aid the patient, if necessary, in accomplishing the foregoing. The designated facility shall document the patient notification in his/her chart.

C. The specific facts supporting the finding of such an emergency condition shall be detailed in the patient's chart, initially and every twenty-four (24) hours thereafter so long as the emergency exists.

D. Non-emergency Involuntary Medication In non-emergency situations, a court order is required prior to administering medication to a patient who is refusing medication.

107.6. INVOLUNTARY MEDICATION LOG

The designated facility shall maintain a log of all cases where involuntary medications were administered. The log shall be readily accessible to authorized persons for review. The log shall contain the following:

A. Patient's name and identifying number,

B. Specified use of involuntary medication,

C. Date/time involuntary medication was administered,

D. Date that involuntary medication was discontinued.

108. SECLUSION; UNAUTHORIZED DEPARTURES

The following rules apply to patients being treated and/or evaluated under C.R.S. 27-10-105 through 27-10-109 and apply to all areas of the designated facility including emergency rooms.

The designated facility shall have written policies and procedures that address seclusion. In the event that a facility does not authorize the use of seclusion the policy statement shall reflect the prohibition.

108.1. USE OF SECLUSION

A. Seclusion may be used only for the confinement of a patient alone for the purpose of preventing imminent injury to self or others, or to eliminate continuous and serious disruption of the treatment environment. Any time a patient is placed alone in a locked room it shall be construed as seclusion.

B. Any decision to seclude shall be based on a current clinical assessment, and may also be based on other reliable information including information that was used to support the decision to take the person into custody for treatment and evaluation. The fact that a person is being evaluated or treated under C.R.S. 27-10-105 through 27-10-109 as being gravely disabled, a danger to self, a danger to others, or both a danger to self and others shall not be the sole justification for the use of seclusion.

C. Seclusion shall not be used for punishment or for the convenience of staff.

D. Seclusion shall be used only when other less restrictive methods have failed.

E. Staff shall make ongoing efforts to assure that seclusion shall be as brief as possible.

F. A professional person shall be notified immediately (within one hour) after a patient is placed in seclusion.

108.2. EXPLANATION TO PATIENTS

Upon seclusion, the patient shall be given a clear explanation of reasons for seclusion, the observation procedure, the desired effect, and the circumstances under which the procedure will be terminated.

The fact that this explanation has been given to the patient shall be documented. When supplemental information is given to the patient, the fact that supplemental information has been given shall be documented.

In an emergency room situation or in an emergency situation in a non-psychiatric area, information given to the patient pursuant to this regulation regarding the desired effect and the circumstances under which the procedure will be terminated may not be as detailed as on an inpatient unit. However, as the patient's assessment progresses, staff shall promptly supplement the information given the patient as soon as it becomes available. If the patient is stuporous, unconscious or actively combative or assaultive or receiving acute medical treatment, the information shall be given to the patient as soon as these conditions abate. Information shall be given to a combative or assaultive patient as soon as possible after he/she has been secluded.

108.3. SECLUSION ROOM

A. The seclusion room shall be at least 100 square feet in size.

B. It shall meet all safety code requirements.

C. It shall have appropriate ventilation, light and temperature.

D. It shall be free of objects or fixtures which can be broken or used to inflict injury.

E. It shall have a window for observation of patient by the staff.

F. It shall have a sign or device outside the room to signify when the door is locked.

108.4. FACILITY POLICIES AND PROCEDURES

The designated facility shall have and shall implement written policies and procedures that describe the situations in which the use of seclusion is considered appropriate within each specific program component and the staff members who can order its use. The written policies and procedures for the use of seclusion shall include the requirements in 108.1., pages 43–44.

108.5. DOCUMENTATION OF THE USE OF SECLUSION IN THE PATIENTS CHART

A direct-care staff member shall record each use of seclusion and the clinical justification for the use in the patient's chart.

A. The justification shall:

A.1. describe the patient's behaviors,

A.2. clearly specify the nature of the danger, or disruption

A.3. describe the attempts made to quiet or control the patient's behavior prior to using seclusion, and the documentation shall include a description of the circumstances under which

seclusion will be terminated.

B. Staff shall document that an explanation has been given to the patient as required by Section 108.2. hevein.

C. The documentation shall describe the ongoing efforts to assure that seclusion shall be as brief as possible.

108.6. SECLUSION LOG

Each use of seclusion shall also be documented in a log separate from the clinical records. The log shall be readily accessible to authorized persons for review. The log shall contain the following information:

A. patient's name and identifying number,

B. specified use of seclusion,

C. date/time that seclusion episode was initiated,

D. date/time that seclusion episode was terminated.

108.7. SECLUSION LONGER THAN ONE HOUR

A verbal order (including orders given over the telephone) followed by a written order from a professional person shall be required for the use of seclusion for longer than one hour. Seclusion shall not be ordered on an “as needed” basis.

A. If the patient has not been examined by a professional person within the previous twenty-four (24) hours, seclusion continued in excess of four (4) hours will require face-to-face examination and a new written order by a professional person. If there has been a documented examination of the patient by a professional person within the previous twenty-four (24) hours seclusion continued in excess of fourteen (14) hours will require face-to-face examination and a new written order by a professional person. A new examination shall be conducted by a professional person prior to each succeeding twenty-four (24) hours of seclusion to assure that the need for seclusion is still present.

B. An episode of seclusion is terminated when the patient has been out of seclusion for a continuous period of two (2) hours.

108.8. SECLUSION LONGER THAN 24 HOURS; ADMINISTRATIVE REVIEW

Seclusion continued in excess of twenty four (24) hours shall require a face-to-face examination and a new written order by the professional person.

Reasons for continuation shall also be documented by the professional person.

A. Continued seclusion in excess of twenty-four (24) hours will require an administrative review by a person designated by the director of the facility, other than the professional person in charge of treatment. The reviewer shall be a person with the authority and knowledge necessary to review clinical information and reach a determination that the extension of a seclusion episode beyond 24 hours is clinically necessary.

B. The facility shall establish policy and procedures for implementing administrative review including a process for terminating the seclusion episode when the reviewer does not concur with the order for continuation of seclusion. If the reviewer is not a professional person, the seclusion order must

be discontinued by a professional person.

The administrative review shall be initiated at the conclusion of each 24-hour period of continuous use of seclusion and shall be completed as soon as possible within 4 hours. However, if the 24-hour period ends after 6 p.m., the administrative review shall be completed not later than 10 a.m. the next day.

108.9. DOCUMENTATION OF ADMINISTRATIVE REVIEW

The administrative review shall verify that the clinical record contains at a minimum the following:

A. Documentation that the professional person ordering the continuous use of seclusion in excess of 24-hours has conducted a face-to-face evaluation of the patient within the previous 24-hours.

B. Documentation that the ongoing behaviors warrant the continued use of seclusion.

C. Documentation of the consideration or use of less restrictive alternatives, including a plan for ongoing efforts to actively address the behaviors which results in the use of seclusion.

D. The administrative review shall determine the clinical appropriateness of the continuation of seclusion.

E. Documentation in the clinical record shall include a summary of the information considered by the reviewer, and the result of the administrative review together with the date, time, and signature of the person completing the review, and the behaviors that warrant the continued use of seclusion.

108.10. OBSERVATION AND CARE OF SECLUDED PATIENT

A. A secluded patient shall be observed by the staff at least every fifteen (15) minutes and such observation, along with the behavior of the patient, shall be recorded and initialed each time. Unless contraindicated by the patient's condition, such observations shall include efforts to interact personally with the patient.

B. Ongoing provisions shall be made for nursing care, hygiene, and diet. The patient shall have access to fluids, food and toileting at least every four hours.

108.11. STAFF TRAINING

All staff placing patients in seclusion shall be trained in the use of these procedures.

All training shall be documented.

108.12. UNAUTHORIZED DEPARTURES

Each designated facility shall be responsible for maintaining reasonable security capabilities to guard against the risk of unauthorized departure. An open unit may place a patient in a seclusion room which is locked to prevent an unauthorized departure when such departure carries an imminent risk of dangerousness for the patient or others. In any event, the least restrictive method to prevent an unauthorized departure shall be used. The seclusion procedures in Section 108. shall be followed if seclusion is used. Physical restraint shall not be used unless the criteria in Section 109. are met.

109. PHYSICAL RESTRAINTS

The following rules on the use of restraints are for patients being evaluated or treated under C.R.S. 27-10-105 through 27-10-109 and apply to all areas of the designated facility including emergency rooms. The designated facility shall have written policies and procedures that address restraints. In the event that

a facility does not authorize the use of restraints, the policy statement shall note the prohibition.

The purpose of these restraints is to modify behavior for the safety of the patient and others in the patient's environment. These rules do not apply to the use of restraints for medical, surgical, or postural support purposes, which are described in the following two paragraphs, and which are regulated by the Colorado Department of Health.

Medical/surgical physical restraints may be used where restraints are usually and customarily employed during medical, diagnostic, or surgical procedures when restraint usage is considered a regular and usual part of the procedure.

Examples of medical/surgical physical restraints are: a body restraint during surgery, arm restraint during intravenous administration, restraints to prevent a non-ambulatory patient from falling out of bed or out of a wheelchair. Medical/surgical physical restraint is usually evidenced by the use of soft restraints.

109.1. USE OF RESTRAINTS

A. Physical restraints may be used only for the purpose of preventing such body movement that is likely to result in imminent injury to self or others.

B. Any decision to restrain shall be based on a current clinical assessment, and may also be based on other reliable information including information that was used to support the decision to take the person into custody for treatment and evaluation. The fact that a person is being evaluated or treated involuntarily under C.R.S. 27-10-105 through 27-10-109 as being gravely disabled, a danger to self, a danger to others, or both a danger to self and others shall not be the sole justification for the restraints.

C. Restraint of a single limb is not permissible. Physical restraint shall not be used solely to prevent unauthorized departure.

D. Physical restraint shall not be used for punishment, for the convenience of the staff, or as a substitute for a program of care and treatment.

E. The type of restraint used shall be appropriate to the type of behavior to be controlled.

F. Physical restraint shall be applied only if such restraint imposes the least possible restriction consistent with its purpose, and only if alternative techniques have failed.

Alternative techniques are not required under the following circumstances if the alternatives would be ineffective:

F.1. the patient is physically combative or actively assaultive or self-destructive, or

F.2. the patient is disoriented with behavior that is out of control to the point that the patient is imminently dangerous to self or others, or

F.3. the patient exhibits the diagnostic symptoms of medical syndromes for which alternative techniques are known to be ineffective. Examples are:

F.3.1. Organic conditions that are medically known to cause dangerous behavior, such as:

-toxic states,

-P.C.P. intoxication and similar intoxications, or

-encephalopathies (infectious, metabolic, etc.)

F.3.2 Other medical syndromes for which alternative techniques are known to be ineffective, such as:

-catatonic syndrome, or

-agitated manic states.

F.4. Justification for immediate use of restraints shall be documented.

G. Except in an emergency, physical restraint shall only be ordered by the professional person. An emergency condition exists if the patient is determined to be in imminent danger of hurting himself/herself or others.

H. Staff shall make ongoing efforts to assure that physical restraint shall be as brief as possible.

I. A professional person shall be notified immediately (within one hour) after a patient is placed in restraint(s).

109.2. EXPLANATION TO PATIENT

Upon restraint, the patient shall be given a clear explanation of reasons for use of restraints, theobservation procedure, the desired effect, and the circumstances under which the procedure will be terminated. The fact that this explanation has been given to the patient shall be documented. When supplemental information is given to the patient, the fact that supplemental information has been given shall be documented.

In an emergency room situation or in an emergency situation in a non-psychiatric area, information given to the patient pursuant to this regulation regarding the desired effect and the circumstances under which the procedure will be terminated may not be as detailed as on an inpatient unit. However, as the patient's assessment progresses, staff shall promptly supplement the information given the patient as soon as it becomes available.

If the patient is stuporous, unconscious or actively combative or assaultive or receiving acute medical treatment, the information shall be given to the patient as soon as these conditions abate.

Information shall be given to a combative or assaultive patient as soon as possible after he/she has been restrained.

109.3 PROTECTION OF RESTRAINED PATIENT

Staff shall ensure that no person will harm or harass the restrained patient. If necessary, physical restraint may be used in a seclusion room or other protected area.

109.4. FACILITY POLICIES AND PROCEDURES

The designated facility shall have and shall implement written policies and procedures that describe the situations in which the use of physical restraints are considered appropriate within each specific program and the staff members who can order their use.

The written policies and procedures for the use of physical restraint shall include the requirements in 109.1., pages 52-53.

109.5. DOCUMENTATION OF THE USE OF RESTRAINTS IN PATIENT'S CHART

A. A direct care staff member shall record each use of restraints and the clinical justification for the use in the patient's chart.

The justification shall:

A.1. describe the patient's behaviors,

A.2. clearly specify the nature of the danger,

A.3. describe the attempts made to quiet or control the patient's behavior prior to using restraints, and

A.4. describe the circumstances under which restraints will be terminated.

B. Staff shall document that an explanation has been given to the patient as required by Section 109.2. herein.

C. Staff shall document efforts to assure that the use of restraints shall be as brief as possible.

109.6. RESTRAINT LOG

Each use of restraint shall also be documented in a log separate from the clinical record. The log shall be readily accessible to authorized persons for review. The log shall contain the following information:

A. patient's name and identifying number,

B. specified use of restraint,

C. date/time that restraint episode was started,

D. date/time that restraint episode was terminated.

The professional person shall be notified immediately (within one hour) following a patient's being placed in physical restraint.

109.7. RESTRAINT LONGER THAN ONE HOUR

A verbal order (including orders given over the telephone) followed by a written order by a professional person shall be required for the use of physical restraint for a period longer than one hour. Physical restraint shall not be ordered on an “as needed” basis.

A. If the patient has not been examined by a professional person within the previous twenty-four (24) hours restraint continued in excess of four (4) hours will require face-to-face examination and a new written order by a professional person. If there has been a documented examination by a professional person within the previous twenty-four (24) hours, restraint continued in excess of fourteen (14) hours will require face-to-face examination and a new written order by a professional person. A new examination shall be conducted by a professional person prior to each succeeding twenty-four (24) hours of restraint to assure that the need for physical restraint is still present.

B. An episode of restraint is terminated when the patient has been out of restraints for a continuous period of two (2) hours.

109.8. RESTRAINT LONGER THAN 24 HOURS; ADMINISTRATIVE REVIEW

Physical restraint continued in excess of twenty-four (24) hours shall require a face-to-face examination and a new written order by the professional person. Reasons for continuation shall also be documented by the professional person.

A. Continued physical restraint in excess of twenty-four (24) hours shall require an administrative review by a person designated by the director of the facility other than the professional person in charge of treatment. The reviewer shall be a person with the authority and knowledge necessary to review clinical information and reach a determination that the extension of a physical restraint episode beyond 24-hours is clinically necessary.

B. The facility shall establish policy and procedures for implementing administrative review including a process for terminating the physical restraint episode when the reviewer does not concur with the order for continuation of restraint. If the reviewer is not a professional person, the restraint order must be discontinued by a professional person.

C. The administrative review shall be initiated at the conclusion of each 24-hour period of continuous use of seclusion, and shall be completed as soon as possible within 4 hours. However, if the 24-hour period ends after 6 p.m., the administrative review shall be completed not later than 10 a.m. the next day. In a case of restraining a patient to an object, the administrative review shall be completed prior to the expiration of each 24-hour period.

109.9. DOCUMENTATION OF ADMINISTRATIVE REVIEW

The administrative review shall verify that the clinical record contains at a minimum the following:

A. Documentation that the professional person ordering the continuous use of physical restraints in excess of 24-hours has conducted a face-to-face evaluation of the patient within the previous 24-hours.

B. Documentation of the ongoing behaviors that warrant the continued use of physical restraints.

C. Documentation of the consideration or use of less restrictive alternatives, including a plan for ongoing efforts to actively address the behaviors which resulted in the use of physical restraint.

D. The administrative review shall determine the clinical appropriateness of the continuation of physical restraints.

E. Documentation in the clinical record shall include a summary of the information considered by the reviewer, and the result of the administrative review together with the date, time, and signature of the person completing the review.

109.10. OBSERVATION AND CARE OF RESTRAINED PATIENT

A. A patient who is in physical restraint shall be observed face-to-face by staff at least every fifteen (15) minutes, and such observation, along with the behavior of the patient, shall be recorded each time. Unless contraindicated by the patient's condition, such observation shall include efforts to interact personally with the patient.

B. Ongoing provision shall be made for nursing care, hygiene, diet and motion of the restrained limbs. The patient shall have access to fluids, food, and toileting at least every four hours.

109.11. STAFF TRAINING

All staff placing patients in physical restraints shall be trained in the use of these procedures. All training shall be documented.

110. SPECIFIC THERAPIES AND INFORMED CONSENT

110.1. SPECIFIC THERAPIES

Therapies which require a special procedure for consent are electro-therapy treatment (electro-convulsive therapy), behavior modifications using physically painful, aversive or noxious stimuli, or the use of investigational drugs. Therapies which entail a substantial risk shall also be governed by this regulation.

110.2. FACILITY

The facility shall be suited to the anticipated medical needs of the patient.

110.3. INFORMED CONSENT

110.3. Prior to the administration of any specific therapy, a written informed consent shall be executed by both the patient and his/her legal guardian, if one has been appointed pursuant to C.R.S. 15-14-303 et seq. In the event the patient or the legal guardian refuses to consent, specific therapy shall be administered only 1) with a prior court order, or, 2) in an emergency in which the life of the patient is in imminent danger. In case of electrotherapy treatment (electroconvulsive therapy), the consent form adopted by the Division of Mental Health on May 31, 1993 shall be used. An informed consent means:

A. It is freely, knowingly, given and is expressed in writing.

B. It is preceded by the following:

B.1. A fair explanation of the proposed specific therapy including identification of experimental elements in treatment, if any;

B.2. The anticipated benefit;

B.3. The common discomforts, side effects and risks associated, if any;

B.4. The probable consequences if the treatment is not permitted to proceed;

B.5. The availability of appropriate alternative treatment, if any, and its probable consequences;

B.6. An offer to answer any inquiries concerning the specific therapy;

B.7. An instruction that the patient or other person giving consent is free to withdraw his/her consent and to discontinue the specific therapy at any time.

C. The consent agreement entered into by the patient or other person shall not include exculpatory language through which the patient or other person is made to waive, or appear to waive, any of his/her legal rights, or to release the facility or any other party from liability for negligence.

D. No informed consent for specific therapy shall be valid for more than thirty (30) days.

110.4. EMERGENCY SITUATION

In an emergency situation in which there is imminent danger to the life of the patient because of the patient's condition, the patient is unable to grant informed consent and no legal guardian exists or can be found, and sufficient time does not exist to petition the court for an order prior to the administration of the

specific therapy, the patient's physician, in consultation with the director of the designated facility or his/her designee, may after careful and informed deliberation, under procedures adopted by the facility, order a specific therapy without consent.

110.5. DOCUMENTATION

The reason for the use of any specific therapy shall be fully documented in the patient's record.

110.6. PROCEDURES

Each designated facility shall adopt written procedures for administration of specific therapies in accordance with these rules and regulations.

111. SERVICE PLAN; CONTINUITY OF CARE; TRANSPORTATION

111.1. SERVICE PLAN

A. The designated facility is responsible for assuring the formulation and implementation of an individualized, integrated, comprehensive written service plan designed with the purpose of promoting the client's highest possible level of independent functioning and to reduce the likelihood of rehospitalization or return to restrictive confinement.

B. As soon as possible, but within seventy-two (72) hours of admission, an initial service plan shall be formulated which shall address the immediate and/or emergency needs of the client.

C. If a client is discharged during a seventy-two (72) hour hold without certification by the facility, and an initial service plan has not been completed, then available pertinent information shall be included in the discharge summary.

D. The service plan shall be developed by a multidisciplinary team within ten (10) days after admission.

E. The service plan is based on the client's assessed clinical and other relevant needs including the client's presenting problems, physical health, emotional status, behavior, and support system in the community, and available resources.

F. The service plan contains specific goals that are based on the assessment.

F.1. The service plan contains specific objectives that relate to the goals, are written in measurable terms, include expected dates of achievement, and specific criteria to be met for termination of treatment.

F.2. The type, frequency and duration of services are specified in the service plan.

F.3. The plan assures the provision of or the referral for the needed services.

G. The service plan specifies all services necessary to meet client needs. The following services are included in the service plan when indicated by client needs:

G.1. Clinical Treatment Services

G.2. Case Management Services

G.3. Rehabilitation Services

G.4. Residential Services

G.5. Vocational Services

G.6. Emergency Services

G.7. Medication Management Services

H. The client and the legal guardian shall participate in the formulation, review and revision of the service plan. If the client or legal guardian is unable to participate, or when their participation is clinically contraindicated, the reasons shall be documented in the client's record. In addition, other persons selected by the client, the guardian, or the treating professional person may also be included in the formulation, review, and revision of the service plan.

I. The client shall sign the service plan and shall be offered a copy of the plan. The record shall contain an explanation whenever a service plan is not signed.

J. The facility shall appoint a clinical staff person to be responsible for the formulation, implementation, review, and revision of the service plan. The name of the responsible staff person shall be specified in the plan and that person shall sign the plan. The plan shall also be signed by the treating professional person, if the treating professional person is not the responsible staff person.

The patient shall be given the name and telephone number of the facility's patient representative to contact should the patient have a question or complaint or wish to file a grievance. This shall be noted in the chart.

K. A physician shall be responsible for the component of the plan requiring medication management services.

L. The facility is not responsible for providing nonpsychiatric medical care, but shall facilitate access to proper medical care and shall be responsible for coordinating mental health treatment with medical treatment provided to the patient.

M. The service plan shall be reviewed, and revised if necessary, at least monthly by the staff person responsible for the plan and by the treating professional person.

N. The service plan shall specify criteria for discharge, including provisions for transitional, aftercare and follow-up services based on the needs of the client. At the time of transfer of responsibility for the patient from one facility to another, there shall be sufficient interfacility communication to make continuity of care feasible. See 111.2., Continuity of Care.

O. Service plans shall be readily identifiable and shall be maintained in a place readily accessible to treatment staff.

P. All members of the clinical staff shall be trained annually in the development and review of service plans.

111.2. CONTINUITY OF CARE

A. Each designated facility shall adopt and implement a written policy for continuity of patient care which shall include at a minimum the following:

A.1. Ease of patient movement from one element of service to another within the facility.

A.2. Aftercare planning, to be included with the patient's discharge summary which describes any recommendations for the patient to follow after discharge from the facility.

A.3. Referrals to other agencies and follow-up of such referrals.

B. The placement alternative selected shall be conducive to the optimum restoration of the patient's mental and physical functioning, with due regard for the safety of the patient and those around him/her and the availability of placement alternatives.

C. Patients shall only be transferred to the care of another designated or placement facility when adequate arrangements for care by the receiving facility have been documented. This shall include at least one discharge planning conference, face-to-face or by telephone, with participants from both facilities of which the patient shall be immediately informed. At least twenty-four (24) hours advance notice to the certified or long-term care and treatment patient of the impending transfer shall be given, unless waived in writing by the patient or an emergency condition exists as to the certified or long-term care and treatment patient. Notice of such transfer shall also be provided to the court of jurisdiction and the patient's attorney. The transferring facility shall ask the patient to indicate two (2) persons to whom notification of transfer should be given and shall notify such persons within twenty-four (24) hours of notification of the patient. Such notification shall be made by the transferring facility with the appropriate written patient authorization. Actions taken under this section shall be documented in the clinical record.

111.3. TRANSPORTATION

Whenever transportation of a patient is required, the treating staff of the designated facility shall assess the patient for dangerousness to self or others and potential for escape. If the treating staff assesses the patient as dangerous to self or others or as an escape risk, the staff may request transportation by the Sheriff's Department.

A. A request for transportation from the Sheriff's Department shall be filed with the court of appropriate jurisdiction and shall include:

A.1. Statements from the treating professional person supporting the need for transportation by the Sheriff's Department;

A.2. Recommendations concerning the use of restraints and the impact that handcuffs or shackles would have on the patient;

A.3. Recommendations concerning the placement and management of the patient during the time he/she will be absent from the designated facility due to a court hearing.

B. Notice of the request for transportation by the Sheriff's Department shall be given to the patient and his/her attorney at least twenty-four (24) hours prior to the time it is filed with the court. This notice shall not be required during the time a seventy-two (72) hour hold is in effect or in an emergency situation with a certified patient or when the patient signs a waiver which has been clearly explained.

C. Transportation by the Sheriff's Department does not require a finding of dangerousness to self or others or an escape risk if the Sheriff's Department is willing to transport the patient without the use of physical restraints.

112. TREATMENT RECORDS; CONFIDENTIALITY

112.1. TREATMENT RECORDS

A. Care of Records

A.1. Designated facilities shall maintain an organized, written, current record on each patient

which can be easily reviewed for compliance.

A.2. All treatment entries shall be signed and dated by the author, with his/her degree and title or position, at the time they are written.

A.3. Records shall be kept in a secure location at the facility and only be released in accordance with Section 112.2., Confidentiality, pages 71-75.

B. Admission Data

Records shall include:

B.1. Patient identification and demographic data, source of referral, and previous history, including substance abuse and vocational, if indicated.

B.2. Documentation of patient's legal status such as guardianship, conservatorship, court orders, as to custody, certifications, advisements and consent.

B.3. Medical history and physical examination reports, when required pursuant to Section 107.1., page 36.

B.4. Initial impression, differential diagnosis, or diagnoses in standard terminology (e.g., Diagnostic and Statistical Manual, III R, or International Classification of Diseases and Ailments).

B.5. Treatment Plan.

C. Treatment Progress

Records shall include:

C.1. The individual service plan, to include clinical treatment services and, as pertinent:

C.1.1. Case Management Services

C.1.2. Rehabilitation Services

C.1.3. Medication Management

C.1.4. Emergency Services

C.1.5. Community Support Services

C.1.6. Vocational Services

C.1.7. Residential Services

C.2. Documentation that the client, and the family where appropriate, was/were included in developing and updating the service plan.

C.3. Documentation that the patient was offered a copy of the service plan.

C.4. Ongoing progress on a chronological basis at least monthly for outpatient treatment and weekly for inpatient or residential service.

C.5. Documentation of patient's response to treatment approaches and changes in the treatment plan with the reasons for such changes.

C.6. Documentation of all treatment procedures including brief physical holding, seclusion, physical restraint, involuntary medications and specific therapies in accordance with Sections 107., 108., 109., and 110.

C.7. Information regarding the serious injury of or by the patient and the circumstances.

C.8. Documentation of support services provided.

C.9. Correspondence to and from relevant agencies and individuals.

C.10. Documentation of all transfers and reasons for transfer within the designated facility.

D. Certification Review

Documentation of results of professional person's review at least monthly of:

D.1. Certification;

D.2. effectiveness of mental health treatment;

D.3. legal status of patient;

D.4. medication (reviewed by a physician); and

D.5 less restrictive treatment alternatives.

E. Discharge or Transfers Between Facilities

Records shall include:

E.1. A discharge summary outlining treatment received, progress made.

E.2. For transfers between facilities, documentation of appropriate clinical information and coordination of services between the two facilities.

E.3. Documentation of unplanned discharges and discharges against the professional person's advice.

E.4. Information regarding the death of a patient and the circumstances.

F. Clinical records shall be retained as follows:

F.1. seven years for adults receiving outpatient care;

F.2. seven years beyond age 18 for minors receiving outpatient care;

F.3. ten years for adults receiving inpatient care; and

F.4. ten years beyond age 18 for minors receiving inpatient care.

112.2. CONFIDENTIALITY

A. School records shall be transmitted according to state law, pursuant to C.R.S. 24-72-204, and the Individuals with Disabilities Education Act as amended by Public Law 94-142.

B. Patients and legal guardians may have access to their records subject to C.R.S. 25-1-801, et seq. and C.R.S. 24-72-201, et seq. and C.R.S. 27-10-120 and rules and regulations of the Department of Health, if applicable.

C. The designated facility and the responsible professional person shall have the responsibility to insure that all information obtained and records prepared in the course of treatment shall be maintained as confidential and privileged matter and shall not be subject to public disclosure except as may be provided in paragraphs E through I and K through N below.

D. The designated facility shall provide sufficient privacy to maintain confidentiality of communication between a patient and spouse, staff member, attorney, certified public accountant, and/or clergy.

E. Information and records shall be made available to an adult or minor patient's attorney or personal physician upon the patient's written authorization. Information and records may otherwise be disclosed outside of the designated facility only:

E.1. When the patient or his/her parent(s), if the patient is a minor, designates persons to whom information or records may be released and signs appropriate release of information form. Whenever a patient has a legal guardian or conservator and his/her legal guardian or conservator designates, in writing, persons to whom records or information may be disclosed, such designation shall be valid in lieu of the designation by the patient. Individual authorization for release of information shall be time limited, shall indicate who shall receive the information and what information shall be released.

E.2. When the treating professional person or his/her designee authorizes the release of information in the absence of consent:

E.2.1. To physicians for the purpose of seeking advice and expertise concerning a specific medical problem to assist in the ongoing treatment of a patient in a facility.

E.2.2. To any other qualified professional persons or agencies needing the information because of a life-threatening emergency or in a situation where there is a high likelihood of an imminent life-threatening situation.

E.2.3. In communications between qualified professional personnel in the provision of services or appropriate referrals.

E.2.4. To persons authorized by court order after there has been notice and opportunity for hearing to the person to whom the records pertain and the custodian of the records.

E.2.5. To certain family members, Pursuant to C.R.S. 27-10-120 and 120.5.

F. For claims on behalf of the patient for aid, insurance or medical assistance. Such information shall be limited to information required for the payment of the claim. Unless otherwise specified in Medicaid/Medicare regulations, such disclosure may be made only if a statement is included that the information may not be re-released to any other agency including a centralized computer history agency accessible by others.

G. To the courts as necessary to the administration of the Act for the Care and Treatment of the Mentally Ill, C.R.S. 27-10-101, et seq., as amended;

H. Records shall be released to the staff of the governor's designated Protection and Advocacy System for Persons with Mental Illness for a patient with mental illness:

H.1. receiving publicly-funded mental health treatment, or

H.2. receiving inpatient or residential treatment, or

H.3. having been discharged from inpatient or residential treatment, or

H.4. having died while in inpatient or residential treatment.

I. Nothing in this Section shall be construed to limit the access of duly authorized representatives of the Department access to confidential material for purposes of assuring compliance with the provisions of these rules. Such duly authorized representatives of the Department are obligated to protect the confidentiality of any patient information reviewed.

J. Whenever a family member or other informant (not including a facility) requests that information revealed to treating personnel remain confidential, such information shall not be released unless otherwise provided by law or court orders.

J.1. Whenever confidential information provided by a family member of an informant is ordered released, attempts shall be made to notify the family member or informant of the release of information by the person who has obtained the court order.

J.2. The fact that confidential information is being withheld may be disclosed to persons requesting the information, but if the patient's attorney has requested the information, the fact that confidential information is being withheld shall be disclosed.

K. Any information concerning observed behavior which reasonably appears to constitute a criminal offense committed on the premises of a designated or placement facility or any criminal offense committed against any persons while performing or receiving services is not considered privileged or confidential.

L. All researchers conducting clinical research must sign an oath of confidentiality. All information identifying individual patients by name, address, telephone number and/or social security number collected for research proposes, shall not be disclosed.

M. When names are deleted and other identifying information is disguised or deleted, material from case records may be used for teaching purposes, development of the governing bodies' understanding and knowledge of the facilities' services or similar educational purposes.

N. Information regarding treatment for alcohol or drug abuse may be released only in compliance with the Federal Regulations on Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2.

113. WAIVER

Although it is the policy of the Department that each designated facility comply in all respects with these rules and regulations, a waiver of the specific requirements of the rules and regulations may be granted by the Department in accordance with this Section.

113.1. TIME PERIOD

A waiver of these specific rules and regulations may be granted to designated facilities and facilities seeking initial approval for a period not to exceed one (1) year. However, the waiver may be renewed for

additional one (1) year periods.

113.2. GROUNDS FOR A WAIVER

A waiver may be granted upon a finding that:

113.2.1. the waiver would not adversely affect the health, safety and welfare of the patients, and the further finding that

113.2.2. either it would improve patient care or that application of the particular rule or regulation would create a demonstrated financial hardship on the facility seeking the waiver.

113.3. BURDEN OF PROOF

The facility seeking the waiver has the burden of proof. Consideration will be given as to whether the intent of the specific rule or regulation has been met.

113.4. PLACEMENT FACILITIES

When a designated facility provides mental health services through a placement facility and a waiver is sought for such services, the designated facility and not the placement facility shall request the waiver.

113.5. REQUESTS FOR WAIVERS

Requests for waivers shall be submitted to the Department, and shall be signed by the Board President and/or the Director of the designated facility. The request shall contain a detailed description of the mental health services provided by the designed facility, the effect of the proposed waiver on the health, safety and welfare of the patients, the expected improvement in patient care, and the degree of financial hardship on the designated facility.

113.6. NOTICE

At the time of submission of each waiver request, the designated facility shall be required to post notice of the request and a meaningful description of its substance in a conspicuous place on the designated facility's premises. The Department shall not hold hearings as described in Paragraph 113.7. unless it has been preceded by such notice which shall be reasonably calculated to inform interested persons of the date, time and place of the hearing.

The Department shall give written notice of the time, date, and place of the meeting to interested persons twenty (20) days prior to the meeting. For the purpose of this process, interested persons will included the members of the Mental Health Advisory Board for Service Standards and Regulations, the affected facility, and appropriate Department staff.

113.7. THE HEARING

The Department shall set a date convenient to all parties for a hearing to discuss the waiver request in detail. The hearing shall be conducted by the Director of the Department or his/her designee and shall be open to public attendance and participation. The designated facility shall send representatives to attend the hearing. A record shall be made of the hearing.

113.8. THE DECISION

Unless additional time is required to make inspections or obtain additional information from the designated facility, the Department shall notify the designated facility in writing, within thirty (30) days following the date of the hearing of the decision upon the waiver request. Pursuant to C.R.S. 27-1-102(2)

(a), the Executive Director of the Department hereby delegates to the Director of the Division or his/her designee of the power to make such decisions under waiver requests. The decision of the Division shall constitute “final agency action” of the Department. Appeals may be made pursuant to the Colorado Administrative Procedures Act C.R.S. 24-1-101, et seq.

Appendix

Policies and Procedures

Confidential Information to Family Members

Critical Incidents

Involuntary Medications

Plan for Emergency Care (72-hour facility)

Plan for Medical and Dental Care (short and long-term facilities)

Restraints; Administrative Review

Seclusion; Administrative Review

Specific Therapies: Administration; Emergency Procedures

Use of Jails

Documentation

Patient/client record

- Admission data
- Attorney: patient notification of right to contact attorney about involuntary meds
- Denial of rights: reasons
- Discharge
- Involuntary medications
- Jail: Reasons for holding person in jail
- Medical problems: follow-up
- Medical Review/6 months/involuntary patient medical status
- Medications prescribed
- Professional person review of records
- Restraint: explanation to patient
- Seclusion/Restraint

Seclusion/Restraint: explanation to patient

Service plan

Service plan offered to client certified for involuntary treatment on an outpatient basis

Specific Therapies: reason for use; administration to patient

Treatment progress

Work assignments, with consent forms and hourly compensation

Other documentation

Logs: use of seclusion, restraint, involuntary medications

Quality Assurance every 3 months

Contracts/Agreements

Treating Prof. Person not employed by designated facility (may be staff privileges)

Placement facility

DISCLOSURE STATEMENT TO PERSONS RECEIVING TREATMENT AT FORT LOGAN MENTAL HEALTH CENTER AND AT COLORADO STATE HOSPITAL

Facility disclosure statement

1.1 Upon admission the facility shall provide in writing the following information to the person:

1.1.1 The name, address and telephone number of the facility

1.1.2 A statement that the Department of Regulatory Agencies (DORA) has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy; and that the agency within DORA that has responsibility specifically for licensed and unlicensed psychotherapists is the State Grievance Board, Room 128, 1525 Sherman Street, Denver, Colorado 80203 (telephone (303)866-3248).

1.1.3 A statement that the hospital has a patient's rights specialist or a patient representative who will help the person to contact the regulatory agency. Directions for contacting the patient's rights specialist or patient representative..

1.1.4 A statement that when the person first meets with a therapist, the person will receive information, in writing, giving the name and phone number of the person's primary therapist, as well as the therapist's degrees, licenses and credentials.

1.1.5 A statement that the person is entitled to receive, upon his or her request, the information listed in 1.1.4 concerning any psychotherapist in the employ of the hospital who is providing psychotherapy services to the person, and that the information will be provided within 15 days..

1.1.6 A statement indicating that a person is entitled to receive information about the methods of

therapy, the techniques used, the duration of therapy, if known, and the fee structure, and that the person is entitled, to the extent feasible, to participate in forming and reviewing his/her treatment plan.

1.1.7 A statement that if the person is being treated voluntarily, the person may seek a second opinion from another therapist or may terminate therapy at any time; however, the person is responsible for paying the cost of a second opinion.

1.1.8 A statement that if the person is being treated involuntarily, the person may seek a second opinion through the court.

1.1.9 A statement that in a professional patient/therapist relationship, sexual intimacy is never appropriate and should be reported to the Grievance Board.

1.1.10 A statement that the information provided by the person during therapy sessions is legally confidential except for certain legal exceptions which will be identified by the therapist should any such situation arise during therapy.

Therapist disclosure statement

2.1 During the initial consultation with the person, the primary therapist shall provide, in writing, the following information to the person:

2.1.1 The name and telephone number of the primary therapist.

2.1.2 A listing of the primary therapist's degrees, credentials and licenses.

Exceptions and additional requirements

3.1 If the person is clearly unable to receive or to act upon the information in the disclosure statement due to impairment (such as intoxication, unconsciousness, or acute mental decompensation), disclosure shall be given at the first opportunity such impairment is removed.

3.2 If the person is a child who is consenting to psychotherapy under C.R.S. 27-10-103, the disclosure is made to the child. However, if the client is a child whose parent or legal guardian is consenting to the psychotherapy, disclosure is made to the parent or legal guardian, as well as to the child if appropriate.

3.3 If the recipient of psychotherapy services is an adult for whom a guardian or legal representative has been appointed by a court of competent jurisdiction (irrespective of an appeal of the order) because the adult is an “incapacitated person” within the meaning of C.R.S. 15-14-101(1), the mandatory disclosure is made to the guardian or legal representative, as well as to the person receiving psychotheraty, if appropriate.

3.4 The information must be must be written in the language in which the psychotherapy is conducted and must be given to the person for her/him to keep.

3.5 If the person can not understand the written text, an oral explanation shall be given in language the person can understand.