ARC 1554C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)*"b."*

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code sections 225C.6 and 331.397 and 2014 Iowa Acts, House File 2379, the Department of Human Services proposes to amend Chapter 24, "Accreditation of Providers of Services to Persons with Mental Illness, Mental Retardation, and Developmental Disabilities," Iowa Administrative Code.

These amendments allow for technical correction of the title of the chapter to be in compliance with the accepted change of the term "mental retardation" to the term "intellectual disabilities."

These amendments also restructure the chapter to add divisions that clearly outline service accreditation requirements.

Finally, these amendments provide new accreditation standards in Chapter 24 for crisis response services. Mental health and disability services (MHDS) regions are required to offer basic crisis response services, and as funding is available, additional crisis response services are to be provided in the MHDS regions.

2014 Iowa Acts, House File 2379, requires the Department to accredit crisis stabilization programs. MHDS regions began operation July 1, 2014, and are required to offer basic crisis response services. The MHDS regions will be developing additional core services in accordance with Iowa Code section 331.397. These amendments will set an expected standard that providers must meet for crisis response services.

Any interested person may make written comments on the proposed amendments on or before August 12, 2014. Comments should be directed to Harry Rossander, Bureau of Policy Coordination, Department of Human Services, Hoover State Office Building, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Comments may be sent by fax to (515)281-4980 or by e-mail to policyanalysis@dhs.state.ia.us.

These amendments do not provide for waivers in specified situations because requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 331.397 and 2014 Iowa Acts, House File 2379.

The following amendments are proposed.

ITEM 1. Amend **441—Chapter 24**, title, as follows:

ACCREDITATION OF PROVIDERS OF SERVICES TO PERSONS WITH MENTAL ILLNESS, ~~MENTAL RETARDATION~~ INTELLECTUAL DISABILITIES, ~~AND~~ OR DEVELOPMENTAL DISABILITIES

ITEM 2. Amend **441—Chapter 24**, preamble, as follows:

PREAMBLE

The mental health~~, mental retardation, developmental disabilities,~~ and ~~brain injury~~ disability services commission has ~~established~~ adopted this set of standards to be met by all providers of services to people with mental illness, ~~mental retardation~~ intellectual disabilities, or developmental disabilities ~~that are under the authority of the commission~~. These standards apply to providers that are not required to be licensed by the department of inspections and appeals. These providers include community mental health centers, mental health services providers, case management providers, ~~and~~ supported community living providers, and crisis response providers in accordance with Iowa Code chapter 225C.

The standards serve as the foundation of a performance-based review of those organizations for which the ~~commission~~ department holds accreditation responsibility, as set forth in Iowa Code chapters 225C and 230A. The mission of accreditation is to assure individuals using the services and the general public of organizational accountability for meeting best practices performance levels, for efficient and effective management, and for the provision of quality services that result in quality outcomes for individuals using the services.

The ~~commission's~~ department's intent is to establish standards that are based on the principles of quality improvement and are designed to facilitate the provision of excellent quality services that lead to positive outcomes. The intent of these standards is to make organizations providing services responsible for effecting efficient and effective management and operational systems that enhance the involvement of individuals using the services and to establish a best practices level of performance by which to measure provider organizations.

ITEM 3. Adopt the following **new 441—Chapter 24**, Division I title and preamble:

DIVISION I

SERVICES FOR INDIVIDUALS WITH DISABILITIES

PREAMBLE

This set of standards in this division has been established to be met by all providers of case management, day treatment, intensive psychiatric rehabilitation, supported community living, partial hospitalization, outpatient counseling and emergency services.

ITEM 4. Amend rule **441—24.1(225C)**, definition of "Commission," as follows:

"Commission" means the mental health~~, mental retardation, developmental disabilities,~~ and ~~brain injury~~ disability services commission (~~MH/MR/DD/BI~~ MH/DS commission) as established and defined in Iowa Code section 225C.5.

ITEM 5. Reserve rules **441—24.10** to **441—24.19**.

ITEM 6. Adopt the following **new 441—Chapter 24**, Division II title and preamble:

DIVISION II

CRISIS RESPONSE SERVICES

PREAMBLE

The department of human services in consultation with the mental health and disability services commission has established this set of standards to be met by all providers of crisis response services.

ITEM 7. Adopt the following **new** rules 441—24.20(225C) to 441—24.40(225C):

441—24.20(225C) Definitions.

"Action plan" means a written strategy developed with input from the individual to assist in identifying the presenting problem; methods to prevent, reduce or manage future crises; and discharge options.

"Clinical supervisor" means a mental health professional or psychiatric nurse practitioner who oversees the work of a nonlicensed crisis staff.

"Crisis assessment" means a face-to-face clinical interview to ascertain an individual's current and previous level of functioning, potential for dangerousness, and current psychiatric and medical condition. The crisis assessment becomes part of the individual's action plan.

"Crisis incident" means an occurrence leading to physical injury or death, resulting from a prescription medication error, or triggering a report of child or dependent adult abuse.

"Crisis response services" means short-term individualized mental health services which follow a crisis screening or assessment and which are designed to restore the individual to prior functional level.

"Crisis response staff" means a person trained to provide crisis response services.

"Crisis screening" means a process to determine what crisis stabilization service is appropriate to effectively resolve the presenting crisis.

"Crisis stabilization community-based services" or *"CSCBS"* means services provided short-term in community-based settings to de-escalate a crisis situation and stabilize the individual following a mental health crisis.

"Crisis stabilization residential services" or *"CSRS"* means services provided short-term in non-community-based residential settings to de-escalate a crisis situation and stabilize the individual following a mental health crisis.

"Department" means the department of human services.

"Dispatch" means the function within crisis line operations to coordinate access to crisis care.

"Face-to-face" means services provided in person or via videoconferencing in conformance with the federal Health Insurance Portability and Accountability Act (HIPAA) privacy rules.

"Informed consent" means the same as defined in rule 441—24.1(225C).

"Mental health crisis" means a behavioral, emotional, or psychiatric situation which results in a high level of stress or anxiety for the individual or persons providing care for the individual and which cannot be resolved without intervention.

"Mental health professional" means the same as defined in Iowa Code section 228.1.

"Mobile response" means a mental health service which provides on-site, face-to-face mental health crisis services for an individual experiencing a mental health crisis. Crisis response staff providing mobile response have the capacity to intervene wherever the crisis is occurring, including but not limited to the individual's place of residence, an emergency room, police station, outpatient mental health setting, school, recovery center or any other location where the individual lives, works, attends school, or socializes.

"Psychiatric nurse" means a person who meets the requirements of a certified psychiatric nurse, is eligible for certification by the American Nursing Association, and is licensed by the state of Iowa to practice nursing as defined in Iowa Code chapter 152.

"Qualified prescriber" means a practitioner or other staff following the instruction of a practitioner as defined in Iowa Code section 155A.3 and a physician assistant or advanced registered nurse practitioner operating under the prescribing authority granted in Iowa Code section 147.107.

"Restraint" means the application of physical force or the use of a chemical agent or mechanical device for the purpose of restraining the free movement of an individual's body to protect the individual, or others, from immediate harm.

"Rights restriction" means limitations not imposed on the general public in the areas of communications, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, and place of residence.

"Self-administered medication" means the process where a trained staff member observes an individual inject, inhale, ingest or, by any other means, take medication following the instructions of a qualified prescriber.

"Stabilization plan" means a written short-term strategy that is used to stabilize a crisis and is developed by a mental health professional with the involvement and consent of the individual or the individual's representative.

"Staff-administered medication" means the direct application of a prescription drug, whether by injection, inhalation, ingestion, or any other means, to the body of an individual by a qualified prescriber or authorized staff following instructions of a qualified prescriber.

"Treatment summary" means a written summarization of the treatment and action plan at the point of an individual's discharge or transition to another service.

"Twenty-four-hour crisis line" or *"24-hour crisis line"* means a crisis line that provides information and referral, counseling, crisis service coordination, and linkages to screening and mental health services 24 hours a day.

"Twenty-four-hour crisis response" or *"24-hour crisis response"* means services that are available 24 hours a day and that provide access to screening and assessment and linkage to mental health services.

"Twenty-three-hour observation and holding" or *"23-hour observation and holding"* means a level of care provided for up to 23 hours in a secure and protected, medically staffed, psychiatrically supervised treatment environment.

"Warm line" means a telephone line staffed by peer counselors who provide nonjudgmental, nondirective support to an individual who is experiencing a personal crisis.

441—24.21(225C) Standards for crisis response services. An organization may be accredited to provide any one or all of the identified crisis response services. A provider seeking crisis response service accreditation shall comply with the general standards within this division and additional standards for each specific service.

441—24.22(225C) Standards for policies and procedures. The organization has a policies and procedures manual that contains policy guidelines and administrative procedures for all organizational activities and services specific to the organization and that addresses the standards in rule 441—24.2(225C).

441—24.23(225C) Standards for organizational activities.

24.23(1) *Other standards.* The organization shall meet the standards in subrules 24.3(1) to 24.3(4) in addition to the standards in subrule 24.23(2).

24.23(2) *Organizational environment.*

a. Performance benchmark. The organization provides services in an organizational environment that is safe and supportive for the individuals being served and for the staff providing services.

b. Performance indicators.

(1) The environment supports the self-image and recovery of the individual using the service and preserves the individual's dignity and privacy.

(2) The environment is safe and accessible and meets all applicable local, state, and federal regulations.

(3) The processes that service and maintain the environment and the effectiveness of the environment are reviewed within the organization's monitoring and improvement system.

(4) The organization establishes intervention procedures for behavior that presents significant risk of harm to the individual using the service or to others. The interventions also ensure that the individual's rights are protected and due process is afforded.

(5) All toys and other materials used by children are clean and safe.

441—24.24(225C) Standards for crisis response staff. All crisis response staff shall have the qualifications described in this rule. Additional staff requirements are described in each service.

24.24(1) *Performance benchmark.* The organization shall utilize staff qualified to provide crisis response services.

24.24(2) *Performance indicators.*

a. Crisis response service staff shall meet one or more of the following qualifications:

(1) Be a mental health professional as defined in Iowa Code section 228.1.

(2) Have a bachelor's degree with 30 semester hours or equivalent in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education) and at least one year of experience in behavioral or mental health services.

(3) Be a law enforcement officer trained in crisis intervention including, but not limited to, mental health first aid and mental health in-service training.

(4) Be an emergency medical technician (EMT) trained in crisis intervention including, but not limited to, mental health first aid.

(5) Be a peer support specialist with a minimum certification of mental health first aid.

(6) Be a family peer support specialist with a minimum certification of mental health first aid.

(7) Be a registered nurse with three years of mental health experience.

b. For all staff other than mental health professionals, organizations shall have documentation in staff records to verify satisfactory completion of department-approved training including:

(1) A minimum of 30 hours of department-approved crisis intervention and training.

(2) A posttraining assessment of competency.

441—24.25(225C) Standards for services.

24.25(1) *Standard for eligibility.* An eligible recipient is an individual experiencing a mental health crisis or emergency where a mental health crisis screening is needed to determine the appropriate level of care.

24.25(2) *Confidentiality and legal status.* The organization shall meet the standards in subrule 24.4(6).

24.25(3) *Service systems.* The organization shall meet the standards in subparagraphs 24.4(7)*"b"*(1) to (3).

24.25(4) *Respect for individual rights.* The organization shall meet the standards in subrule 24.4(8).

441—24.26(225C) Accreditation. The administrator for the division of mental health and disability services shall determine whether to grant, deny or revoke the accreditation of the centers, services and programs as determined in Iowa Code section 225C.6(1)*"c."*

24.26(1) The organization shall meet the standards of subrule 24.5(1), with the addition of crisis response service providers.

24.26(2) The organization shall meet the standards in subrules 24.5(2) and 24.5(3).

24.26(3) Performance outcome determinations are as follows:

a. Quality assurance staff shall determine a performance compliance level based on the number of indicators found to be in compliance.

(1) For service indicators, if 25 percent or more of the files reviewed do not comply with the requirements for a performance indicator, then that indicator is considered out of compliance and corrective action is required.

(2) Corrective action is required when any indicator under policies and procedures or organizational activities is not met.

b. In the overall rating, the performance rating for policies and procedures shall count as 15 percent of the total, organizational activities as 15 percent of the total, and services as 70 percent of the total.

(1) Each of the three indicators for policies and procedures has a value of 5.0 out of a possible score of 15.

(2) Each of the 34 indicators for organizational activities has a value of .44 out of a possible score of 15.

(3) Each service has a separate weighting according to the total number of indicators applicable for that service, with a possible score of 70, as follows:

c. Quality assurance staff shall determine a separate score for each service to be accredited. When an organization offers more than one service under this chapter, there shall be one accreditation award for all the services based upon the lowest score of the services surveyed.

Service	Number of Indicators	Value of Each Indicator
24-hour crisis response	16	4.4
Crisis evaluation	15	4.6
24-hour crisis line	14	5.0
Warm line	14	5.0
Mobile response	13	5.4
23-hour observation and holding	41	1.7
Crisis stabilization, community-based	33	2.1
Crisis stabilization, residential	41	1.7

24.26(4) The organization shall meet the standards in subrules 24.5(5) to 24.5(7).

441—24.27(225C) Deemed status. The department shall grant deemed status to organizations accredited by a recognized national, not-for-profit, accrediting body when the department determines the accreditation is for similar services. The provider shall fulfill the standards described in subrules

24.6(1) to 24.6(6). The national accrediting bodies currently recognized as meeting division criteria for possible deeming are:

1. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
2. The Commission on Accreditation of Rehabilitation Facilities (CARF).
3. The Council on Quality and Leadership in Supports for People with Disabilities (The Council).
4. The Council on Accreditation of Services for Families and Children (COA).
5. The American Association of Suicidology (AAS).

441—24.28(225C) Complaint process. The department shall receive and record complaints by individuals using services, employees, any interested people, and the public relating to or alleging violations of applicable requirements of the Iowa Code or administrative rules in accordance with the standards described in rule 441—24.7(225C).

441—24.29(225C) Appeal procedure. The department shall receive appeals according to the process in rule 441—24.8(225C).

441—24.30(225C) Exceptions to policy. The department shall receive exceptions to policy that meet the standards in rule 441—24.9(225C).

441—24.31(225C) Standards for individual crisis response services. Crisis response services provided to children and youth shall include coordination with parents, guardians, family members, natural supports, and service providers and with other systems such as education, juvenile justice and child welfare.

Crisis response services for individuals who have co-occurring or multi-occurring diagnoses shall focus on the integration and coordination of treatment services, and supports necessary to stabilize the individual, without regard to which condition is primary. Crisis response services shall not be denied due to the presence of a co-occurring substance abuse condition or developmental or neurodevelopmental disability.

441—24.32(225C) Crisis evaluation. Crisis evaluation consists of two components: crisis screening and crisis assessment.

24.32(1) *Crisis screening.* The purpose of crisis screening is to determine the presenting problem and appropriate level of care.

a. Performance benchmark. All screening shall include a brief assessment of lethality, substance use, alcohol use and safety needs. Screening can be provided by telephone or face-to-face by crisis response staff.

b. Performance indicators.

(1) The organization shall document the provision of crisis screening training.

(2) The organization shall have written policies and procedures describing a uniform process for screening and referrals and identifying the types of records kept on individuals.

(3) Screening services are available 24 hours a day, 365 days a year.

24.32(2) *Crisis assessment.* The purpose of crisis assessment is to determine the precipitating factors of the crisis, the individual and family functioning needs, and the diagnosis if present and to initiate an action plan and discharge plan. A licensed mental health professional shall conduct a crisis assessment within 24 hours of an individual's admission to a crisis stabilization service.

a. Assessment requirements. The assessment shall include:

(1) Action plan.
(2) Active symptoms of psychosis.
(3) Alcohol use.
(4) Coping ability.
(5) History of trauma.
(6) Impulsivity or absence of protective factors.
(7) Intensity and duration of depression.

(8) Lethality assessment.
(9) Level of external support available to the individual.
(10) Medical history.
(11) Physical health.
(12) Prescription medication.
(13) Crisis details.
(14) Stress indicators and level of stress.
(15) Substance use.

b. *Performance benchmark.* Individuals using this service receive comprehensive evaluation to determine the appropriate level of care.

c. *Performance indicators.*

(1) The organization shall have written policies and procedures describing a uniform process for assessment by a mental health professional, making referrals, and identifying types of records.

(2) The organization shall document the use of mental health professionals as defined in Iowa Code section 228.1(6) to complete assessments.

(3) The organization shall document that information collected is sufficient to determine the appropriate level of care.

(4) The results of the assessment shall be clearly explained to the individual and the individual's family or guardian when appropriate and shall be documented in the individual's record.

(5) The organization shall document the individual's strengths, preferences and needs in an action plan. The individual's family or guardian may receive a copy of an action plan with a signed release.

441—24.33(225C) Twenty-four-hour crisis response. The purpose of 24-hour crisis response shall be to provide access to screening and assessment designed to de-escalate and stabilize the crisis. When the assessment indicates, an action plan will be developed to support the individual in returning to the individual's precrisis level of functioning. Twenty-four-hour crisis response staff shall link the individual to appropriate services. Crisis response staff shall provide service to individuals of any age.

24.33(1) *Performance benchmark.* Individuals in mental health crisis have the ability to access services, including, but not limited to, screening, assessment and stabilization in the least restrictive level of care appropriate.

24.33(2) *Performance indicators.*

a. The organization publicizes the availability of 24-hour crisis response.

b. Access is available 24 hours a day, 365 days a year to crisis response screening, and services are available face-to-face or by telephone.

c. When an action plan is developed, an individual shall receive support identified in the plan.

d. Mental health services shall be provided by a mental health professional as defined in Iowa Code section 228.1(6).

e. At least one advanced registered nurse practitioner, physician assistant, or psychiatrist shall be available for consultation 24 hours a day, 365 days a year.

f. The organization shall provide documentation of the staffing pattern and schedule.

g. The organization shall maintain a contact log that includes demographic information for tracking purposes.

h. The organization shall document the integration and coordination of care in the individual's record.

i. The organization shall document the discharge and follow-up plan in the individual's record, and a copy of the summary shall be provided to the individual and to the members of the treatment team.

441—24.34(225C) Twenty-four-hour crisis line. A 24-hour crisis line shall provide counseling, crisis service coordination, information and referral, linkage to services and screening.

24.34(1) *Performance benchmark.* Individualized and appropriate screening, crisis service coordination and referrals are provided to individuals in crisis.

24.34(2) *Performance indicators.*

a. The crisis line service shall be available 24 hours a day, 365 days a year.

b. The crisis line shall utilize standardized call center software with the capability to track:

(1) Date and time of answered call, topic of call, screening provided, referral, hold time, and demographics of call.

(2) Number of contacts, including terminated and lost calls.

c. The organization shall have a triage procedure to link to emergency services, mobile response and provider support services.

d. The organization shall have written policies and procedures describing a uniform process of screening and training for crisis line staff.

e. The crisis line staff shall be trained in screening, peer counseling, crisis service coordination, and information and referral.

f. Within two years of operation, the crisis line shall meet accreditation standards through the American Association of Suicidology, with a level I or level II rating.

g. The organization shall provide documentation that verifies the following:

(1) Callers are screened for lethality and vulnerability.

(2) Callers receive crisis service coordination.

(3) The staffing pattern is in accordance with organizational policies and procedures.

441—24.35(225C) Warm line. A warm line shall provide short-term and nondirective support to assist the caller.

24.35(1) *Performance benchmark.* A warm line will provide nonjudgmental listening, nondirective assistance, information, referral, and triage when appropriate.

24.35(2) *Performance indicators.*

a. A warm line is answered by a live person with live transfer capability to crisis response services as needed.

b. The organization shall have written policies and procedures for standard collection of demographics of warm-line callers.

c. The organization shall have written policies and procedures for a standard screening process.

d. The organization shall provide referral to crisis response or other appropriate services.

e. The organization shall collect data on call answer times, duration of calls, and number of calls dropped, lost or terminated.

f. The organization shall describe the staffing pattern and schedule in its policies and procedures manual.

g. The organization shall document staff qualifications and training for peer support specialists, family peer support specialists, and peer counselors.

441—24.36(225C) Mobile response. Mobile response provides on-site, in-person intervention for individuals experiencing a mental health crisis. The mobile response staff shall provide crisis response services in the individual's home or at locations in the community. Staff shall respond in pairs to ensure the safety of both the provider and the individual served. A single staff person may respond if accompanied by another person who meets one of the criteria listed in paragraph 24.24(2)*"a."* Twenty-four-hour access to a mental health professional is required.

24.36(1) *Performance benchmark.* Mobile response services are delivered to individuals in crisis in a timely manner.

24.36(2) *Performance indicators.*

a. The organization shall dispatch mobile response staff in less than 15 minutes from the initial call for assistance.

b. Mobile response staff shall have face-to-face contact with the individual in crisis within 60 minutes from dispatch.

c. The organization shall track and trend data of response time for initial dispatch, response resulting in hospitalization, diversion from inpatient, or diversion from jail. The data for each fiscal year shall be reported to the department within 60 days of the close of the fiscal year.

d. When an action plan is developed, a copy shall be sent to the individual's service providers within 24 hours of the assessment.

e. The organization shall document in the individual's service record:

(1) Triage and referral information.

(2) Reduction in the level of risk present in the crisis situation.

(3) Coordination with other mental health resources.

(4) Names and affiliation of all individuals participating in the mobile response.

(5) Evaluation criteria for admission to inpatient psychiatric hospital care.

f. The organization shall document contact with the individual at 10, 30 and 60 days postdischarge.

441—24.37(225C) Twenty-three-hour crisis observation and holding. Twenty-three-hour crisis observation and holding services may be a stand-alone service or embedded within a crisis stabilization residential service. Twenty-three-hour crisis observation and holding services are designed for individuals who need short-term crisis intervention in a safe environment that is less restrictive than hospitalization. This level of service is appropriate for individuals who require protection or when an individual's ability to cope in the community is severely compromised and it is expected that the crisis can be resolved in 23 hours. Twenty-three-hour crisis observation and holding services include, but are not limited to, treatment, administering medication, meeting with extended family or significant others, and referral to appropriate services. Twenty-three-hour crisis observation and holding chairs can be utilized.

24.37(1) *Admission criteria.* The services may be provided if any of the following admission criteria are met:

a. There are indications that the symptoms can be stabilized and an alternative treatment can be initiated within a 23-hour period.

b. There is an indication of a potential suicide attempt or persistent ideation with strong intent or suicide rehearsal.

c. The presenting crisis cannot be safely evaluated or managed in a less restrictive setting, or no such setting is available.

d. The individual does not meet inpatient criteria, and it is determined a period of observation will assist in the stabilization and prevention of symptom exacerbation.

e. Further evaluation is necessary to determine the individual's service needs.

f. There is an indication of actual or potential danger to self or others as evidenced by a current threat.

g. There is a loss of impulse control leading to life-threatening behavior and other psychiatric symptoms that require stabilization in a structured, monitored setting.

h. The individual is experiencing a crisis demonstrated by an abrupt or substantial change in normal life functioning brought on by a specific cause, sudden event or severe stressor.

24.37(2) *Staffing requirements.*

a. The organization shall have a designated medical director or administrator who is responsible for the management and operation of the program or facility.

b. Registered nurse practitioners and physician assistants shall have at least three years of mental health experience.

c. At least one registered nurse practitioner, physician assistant or psychiatrist shall be available for consultation 24 hours a day, 365 days a year.

d. Mental health services appropriate to the individual's service needs shall be provided by a mental health professional as defined in Iowa Code section 228.1(6).

e. Staff shall be on duty 24 hours a day and shall remain awake for the 24-hour schedule.

f. A registered nurse is available on site 24 hours a day.

24.37(3) *Twenty-three-hour observation and holding safety.*

a. Performance benchmark. The organization completes an incident report when organizational staff is notified an incident has occurred.

b. Performance indicators.

(1) The incident report shall document:

1. The name of the individual or individuals who were involved in the incident.
2. Date and time of occurrence of the incident.
3. A description of the incident.
4. Names and signatures of all staff present at the time of the incident.
5. The action taken by the staff.
6. The resolution or follow-up to the incident.

(2) The provider shall keep a copy of the incident report in a centralized file and give a copy to the individual, the mental health and disability services region, and the individual's parent or guardian when appropriate.

24.37(4) *Treatment summary.* A treatment summary shall be prepared and a copy of the summary provided to the individual and the individual's treatment team.

a. Contents. At a minimum, the treatment summary shall include:

(1) Action plan.

(2) Assessment of the crisis, including challenges and strengths.

(3) Course and progress of the individual with regard to each identified challenge.

(4) Evaluation of the individual's mental status to inform ongoing placement and support decisions.

(5) Recommendations and arrangements for further service needs.

(6) Signature of the treating mental health professional.

(7) Treatment interventions.

b. Treatment indicators.

(1) Individuals shall give informed consent.

(2) Treatment providers, family members and other natural supports as appropriate are contacted within 23 hours of the individual's admission.

(3) The organization shall have written policies and procedures for medication administration, storage and documentation.

(4) The organization shall maintain individual records including, but not limited to, a treatment summary and verification of individual choice.

(5) The 23-hour crisis observation and holding facility has a homelike, comfortable environment conducive to recovery.

(6) The 23-hour crisis observation and holding is primarily used as a diversion from inpatient level of care.

(7) The organization shall have a plan to demonstrate telephone contact for parents and significant others.

(8) The organization shall have written policies and procedures for standardized documentation of discharge locations to track how many individuals were discharged home, to a community provider or to a higher level of care.

(9) The organization shall document the actual number of individuals served within the 23-hour period. For those individuals staying beyond the 23-hour period, documentation for the delay shall be included in the individual treatment record.

(10) The organization shall track and trend data of individual readmission.

(11) Twenty-three-hour observation and holding services shall comply with applicable state fire marshal rules and fire ordinances and applicable local health, fire, occupancy code, and safety regulations. The organization shall maintain documentation of such compliance.

1. Based on standards used for public facilities, all food and drink shall be clean, wholesome, free from spoilage, and stored and served in a manner safe for human consumption.
2. Doors must not be locked from the inside. The use of door locks shall be approved by the fire marshal and professional staff.

3. Twenty-three-hour observation and holding programs shall have an emergency preparedness program to describe the process for an individual to continue receiving services during a disaster including, but not limited to, cases of severe weather or fire.

(12) Twenty-three-hour observation and holding services shall provide a safe, clean, well-ventilated, properly heated environment in good repair and free from vermin.

(13) An individual's resting or sleeping area shall include:

1. A sturdily constructed bed or comfortable chair.
2. A sanitized mattress protected with a clean mattress pad, or sanitized chair.
3. Windows in bedrooms shall have curtains or window blinds.
4. Clean linen shall be available.
5. Doors or partitions for privacy.
6. Staff shall respect the individual's right to privacy.

(14) Bathrooms shall provide individuals with facilities necessary for personal hygiene and personal privacy.

1. A safe supply of hot and cold running water which is potable.
2. Clean towels, electric hand dryers or paper towel dispensers, and an available supply of toilet paper and soap.
3. Natural or mechanical ventilation capable of removing odors.
4. Tubs or showers shall have slip-proof surfaces.
5. Partitions with doors which provide privacy if a bathroom has multiple toilet stools.
6. Toilets, wash basins, and other plumbing or sanitary facilities shall at all times be maintained in good operating condition.
7. If the facility is coeducational, the program shall designate and have privacy in bathrooms for male and female individuals.

(15) The organization shall provide:

1. Areas in which an individual may be alone when appropriate.
2. Areas for private conversations with others.
3. Secure space for personal belongings.

(16) Clothing. Individuals shall be allowed to wear their own clothing in accordance with program rules.

(17) Twenty-three-hour observation and holding shall have written policies on safety.

1. Twenty-three-hour observation and holding shall not use seclusion.
2. Twenty-three-hour observation and holding shall not use mechanical or chemical restraints at any time.

(18) Smoking. The organization shall follow the smokefree air Act, Iowa Code chapter 142D.

(19) Health and safety.

1. Performance benchmark.

- Twenty-three-hour observation and holding services shall have emergency preparedness policies and procedures which include health and safety measures.
- The organization shall follow the medication administration and documentation standards in rule 441—24.40(225C).

2. Performance indicators.

- Twenty-three-hour observation and holding services shall have an emergency preparedness program designed to provide effective utilization of available resources for an individual's care during a disaster event including, but not limited to, cases of severe weather or fire.
- Twenty-three-hour observation and holding services shall comply with rule 441—24.39(225C).

441—24.38(225C) Crisis stabilization community-based services (CSCBS). The goal of CSCBS is to stabilize and reintegrate the individual back into the community. CSCBS is designed for voluntary individuals in need of a safe, secure environment that is less intensive and restrictive than an inpatient hospital. Individuals in CSCBS receive services including, but not limited to, psychiatric services,

medication, counseling, referrals, peer support and linkage to ongoing services. The length of stay in a CSCBS is expected to be less than five days.

24.38(1) *Eligibility.* To be eligible, an individual must:

a. Be aged 18 or older, for an adult facility, or aged 17 or under, for a juvenile facility;

b. Be determined appropriate for placement by mental health assessment; and

c. Be determined not to need inpatient acute hospital psychiatric services.

24.38(2) *Staffing requirements.*

a. The program shall have a designated director or administrator who is responsible for the management and operation of the program.

b. At least one licensed nurse practitioner, physician assistant, or psychiatrist shall be available for consultation 24 hours a day, 365 days a year.

c. Mental health services shall be provided by a mental health professional with expertise appropriate to the individual's needs.

d. Each individual receiving crisis stabilization services shall have contact with a mental health professional at least one time a day.

e. Each individual receiving crisis stabilization services shall have a minimum of one hour per day of additional services including, but not limited to, skill building, peer support or family peer support services; or other therapeutic programming.

24.38(3) *Performance benchmark.* The individual using this service is provided safe, secure and structured crisis stabilization services in the least restrictive location that meets the needs of the individual. This program can be for youth aged 17 and under or adults aged 18 and older.

24.38(4) *Performance indicators.*

a. The organization shall document that, with the individual's consent, treatment providers, family members and other natural supports are contacted within 24 hours of the individual's admission.

b. The organization shall provide daily programming including, at minimum, daily contact with a mental health professional and one hour of additional programming.

c. The organization shall document the numbers of days an individual receives crisis stabilization services. The documentation shall record specific reasons for the delivery of services beyond three to five days.

d. The organization shall maintain individual records that include:

(1) Daily contact with a mental health professional.

(2) Additional services provided including, but not limited to, skill building, peer support or family support peer services.

(3) Medication record.

e. The organization shall provide verification of individual choice including, but not limited to, treatment participation and discharge plan options.

f. The organization shall track and trend data of readmission, including an analysis of data trends looking at effectiveness, and shall take appropriate corrective action. The information shall be documented in the organization's performance improvement system.

24.38(5) *Crisis stabilization incident reporting.*

a. Performance benchmark. The organization completes an incident report when organizational staff is notified that an incident has occurred.

b. Performance indicators.

(1) The incident report shall document:

1. The name of the individual served who was involved in the incident.
2. Date and time of occurrence of the incident.
3. A description of the incident.
4. Names and signatures of all staff present at the time of the incident.
5. The action the staff took to handle the situation.
6. The resolution or follow-up to the incident.

(2) The provider shall keep a copy of the incident report in a centralized file and give a copy to the individual, the mental health and disability services region, and the individual's parent or guardian when appropriate.

24.38(6) *Service requirements.*

a. Stabilization plan. The individual in crisis shall be involved collaboratively in all aspects of crisis stabilization services including, but not limited to, admission, treatment planning, intervention, and discharge. The involvement of family members and others shall be encouraged.

Within 24 hours of an individual's admission to crisis stabilization services, a written short-term stabilization strategy will be developed, with the involvement and consent of the individual, and will be reviewed frequently to assess the need for the individual's continued placement in the program. At a minimum, this plan will include:

(1) Criteria for discharge, including referrals and linkages to appropriate services and coordination with other systems.

(2) Description of any physical disability and any accommodations necessary to provide the same or equal services and benefits as those afforded nondisabled individuals.

(3) Evidence of input by the individual, including the individual's signature.

(4) Goal statement. Goals shall be consistent with the individual's needs and projected duration of service delivery and shall include objectives which build on the individual's strengths and which are stated in terms that allow measurement of progress.

(5) Rights restrictions.

(6) Names of all other persons participating in the development of the plan.

(7) Specification of treatment responsibilities and methods.

b. Performance benchmark. The organization completes a stabilization plan within 24 hours of the individual's admittance.

c. Performance indicators.

(1) The organization shall maintain in individual records a written short-term stabilization strategy that is developed with the involvement and consent of the individual and within 24 hours of the individual's admittance and that is reviewed frequently to assess the need for the individual's continued placement in the program.

(2) The organization shall maintain individual records that indicate a stabilization plan has been completed within the 24-hour time frame.

(3) The organization shall document reasons for stabilization plans that do not meet the criteria.

24.38(7) *Treatment summary.* Prior to the individual's discharge from this service, a treatment summary shall be completed. A copy of the summary will be provided to the individual and shared with the individual's treatment team of providers, if applicable.

a. Contents. At a minimum, this treatment summary will include:

(1) Course and progress of the individual with regard to each identified problem.

(2) Documented note of a mental health professional contact one time daily.

(3) Evolution of the mental status to inform ongoing placement and support decisions.

(4) Final assessment, including general observations and significant findings of the individual's condition initially while services were being provided and at discharge.

(5) Recommendations and arrangements for further service needs.

(6) Signature of the mental health professional.

(7) Stabilization plan.

(8) Reasons for termination of service.

(9) Treatment interventions.

b. Performance benchmark. An individual treatment summary shall be completed during the length of stay in crisis stabilization residential services.

c. Performance indicators.

(1) The organization shall maintain in individual records a written treatment summary developed with the involvement of the individual. A copy of the summary shall be provided to the individual upon discharge.

(2) The organization shall document incidents in which a treatment plan was not completed within the length of stay and any corrective action necessary to alleviate this issue.

24.38(8) *Health and safety.*

a. Performance benchmark. Crisis stabilization community-based services shall have emergency preparedness policies and procedures which include health and safety measures.

b. Performance indicators.

(1) Crisis stabilization community-based services shall have an emergency preparedness program designed to provide effective utilization of available resources for an individual's care to continue during a disaster event including, but not limited to, cases of severe weather or fire.

(2) Crisis stabilization community-based services shall comply with rule 441—24.39(225C).

441—24.39(225C) Crisis stabilization residential services (CSRS). The goal of CSRS is to stabilize and reintegrate the individual back into the community. CSRS is designed for voluntary individuals who are in need of a safe, secure environment that is less intensive and restrictive than an inpatient hospital. Group residential services shall have the capacity to serve more than two individuals at a time. This program can be for youth aged 17 and under or adults aged 18 and older. Youth and adults cannot be housed in the same facility setting.

24.39(1) *Eligibility.* To be eligible, an individual must:

a. Be aged 18 or older, for an adult facility, or aged 17 or under, for a juvenile facility;

b. Be determined appropriate for placement by mental health assessment; and

c. Be determined not to need inpatient acute hospital psychiatric services.

24.39(2) *Staffing requirements.*

a. The program shall have a designated director or administrator who is responsible for the management and operation of the program or facility of no more than 16 beds.

b. At least one licensed nurse practitioner, physician assistant, or psychiatrist shall be available for consultation 24 hours a day, 365 days a year.

c. Mental health services shall be provided by a mental health professional with expertise appropriate to the individual's needs.

d. Each individual receiving crisis stabilization services shall have contact with a mental health professional at least one time a day.

e. Each individual receiving crisis stabilization services shall have a minimum of one hour per day of additional services including, but not limited to, skill building, peer support or family peer support services; or other therapeutic programming.

f. The crisis stabilization service shall provide awake staffing 24 hours a day, 365 days a year.

24.39(3) *Performance benchmark.* The individual is provided safe, secure and structured crisis stabilization services in the least restrictive location that meets the needs of the individual.

24.39(4) *Performance indicators.*

a. The organization shall document that, with the individual's consent, treatment providers, family members and other natural supports are contacted within 24 hours of the individual's admission.

b. The organization shall ensure that a comprehensive mental health assessment is completed within 24 hours of the individual's admission.

c. The organization shall provide daily programming including, at minimum, daily contact with a mental health professional and one hour of additional programming.

d. The average length of stay in a CSRS is expected to be less than five days.

e. The organization shall document the number of days an individual receives crisis stabilization services. The documentation shall record specific reasons for lengths of stay beyond three to five days.

f. The organization shall maintain individual records that include:

(1) Stabilization plan.

(2) Medication record.

(3) Treatment summary.

(4) Daily contact with a mental health professional.

g. Additional services provided include, but are not limited to, skill building, peer support or family peer support services.

h. The organization shall provide verification of individual choice including, but not limited to, treatment participation and discharge plan options.

i. The organization shall track and trend data of readmission including an analysis of data trends, looking at effectiveness, and shall take appropriate corrective action. The information shall be documented in the organization's performance improvement system.

j. For a youth facility, the organization shall document that the youth's education needs are met, with educational services received in the program, and that a transition program is in place to return the youth to school upon discharge.

24.39(5) *Crisis stabilization incident reporting.*

a. Performance benchmark. The organization completes an incident report when organizational staff is notified that an incident has occurred.

b. Performance indicators.

(1) The incident report shall document:

1. The name of the individual who was involved in the incident.
2. Date and time of occurrence of the incident.
3. A description of the incident.
4. Names and signatures of all organizational staff present at the time of the incident.
5. The action the organizational staff took to handle the situation.
6. The resolution or follow-up to the incident.

(2) The provider shall keep a copy of the incident report in a centralized file and give a copy to the individual, the mental health and disability services region, and the individual's parent or guardian when appropriate.

24.39(6) *Service requirements.*

a. Stabilization plan. The individual in crisis shall be involved collaboratively in all aspects of crisis stabilization services including, but not limited to, admission, treatment planning, intervention, and discharge. The involvement of family members and others shall be encouraged.

Within 24 hours of an individual's admission to crisis stabilization services, a written short-term stabilization strategy will be developed, with the involvement and consent of the individual, and will be reviewed frequently to assess the need for the individual's continued placement in the program. At a minimum, this plan will include:

(1) Criteria for discharge, including referrals and linkages to appropriate services and coordination with other systems.

(2) Description of any physical disability and any accommodations necessary to provide the same or equal services and benefits as those afforded nondisabled individuals.

(3) Evidence of input by the individual, including the individual's signature.

(4) Goal statement.

(5) Goals that are consistent with the individual's needs and projected length of stay.

(6) Objectives that build on the individual's strengths and that are stated in terms that allow measurement of progress.

(7) Rights restrictions.

(8) Signatures of all other individuals participating in the development of the plan.

(9) Specification of treatment responsibilities and methods.

b. Performance benchmark. The organization completes a stabilization plan within 24 hours of the individual's admittance.

c. Performance indicators.

(1) The organization shall maintain in individual records a written short-term stabilization strategy that is developed with the involvement and consent of the individual and within 24 hours of the individual's admission and that is reviewed frequently to assess the need for the individual's continued placement in the program.

(2) The organization shall maintain individual records that indicate a stabilization plan has been completed within the 24-hour time frame.

(3) The organization shall document reasons for stabilization plans that do not meet the criteria.

24.39(7) *Treatment summary.* Prior to the individual's discharge, a treatment summary shall be completed. A copy of the summary will be provided to the individual and shared with the individual's treatment team of providers, if applicable.

a. Contents. At a minimum, this treatment summary will include:

(1) Course and progress of the individual with regard to each identified problem.

(2) Documented daily contact with a mental health professional.

(3) Evolution of the individual's mental status to inform ongoing placement and support decisions.

(4) Final assessment, including general observations and significant findings of the individual's condition while services were being provided and at discharge.

(5) Recommendations and arrangements for further service needs.

(6) Signature of the mental health professional.

(7) Stabilization plan.

(8) Reasons for termination of service.

(9) Treatment interventions.

b. Performance benchmark. A treatment summary shall be completed during the individual's length of stay in CSRS.

c. Performance indicators.

(1) The organization shall maintain in individual records a written treatment summary developed with the involvement and consent of the individual.

(2) A copy of the summary shall be provided to an individual upon discharge.

(3) The organization shall document incidents in which a treatment plan was not completed within the length of stay and any corrective action necessary to alleviate this issue.

24.39(8) *Health and safety.*

a. Performance benchmarks.

(1) CSRS shall have emergency preparedness policies and procedures which include health and safety measures.

(2) The organization provides crisis stabilization services in a facility that meets all applicable local, state and federal regulations.

(3) The organization shall follow the medication administration and documentation standards in rule 441—24.40(225C).

b. Performance indicators.

(1) Health and fire safety inspections.

1. Crisis stabilization residential services shall comply with state fire marshal rules and fire ordinances and applicable local health, fire, occupancy code, and safety regulations. The program shall maintain documentation of such compliance.

2. Based on standards used for public facilities, all food and drink shall be clean, wholesome, free from spoilage, and stored and served in a manner safe for human consumption.

3. Crisis stabilization residential services shall comply with rule 441—24.40(225C).

(2) Emergency preparedness. Crisis stabilization residential services shall have an emergency preparedness program designed to provide effective utilization of available resources for an individual's care to continue during a disaster event including, but not limited to, cases of severe weather or fire.

(3) Crisis stabilization residential services shall provide a safe, clean, well-ventilated, properly heated environment in good repair and free from vermin.

(4) Individuals' bedrooms shall include:

1. A sturdily constructed bed.

2. A sanitized mattress protected with a clean mattress pad.

3. A designated space in proximity to the sleeping area, for personal possessions and for hanging clothing.

4. Windows in bedrooms shall have curtains or window blinds.

5. Clean linens shall be available.

(5) Sleeping areas shall include:

1. Doors for privacy.

2. Partitioning or placement of furniture to provide privacy for all individuals.

3. There shall be no more than two individuals per room. Single rooms shall be at least 80 square feet not including closets. Dual occupancy rooms shall be at least 120 square feet not including closets.

4. Individuals shall be allowed to keep and display personal belongings and add personal touches to the decoration of their rooms in accordance with program policy.

5. Staff shall respect the individual's right to privacy by knocking on the door of the individual's room before entering.

(6) Bathrooms shall provide individuals with facilities necessary for personal hygiene and personal privacy, including:

1. A safe supply of hot and cold running water which is potable.

2. Clean towels, electric hand dryers or paper towel dispensers, and an available supply of toilet paper and soap.

3. Natural or mechanical ventilation capable of removing odors.

4. Tubs or showers shall have slip-proof surfaces.

5. Partitions with doors which provide privacy if a bathroom has multiple toilet stools.

6. Toilets, wash basins, and other plumbing or sanitary facilities shall at all times be maintained in good operating condition.

7. If the facility is coeducational, the program shall designate and have privacy in bathrooms for male and female individuals.

(7) Facilities shall follow state and federal laws regarding smoking on property.

(8) The organization shall allow for the following:

1. Areas in which an individual may be alone when appropriate.

2. Areas for private conversations with others.

3. The organization shall provide secure space for personal belongings.

c. Housekeeping. If individuals take responsibility for maintaining their own living quarters and for the day-to-day housekeeping activities of the program, the individuals' responsibilities shall be clearly defined in writing and shall be a part of the orientation program. Staff assistance and equipment shall be provided as needed.

d. Clothing.

(1) Individuals shall be allowed to wear their own clothing in accordance with program rules. If clothing is provided by programs, it shall be suited to the climate and appropriate.

(2) Laundry facilities shall be accessible so that individuals may wash their clothing.

e. Religion/culture. The organization shall ensure an individual's rights to religion and culture to include:

(1) The individual shall have the opportunity to participate in religious activities and services in accordance with the individual's own faith or that of a minor individual's parent(s) or guardian.

(2) The facility shall, when necessary and reasonable, arrange for transportation to religious activities.

f. Smoking. The organization shall follow the smokefree air Act, Iowa Code chapter 142D.

441—24.40(225C) Medication—administration, storage and documentation. This rule sets forth medication requirements for 23-hour crisis observation and holding, crisis stabilization community-based services, and crisis stabilization residential services.

24.40(1) *Performance benchmark.* Policies and procedures shall be developed to ensure prescription and over-the-counter drugs are administered or self-administered safely and properly in accordance with federal, state and local laws and regulations. Medication shall be administered by a qualified prescriber or an individual following instructions of a qualified prescriber. Trained staff shall observe an individual taking medication following instructions of a qualified prescriber. Medication storage shall be maintained in accordance with the security requirements of federal, state and local

laws. Organizations shall have in individual case records written policies and procedures regarding use of medication.

24.40(2) *Performance indicators.*

a. Administration of medication.

(1) There shall be a specific routine for medication administration, indicating dose schedules and standardization of abbreviations.

(2) There shall be specific methods for control and accountability of medication products throughout the program.

(3) The organization ensures prescription and over-the-counter drugs are administered or self-administered safely and properly in accordance with federal, state and local laws and regulations.

(4) Medications are prescribed by a qualified prescriber under Iowa law.

(5) Prescription drugs shall not be administered to or self-administered by an individual without a written order signed by a qualified prescriber.

b. Staff-administered medication.

(1) Authorized staff administering medications shall be qualified, and a current, accurate list of such staff shall be maintained.

(2) Medications shall be administered only in accordance with the instructions of the qualified prescriber. The type and amount of the medication, the time and date of medication administration, and the authorized staff administering the medication shall be documented in the individual's medication record.

c. Self-administered medication.

(1) Only staff who have completed department-approved training in policies and procedures on self-administration can monitor self-administration of prescription medication.

(2) Self-administration of prescription and over-the-counter medications shall be permitted only when the medication is clearly and completely labeled.

d. Medication storage. Medication storage policies for medications under the care and control of the provider shall include:

(1) All medication shall be maintained in locked storage. Controlled substances shall be maintained in a locked box within the locked cabinet.

(2) Medications requiring refrigeration shall be kept in a refrigerator and separated from food and other items.

(3) Disinfectants and medication for external use shall be stored separately from internal and injectable medications.

(4) The medication for each individual shall be stored in the original containers.

(5) All potent poisonous or caustic medication shall be plainly labeled; stored separately from other medication in a specific well-illuminated cabinet, closet, or storeroom; and made accessible only to authorized staff.

(6) Medication shall be dispensed from a licensed pharmacy. Medication provided to an individual shall be dispensed only from a licensed pharmacy in the state of Iowa in accordance with the pharmacy laws of the Iowa Code, or from a licensed pharmacy in another state according to the laws of that state, or by a qualified prescriber.

(7) Prescription medications prescribed for one individual shall not be administered to or allowed to be in the possession of another individual.

e. Medication labeling. All prescribed medications shall be clearly labeled with the individual's full name; prescriber's name; prescription number; name and strength of the medication; dosage; directions for use; date of issue; and name, address and telephone number of the pharmacy or prescriber issuing the medication. Medications shall be packaged and labeled according to state and federal guidelines.

f. Monthly inspection. The staff member in charge of medications shall provide monthly inspection of all storage units.

g. Damaged labels. Medication containers having soiled, damaged, illegible, or makeshift labels shall be returned to the issuing pharmacist, pharmacy, or qualified prescriber for relabeling or disposal.

h. Unused medications. Unused prescription drugs prescribed for individuals who have left the facility without their medication shall be destroyed by the staff in charge with a witness present, and a notation shall be made on the individual's record. When an individual is discharged or leaves the facility, medications currently being administered shall be sent, in their original containers, with the individual or with a responsible agent, and with the approval of the qualified prescriber.

i. Medication brought by individual. If the prescribed and over-the-counter medication the individual brings to the program is not to be used, the medication shall be packaged, sealed and stored. The sealed packages of medications shall be returned to the individual or family at the time of the individual's discharge.

j. Medication documentation.

(1) The organization shall have written policies and procedures for the review, approval, and implementation of ethical, safe, human and efficient behavioral intervention procedures.

(2) The organization shall have written policies and procedures to inform the individual and the individual's legal guardian, if appropriate, about all prohibitions on the use of medication as a restraint.

(3) All medications administered and self-administered and the detection of adverse drug reactions shall be documented in the case record.

(4) All medication orders shall be documented in the individual's case records and shall define the name of the medication, dose, route of administration, frequency of administration, the name of the qualified prescriber who prescribed the medication, and the name of the provider administering or dispensing the medication.

(5) Medication records shall be documented by authorized staff administering the medication.

k. Medication rights and responsibilities.

(1) Medication shall not be used as a restraint. The use of psychopharmacological medication in excess of the individual's standard plan of care is prohibited. Using medication as a restraint includes:

1. Drugs or medications used to control behavior or restrict the individual's freedom of movement.
2. Drugs or medications used in excessive amounts or in excessive frequency.
3. Neuroleptics, anxiolytics, antihistamines, and atypical neuroleptics, or other medication used for calming, rather than for the medication's indicated treatment.

(2) Drugs or medication used for standard treatment of the individual's medical or psychiatric condition shall not be considered a restraint.

These rules are intended to implement Iowa Code section 331.397 and 2014 Iowa Acts, House File 2379.