SUBCHAPTER 28D - TREATMENT OR HABILITATION RIGHTS

SECTION .0100 - RIGHT TO TREATMENT OR HABILITATION

10A NCAC 28D .0101 APPROPRIATE EVALUATION AND TREATMENT OR HABILITATION

(a) Each client except day clients shall receive a prompt and comprehensive physical and brief mental status examination, including laboratory evaluation where appropriate, within 24 hours after admission to the state facility. Comprehensive psychological or developmental evaluations shall be performed when needed, as determined by the treatment/habilitation team. The type and dates of all examinations shall be documented in the client record. There must be a physical examination of the client before ordering medication except in an emergency.
(b) In addition to the treatment rights specified in G.S. 122C-57(a), all handicapped clients have a right to habilitation and rehabilitation as specified in G.S. 168-8.
(c) Each client shall receive evaluation and treatment/habilitation in accordance with G.S. 122C-57(b), G.S. 122C-60 and G.S. 122C-61. Evaluation and treatment/habilitation shall be provided in the least restrictive environment.

History Note: *Authority G.S. 122C-51; 122C-57; 122C-60; 122C-61; 122C-211; 122C-221; 122C-231; 122C-241; 122C-266; 122C-285; 131E-67; 143B-147; 168-8;*
Eff. October 1, 1984;
Amended Eff. April 1, 1990; July 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

10A NCAC 28D .0102 MEDICAL AND DENTAL CARE

(a) The State Facility Director shall assure access to prompt, adequate and necessary medical and dental care and treatment to the client for physical and mental ailments and injuries and for the prevention of illness or disability as specified in G.S. 122C-61(1). "Necessary" may be determined in light of the client's length of stay and condition. Short term clients shall be apprised of other medical and dental conditions and informed of appropriate medical and dental care.
(b) All medical and dental care and treatment shall be consistent with accepted standards of medical and dental practice. The medical care shall be performed under appropriate supervision of licensed physicians and the dental care shall be performed under appropriate supervision of licensed dentists.
(c) Each client shall receive physical and dental examinations at least annually.
(d) In cases of medical emergency or necessity:

(1) if the necessary equipment or expertise is not available at the state facility, the attending physician shall arrange treatment at an appropriate medical facility;
(2) if the client is at an unreasonable distance from his home facility, he shall be taken to a nearer appropriate hospital or clinic; and
(3) if the events in Subparagraphs (d)(1) or (2) of this Rule occur, the State Facility Director shall assure that those persons specified in G.S. 122C-206(e) are notified.

History Note: *Authority G.S. 122C-57; 122C-61; 122C-206; 131E-67; 143B-147;*
Eff. October 1, 1984;
Amended Eff. April 1, 1990; July 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

10A NCAC 28D .0103 INDIVIDUALIZED TREATMENT OR HABILITATION PLAN

(a) The state facility shall provide qualified professionals to formulate and supervise implementation of the treatment/habilitation plan in accordance with G.S. 122C-57(a).
(b) Each client shall be encouraged and helped to attend the treatment/habilitation team meeting and to actively and meaningfully participate in the formulation of his treatment or habilitation plan. The legally responsible person of a minor or incompetent adult client shall also be encouraged to attend. The amount of participation by the client or legally responsible person shall be documented in the client record. The internal client advocate shall be allowed to attend the treatment/habilitation team meeting in accordance with G.S. 122C-53(g).

(c) Each client may, upon request, have an in-house review of his individual treatment or habilitation plan or request the opinion of another person at no cost to the state.
(d) The client's treatment or habilitation plan shall be reviewed at least quarterly by the treatment/habilitation team.
(e) A discharge plan shall be formulated in accordance with Rule .0105 of this Section.
(f) Upon request, a copy of the client's treatment or habilitation plan or an interpretive letter shall be furnished to the legally responsible person of an incompetent adult client or legally responsible person of a minor client except for minor clients in alcohol or drug rehabilitation programs as specified in 42 C.F.R. Part 2 or when minors are receiving treatment upon their own consent in accordance with G.S. 90-21.5.
(g) The treatment/habilitation team shall inform the client of the availability of his treatment/habilitation plan and shall provide the client with a copy of his treatment/habilitation plan upon request by the client when filed in accordance with G.S. 122C-53(c).

History Note: *Authority G.S. 90-21.5; 122C-51; 122C-53; 122C-57; 122C-61; 122C-62; 131E-67; 143B-147; Eff. October 1, 1984; Amended Eff. April 1, 1990; July 1, 1989; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.*

10A NCAC 28D .0104 TRANSFER
When transferring clients, the State Facility Director shall follow the procedures specified in G.S. 122C-206 and division publication "Transfer of Clients Between State Facilities, APSM 45-1", adopted pursuant to G.S. 150B-14(c). The Division publication is available for inspection in each state facility or in the Publications Office of the Division.

History Note: *Authority G.S. 122C-206; 131E-67; 143B-147; Eff. October 1, 1984; Amended Eff. April 1, 1990; July 1, 1989; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.*

10A NCAC 28D .0105 DISCHARGE
(a) When a state facility discharges a client, each client shall have a discharge plan as specified in G.S. 122C-61(2) unless the client:
(1) is receiving respite services;
(2) escapes or breaches the conditions of a conditional release;
(3) is unanticipatedly discharged by the court following district court hearing; or
(4) is immediately discharged upon request of the client or legally responsible person.
(b) The discharge plan shall:
(1) be formulated by qualified professionals;
(2) inform the client of where and how to receive treatment or habilitation services in the community;
(3) identify continuing treatment or habilitation needs, and address issues such as food, housing, and employment;
(4) involve the appropriate area program, with consent of the client or his legally responsible person or in accordance with G.S. 122C-55(a) or G.S. 122C-63; and
(5) be provided to the client or legally responsible person as specified in G.S. 122C-61(2).
(c) When the client is unexpectedly discharged by the court in hearing subsequent to the initial hearing, the client's discharge plan shall contain at least the following:
(1) address and phone number of the agency in the community where follow-up services can be provided, including name of contact person in Department of Social Services if food and housing are issues;
(2) current medications, if applicable; and
(3) recommendations for continued care in anticipated problem areas.
(d) With the exception of the State Hospital Director who shall follow the provisions of 10A NCAC 28F .0113, the State Facility Director in each of the other state facilities shall establish written policies and procedures to ensure that reasonable efforts are made to assist the client in obtaining needed services in the community upon discharge or placement. The policy shall include the designation of qualified professional staff to assist clients in establishing

contact with the appropriate area program and furnishing information to the area program with the client or legally responsible person's consent or as permitted by G.S. 122C-55(a).

History Note: *Authority G.S. 122C-55; 122C-61; 122C-63; 122C-132; 131E-67; 143B-147;*
Eff. October 1, 1984;
Amended Eff. July 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

10A NCAC 28D .0106 CONSENT

(a) Consents required in Sections .0200, .0300 and .0400 in this Subchapter shall be obtained in writing or verbally over the telephone.

(b) Written consent of the client or his legally responsible person shall be obtained whenever possible. Information which is necessary to adequately inform the client shall be documented in the client record and shall include the following:

(1) name of the procedure or treatment and its purpose expressed in laymen's terms;
(2) evidence that the benefits, risks, possible complications and possible alternative methods of treatment have been explained to the client or his legally responsible person;
(3) notification that the consent may be withdrawn at any time without reprisal;
(4) specific length of time for which consent is valid;
(5) when anesthesia is indicated, permission to administer a specified type of anesthesia;
(6) permission to perform the procedure or treatment;
(7) when applicable, authorization for the examination and disposal of any tissue or body parts that may be removed; and
(8) signature of the client or his legally responsible person on written authorizations.

(c) Whenever written consent cannot be obtained in a timely manner, verbal (telephone) consent may be obtained from the legally responsible person. The legally responsible person shall be asked to sign a written authorization and return it to the state facility but the treatment or procedure may be administered in accordance with the verbal consent. Verbal consent shall be witnessed by two staff members and documented in the client record. The client record shall also include documentation specifying the reason why written consent could not be obtained.

History Note: *Authority G.S. 122C-51; 122C-57; 131E-67; 143B-147;*
Eff. July 1, 1989;
Amended Eff. April 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

SECTION .0200 – PROTECTIONS REGARDING CERTAIN PROCEDURES

10A NCAC 28D .0201 LEAST RESTRICTIVE ALTERNATIVE AND PROHIBITED PROCEDURES

(a) Each facility shall provide services/supports that promote a safe and respectful environment. These include:

(1) using the least restrictive and most appropriate settings and methods;
(2) promoting coping and engagements skills that are alternatives to injurious behavior towards self or others;
(3) providing choices of activities meaningful to the clients serviced/supported; and
(4) sharing of control over decisions with the client/legally responsible person and staff.

(b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include:

(1) using the intervention as a last resort; and
(2) employing the intervention by people trained in its use.

(c) Each state facility shall develop policies relative to prohibited interventions. Such policies shall specify:

(1) those interventions which have been prohibited by statute or rule which shall include:
    (A) any intervention which would be considered corporal punishment under G.S. 122C-59;
    (B) the contingent use of painful body contact;
    (C) substances administered to induce painful bodily reactions exclusive of Antabuse;
    (D) electric shock (excluding medically administered electroconvulsive therapy);

(E) insulin shock; and
(F) psychosurgery; and

(2) those interventions specified in this Subchapter determined by the state facility director to be unacceptable for use in the state facility. Such policies shall specify interventions prohibited by funding sources including the use of seclusion or the emergency use of isolation time out in an ICF/MR facility.

(d) In addition to the procedures prohibited in Paragraph (c) of this Rule, the state facility director may specify other procedures which shall be prohibited.

History Note: *Authority G.S. 122C-51; 122C-57; 122C-59; 143B-147;*
Eff. October 1, 1984;
Amended Eff. November 1, 1993; July 1, 1989;
Temporary Amendment Eff. January 1, 2001;
Amended Eff. August 1, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

10A NCAC 28D .0202 ELECTROCONVULSIVE THERAPY

(a) The treatment/habilitation team may recommend the use of electroconvulsive therapy.

(b) Before electroconvulsive therapy can be utilized two licensed physicians, one of whom shall be clinically privileged to perform electroconvulsive therapy, shall approve a written plan, which includes indication of need, specific goals to be achieved, methods for measuring treatment efficacy, and indications for discontinuation of treatment. In addition, electroconvulsive therapy shall not be administered to any client under age 18 unless, prior to the treatment, two independent psychiatric consultants with training or experience in the treatment of adolescents have examined the client, consulted with the responsible state facility psychiatrist and have written and signed reports which document concurrence with the use of such treatment. For clients under the age of 13, such reviews shall be conducted by child psychiatrists.

(c) The internal client advocate shall be informed at the time of the decision to utilize electroconvulsive therapy whenever the legally competent client requests such notification or when proposed for use with minor clients or adults adjudicated incompetent.

(d) Electroconvulsive therapy shall not be initiated without prior consent in accordance with G.S. 122C-57(f).

(e) If the adult client is determined to be de facto incompetent by the treatment/habilitation team and is determined to need electroconvulsive therapy, legal guardianship procedures shall be initiated and consent requirements of Paragraph (d) of this Rule shall be met.

(f) All electroconvulsive therapy shall be administered in accordance with generally accepted medical practice and shall be documented in the client record.

(g) The State Facility Director shall maintain a statistical record of the use of electroconvulsive therapy which shall include, but not be limited to, the number of treatments by client, unit or like grouping, responsible physician, and client characteristics. The statistical record shall be made available to the Division Director on a monthly basis.

History Note: *Authority G.S. 122C-51; 122C-56; 122C-57; 131E-67; 143B-147;*
Eff. October 1, 1984;
Amended Eff. July 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

10A NCAC 28D .0203 GENERAL POLICIES REGARDING INTERVENTIVE PROCEDURES

(a) This Rule governs the policies and requirements regarding the use of the following interventions:

(1) seclusion;
(2) physical restraint including:
(A) mechanical restraint; or
(B) manual restraint;
(3) isolation time-out;
(4) exclusionary time-out for more than 15 minutes;
(5) time-out for more than one hour;
(6) protective devices when used for behavioral control;

(7) contingent withdrawal or delay of access to personal possessions or goods to which the client would ordinarily be entitled;
(8) consistent deprivation of items or cessation of an activity which the client is scheduled to receive (other than basic necessities); and
(9) overcorrection which the client resists.

(b) The state facility director shall develop policies and procedures for those interventions determined to be acceptable for use in the state facility. Such policies and procedures shall include that:

(1) positive alternatives and less restrictive alternatives are considered and used whenever possible prior to the use of seclusion, physical restraint or isolation time-out; and
(2) consideration is given to the client's physical and psychological well-being before, during and after utilization of a restrictive intervention, including:
    (A) review of the client's health history or the comprehensive health assessment conducted upon admission to a facility. The health history or comprehensive health assessment shall include the identification of pre-existing medical conditions or any disabilities and limitations that would place the client at greater risk during the use of restrictive interventions;
    (B) continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of physical restraint throughout the duration of the restrictive intervention by staff who are physically present and trained in the use of emergency safety interventions;
    (C) continuous monitoring of the client's physical and psychological well-being by an individual trained in the use of cardiopulmonary resuscitation during the use of manual restraint; and
    (D) continued monitoring of the client's physical and psychological well-being by an individual trained in the use of cardiopulmonary resuscitation for a minimum of 30 minutes subsequent to the termination of a restrictive intervention;
(3) procedures for ensuring that the competent adult client or legally responsible person of a minor client or incompetent adult client is informed in a manner he or she can understand:
    (A) of the general types of intrusive interventions that are authorized for use by the state facility; and
    (B) that the legally responsible person can request notification of each use of an intervention as specified in this Rule, in addition to those situations required by G.S. 122C-62;
(4) provisions for humane, secure and safe conditions in areas used for the intervention, such as ventilation, light and a room temperature consistent with the rest of the state facility;
(5) attention paid to the need for fluid intake and the provision of regular meals, bathing and the use of the toilet. Such attention shall be documented in the client record; and
(6) procedures for assuring that when an intervention as specified in this Rule has been used with a client three or more times in a calendar month, the following requirements are met:
    (A) A treatment/habilitation plan shall be developed within 10 working days of the third intervention. The treatment/habilitation plan shall include, but not be limited to:
        (i) indication of need;
        (ii) specific description of problem behavior;
        (iii) specific goals to be achieved and estimated duration of procedures;
        (iv) specific early interventions to prevent tension from escalating to the point of loss of control whenever possible;
        (v) consideration, whenever possible, for client's preference for the type of physical restraint to be used;
        (vi) specific procedure(s) to be employed;
        (vii) specific methodology of the intervention;
        (viii) methods for measuring treatment efficacy;
        (ix) guidelines for discontinuation of the procedure;
        (x) the accompanying positive treatment or habilitation methods which shall be at least as strong as the negative aspects of the plan;
        (xi) description and frequency of debriefing, if determined to be clinically necessary;
        (xii) specific limitations on approved uses of the intervention per episode, per day and requirements for on-site assessments by the responsible professional; and

(xiii) description of any requirements in Rule .0206 of this Section to be incorporated into the plan;

(B) In emergency situations, with the approval of the state facility director, the treatment/habilitation team may continue to use the intervention until the planned intervention is addressed in the treatment/habilitation plan;

(C) The treatment/habilitation team shall explain the intervention and the reason for the intervention to the client and the legally responsible person, if applicable, and document such explanation in the client record;

(D) Before implementation of the planned intervention, the treatment/habilitation team, with the participation of the client and legally responsible person if applicable, shall approve the treatment/habilitation plan and consent shall be obtained as specified in Rule .0210(e) in this Section;

(E) The use of the intervention shall be reviewed at least monthly by the treatment/habilitation team and at least quarterly, if still in effect, by a designee of the state facility director. The designee of the state facility director may not be a member of the client's treatment/habilitation team. Reviews shall be documented in the client record;

(F) Treatment/habilitation plans which include these interventions shall be subject to review by the Human Rights Committee in compliance with confidentiality rules as specified in 10A NCAC 28A;

(G) Each treatment/habilitation team shall maintain a record of the use of the intervention. Such records or reports shall be available to the Human Rights Committee and internal client advocate within the constraints of 10A NCAC 26B .0209 and G.S. 122C-53(g);

(H) The state facility director shall follow the Right to Refuse Treatment Procedures as specified in Section .0300 of this Subchapter; and

(I) The interventions specified in this Rule shall never be the sole treatment modality designed to eliminate the target behavior. The interventions are to be used consistently and shall always be accompanied by positive treatment or habilitation methods.

(c) Whenever the interventions specified in this Subchapter other than seclusion, physical restraint or isolation time-out result in the restriction of a right specified in G.S. 122C-62(b) and (d), the procedures specified in G.S. 122C-62(e) shall be followed. The requirements for restriction of rights associated with the use of seclusion, physical restraint or isolation time-out are specified in Paragraph (f) of Rule .0206 of this Section.

(d) The state facility director shall assure by documentation in the personnel records that state facility employees who authorize interventions shall be qualified professionals and state facility employees who implement interventions shall be trained and shall demonstrate competence in the area of such interventions, as well as in the use of alternative approaches.

(e) The state facility director shall maintain a statistical record that reflects the frequency and duration of the individual uses of interventions specified in this Rule. This statistical record shall be made available to the Human Rights Committee and the Division at least quarterly.

History Note: *Authority G.S. 122C-51; 122C-53; 122C-60; 122C-62; 131E-67; 143B-147;*
Eff. October 1, 1984;
Amended Eff. November 1, 1993; July 1, 1989;
Temporary Amendment Eff. January 1, 2001;
Temporary Amendment Expired October 13, 2001;
Amended Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

10A NCAC 28D .0204 INDICATIONS FOR USE OF SECLUSION AND ISOLATION TIME-OUT

Seclusion and isolation time-out shall be used only:

(1) in those situations specified in G.S. 122C-60;

(2) after less restrictive measures have been attempted and have proven ineffective. Less restrictive measures that shall be considered include:

(a) counseling;

(b) environmental changes;

(c) education techniques; and

(d) interruptive or re-direction techniques; and

(3) after consideration of the client's physical and psychological well-being as specified in Rule .0203(b) of this Section.

History Note: *Authority G.S. 122C-51; 122C-53; 122C-60; 122C-62; 143B-147;*
Eff. October 1, 1984;
Amended Eff. November 1, 1993; April 1, 1990; July 1, 1989;
Temporary Amendment Eff. January 1, 2001;
Amended Eff. August 1, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

10A NCAC 28D .0205 INDICATIONS FOR USE OF PHYSICAL RESTRAINTS

Physical restraints shall be used only:

(1) in those situations specified in G.S. 122C-60;

(2) after consideration of the client's physical and psychological well-being as specified in Rule .0203(b) of this Section; and

(3) after a less restrictive alternative has been attempted or has been determined and documented to be clinically inappropriate or inadequate to avoid injury. Less restrictive alternatives that shall be considered include but are not limited to:

(a) counseling;

(b) environmental changes;

(c) education techniques; and

(d) interruptive or re-direction techniques.

History Note: *Authority G.S. 122C-51; 122C-53; 122C-60; 122C-62; 143B-147;*
Eff. October 1, 1984;
Amended Eff. November 1, 1993; April 1, 1990; July 1, 1989;
Temporary Amendment Eff. January 1, 2001;
Amended Eff. August 1, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

10A NCAC 28D .0206 PROCEDURES: SECLUSION, PHYSICAL RESTRAINTS, OR ISOLATION TIME OUT

(a) This Rule delineates the procedures to be followed for use of seclusion, physical restraint or isolation time-out in addition to the procedures specified in Rule .0203 of this Section.

(b) This Rule governs the use of physical or behavioral interventions which are used to terminate a behavior or action in which a client is in imminent danger of injury to self or other persons or when property damage is occurring that poses imminent risk of danger, of injury or harm to self or others, or which are used as a measure of therapeutic treatment. Such interventions include seclusion, physical restraint and isolation time-out.

(c) If determined to be acceptable for use within the state facility, the state facility director shall establish written policies and procedures that govern the use of seclusion, physical restraint or isolation time-out which shall include the following:

(1) techniques for seclusion, physical restraint or isolation time-out;

(2) provision for required debriefing for emergency use of seclusion, physical restraint or isolation time-out;

(3) provision, to both new clinical and habilitation staff as part of in-service training, and as a condition of continued employment, for those authorized to use or apply intrusive interventions which shall include, but not be limited to:

(A) competency-based training and periodic reviews on the use of seclusion, physical restraint or isolation time-out; and

(B) skills for less intrusive interventions specified in Rules .0203 and .0204 of this Section;

(4) process for identifying, training and assessing the competence of state facility employees who are authorized to use such interventions;

(5) provisions that a responsible professional shall:

(A) meet with the client and review the use of the intervention as soon as possible but at least within one hour after the initiation of its use;
(B) verify the inadequacy of positive alternatives and less restrictive intervention techniques;
(C) document in the client record evidence of approval or disapproval of continued use; and
(D) inspect to ensure that any devices to be used are in good repair and free of tears and protrusions;

(6) procedures for documenting the intervention which occurred to include, but not be limited to:
(A) consideration that was given to the physical and psychological well-being of the client prior to the use of the restrictive intervention;
(B) the rationale for the use of the intervention which addresses attempts at and inadequacy of positive alternatives and less restrictive intervention techniques; this shall contain a description of the specific behaviors justifying the use of seclusion, physical restraint or isolation time-out;
(C) notation of the frequency, intensity and duration of the behavior and any precipitating circumstances contributing to the onset of the behavior;
(D) description of the intervention and the date, time and duration of its use;
(E) estimated amount of additional time needed in seclusion, physical restraint or isolation time-out;
(F) signature and title of the state facility employee responsible for the use of the intervention;
(G) the time the responsible professional met with the client; and
(H) description of the debriefing and planning with the client and the legally responsible person, if applicable, as specified in Subparagraph (c)(2) of this Rule, or Subpart (b)(6)(A)(xi) of Rule .0203 of this Section, to eliminate or reduce the probability of the future use of restrictive interventions; and

(7) procedures for the notification of others to include:
(A) those to be notified as soon as possible but no more than one working day after the behavior has been controlled to include:
(i) the treatment/habilitation team, or its designee, after each use of the intervention;
(ii) a designee of the State Facility Director; and
(iii) the internal client advocate, in accordance with the provisions of G.S. 122C-53(g); and
(B) immediate notification of the legally responsible person of a minor client or an incompetent adult client unless she/he has requested not to be notified.

(d) Seclusion, physical restraint and isolation time-out shall not be employed as coercion, punishment or retaliation or for the convenience of staff or due to inadequate staffing or be used in a manner that causes harm or pain to the client. Care shall be taken to minimize any physical or mental discomfort in the use of these interventions.

(e) Whenever a client is in seclusion, physical restraint or isolation time-out, the client's rights, as specified in G.S. 122C-62, are restricted. The documentation requirements in this Rule shall satisfy the requirements specified in G.S. 122C-62(e) for restriction of rights.

(f) Whenever seclusion, physical restraint or isolation time-out is used more than three times in a calendar month:
(1) a pattern of behavior has developed and future emergencies can be reasonably predicted;
(2) dangerous behavior can no longer be considered unanticipated; and
(3) emergency procedures shall be addressed as a planned intervention in the treatment/habilitation plan.

(g) In addition to the requirements in this Rule, additional safeguards as specified in Rule .0208 of this Section shall be initiated whenever:
(1) a client exceeds spending 40 hours in emergency seclusion, physical restraint or isolation timeout in a calendar month; or one episode in which the original order is renewed for up to a total of 24 hours in accordance with the limits specified in Subparagraph (l)(8) of this Rule; or
(2) seclusion, physical restraint or isolation time-out is:
(A) used as a measure of therapeutic treatment as specified in G.S. 122C-60; and
(B) limited to specific planned behavioral interventions designed for the extinction of dangerous, aggressive or undesirable behaviors.

(h) The written approval of the State Facility Director or designee shall be required when the original order for seclusion, physical restraint or isolation time-out is renewed for up to a total of 24 hours in accordance with the limits specified in Subparagraph (l)(8) of this Rule.
(i) Standing orders or as needed (PRN) orders shall not be used to authorize the use of seclusion, physical restraint or isolation time-out.
(j) A state facility employee shall remove the client from seclusion, physical restraint or isolation time-out and seek medical attention immediately if monitoring of the physical and psychological well-being of the client indicates there is a risk to health or safety.
(k) The client shall be removed from seclusion, physical restraint or isolation time-out when the client no longer demonstrates the behavior which precipitated the seclusion, physical restraint or isolation time-out; however, if the client is unable to gain self-control within the time frame specified in the authorization, a new authorization shall be obtained.
(l) Whenever seclusion, physical restraint or isolation time-out are used on an emergency basis prior to inclusion in the treatment/ habilitation plan, the following procedures shall be followed:

(1) A state facility employee authorized to administer emergency interventions may employ such procedures for up to 15 minutes without further authorization.

(2) A qualified professional may authorize the continued use of seclusion, physical restraint or isolation time-out for up to one hour from the initial employment of the intervention if the qualified professional:
   (A) has experience and training in the use of seclusion, physical restraint or isolation time-out; and
   (B) has been approved to employ and authorize such interventions.

(3) If a qualified professional is not immediately available to conduct a face-to-face assessment of the client, but after discussion with the state facility employee, the qualified professional concurs that the intervention is justified for longer than 15 minutes, then the qualified professional:
   (A) may verbally authorize the continuation of the intervention for up to one hour;
   (B) shall meet with and assess the client within one hour after authorizing the continued use of the intervention; and
   (C) shall immediately consult with the professional responsible for the client's treatment/habilitation plan, if the intervention needs to be continued for longer than one hour.

(4) The responsible professional shall authorize the continued use of seclusion, physical restraint or isolation time-out for periods over one hour.

(5) If the responsible professional is not immediately available to conduct a clinical assessment of the client but, after consideration of the physical and psychological well-being of the client and discussion with the qualified professional, concurs that the intervention is justified for longer than one hour the responsible professional may verbally authorize the continuation of the intervention until an on-site assessment of the client can be made. However, if such authorization cannot be obtained, the intervention shall be discontinued.

(6) If the responsible professional and the qualified professional are the same person, the documentation requirements of this Rule may be done at the time of the documentation required by Subparagraph .0206(d)(5) of this Section.

(7) The responsible professional, or if the responsible professional is unavailable, the on-service or covering professional, shall meet with and assess the client within three hours after the client is first placed in seclusion, physical restraint or isolation time-out, and document:
   (A) the reasons for continuing seclusion, physical restraint or isolation time-out; and
   (B) the client's response to the intervention. In addition, the responsible professional shall provide an evaluation of the episode and propose recommendations regarding specific means for preventing future episodes. Clients who have been placed in seclusion, physical restraint or isolation time-out and released in less than three hours shall be examined by the responsible professional who authorized the intervention no later than 24 hours after the episode.

(8) Each written order for physical restraint, seclusion or isolation timeout is limited to four hours for adult clients; two hours for children and adolescent clients ages nine to 17; or one hour for clients under the age of nine. The original order shall only be renewed in accordance with these limits for up to a total of 24 hours.

(9) Each incident shall be reviewed by the treatment team, which shall include possible alternative actions and specific means for preventing future episodes.

(m) While the client is in seclusion, physical restraint or isolation time-out, the following precautions shall be followed:

(1) Whenever a client is in seclusion:

(A) periodic observation of the client shall occur at least every 15 minutes to assure the safety of the client. Observation shall include direct line of sight or the use of video surveillance that ensures that the client is within the view of the state facility employee observing the client;

(B) attention shall be paid to the provision of regular meals, bathing and the use of the toilet; and

(C) such observation and attention shall be documented in the client record.

(2) Whenever a client is in physical restraint, the facility shall provide:

(A) the degree of observation needed to assure the safety of the client placed in physical restraint. The degree of observation needed is determined at the time of application of the physical restraint after consideration of the following:

(i) the type of physical restraint used;

(ii) the individual client's situation, including physical and psychological well-being; and

(iii) the existence of any specific manufacturer's warning concerning the safe use of a particular product.

Observation shall include direct line of sight or the use of video surveillance that ensures that the client is within the view of the state facility employee observing the client. In no instance shall observation be less frequent than at 15-minute intervals.

(B) attention to the provision of regular meals, bathing and the use of the toilet; and

(C) documentation of the above observation and attention in the client record.

(3) Whenever a client is in isolation time-out there shall be:

(A) a state facility employee in attendance with no other immediate responsibility than to monitor the client who is placed in isolation time-out;

(B) continuous observation and verbal interaction with the client when necessary to prevent tension from escalating; and

(C) documentation of such observation and verbal interaction in the client record.

(n) After a restrictive intervention is utilized, staff shall conduct debriefing and planning with the client and the legally responsible person, if applicable, as specified in Subparagraph (d)(2) of this Rule, or Subpart (b)(6)(A)(xi) of Rule .0203 of this Section, to eliminate or reduce the probability of the future use of restrictive interventions. Debriefing and planning shall be conducted as appropriate to the level of cognitive functioning of the client.

(o) Reviews and reports on the use of seclusion, physical restraint or isolation time-out shall be conducted as follows:

(1) the State Facility Director or designee shall review all uses of seclusion, physical restraint or isolation time-out and investigate unusual patterns of utilization to determine whether such patterns are unwarranted. At least quarterly, the State Facility Director or designee shall review all uses of seclusion and physical restraint to monitor effectiveness, identify trends and take corrective action where necessary.

(2) each State Facility Director shall maintain a log which includes the following information on each use of seclusion, physical restraint or isolation time-out:

(A) name of the client;

(B) name of the responsible professional;

(C) date of each intervention;

(D) time of each intervention;

(E) duration of each intervention;

(F) name of the state facility employee who implemented the restrictive intervention;

(G) date and time of the debriefing and planning conducted with the client and the legally responsible person if applicable and staff to eliminate or reduce the probability of the future use of restrictive interventions; and

(H) negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client.

(p) The facility shall collect and analyze data on the use of seclusion and physical restraint. The data collected and analyzed shall reflect for each incident:

(1) the type of procedure used and length of time employed;
(2) alternatives considered or employed; and
(3) the effectiveness of the procedure or alternative employed.

The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends and take corrective action where necessary. The facility shall make the data available to the Secretary of the Department of Health and Human Services upon request.

(q) Nothing in this Rule shall be interpreted to prohibit the use of voluntary seclusion, physical restraint or isolation time-out at the client's request; however, the procedures in Paragraphs (a) through (p) of this Rule shall apply.

History Note: *Authority G.S. 122C-51; 122C-53; 122C-57; 122C-60; 122C-62; 131E-67; 143B-147;*
Eff. October 1, 1984;
Amended Eff. July 1, 1994; January 4, 1994; November 1, 1993; April 1, 1990;
Temporary Amendment Eff. January 1, 2001;
Temporary Amendment Expired October 13, 2001;
Amended Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

10A NCAC 28D .0207 PROTECTIVE DEVICES

(a) Whenever protective devices that cannot be removed at will by the client are utilized, the state facility shall:

(1) assure that the protective device shall be used only to promote the client's physical safety;
(2) assure that the factors putting the client's physical safety at risk are fully explored and addressed in treatment planning with the participation of the client and legally responsible person if applicable;
(3) document the utilization of protective device in the client's nursing care plan, when applicable, and treatment/habilitation plan;
(4) document what positive alternatives and less restrictive alternatives were considered, whether those alternatives were tried, and why those alternatives were unsuccessful;
(5) assure that the protective device is used only upon the written order of a qualified professional that specifies the type of protective device and the duration and circumstances under which the protective device is used;
(6) assure and document that the staff applying the protective device is trained and has demonstrated competence to do so;
(7) inspect to ensure that the devices are in good repair and free of tears and protrusions;
(8) determine, at the time of application of the protective device, the degree of observation needed to assure the safety of those placed in restraints. The type of protective device used, the individual patient situation, and the existence of any specific manufacturer's warning concerning the safe use of a particular product shall all be considered in determining the degree of observation needed. Observation shall include direct line of sight or the use of video surveillance. In no instance shall observation be less frequent than at 30-minute intervals.
(9) assure that whenever the client is restrained and subject to injury by another client, a state facility employee shall remain present with the client continuously.
(10) assure that the person is released as needed, but at least every two hours;
(11) re-evaluate need for and impact on client of protective device at least every 30 days; and
(12) assure that observations and interventions shall be documented in the client record.

(b) In addition to the requirements specified in Paragraph (a) of this Rule, protective devices used for behavioral control shall comply with the requirements specified in Rule .0203 of this Section.

History Note: *Authority G.S. 122C-51; 122C-57; 143B-147;*
Eff. October 1, 1984;
Amended Eff. November 1, 1993; July 1, 1989;
Temporary Amendment Eff. January 1, 2001;
Amended Eff. August 1, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

10A NCAC 28D .0208 INTERVENTIONS REQUIRING ADDITIONAL SAFEGUARDS

(a) The interventions specified in this Rule present a significant risk to the client and therefore require additional safeguards. These procedures shall be followed in addition to the procedures specified in Rule .0203 of this Section.

(b) The following interventions are designed for the primary purpose of reducing the incidence of aggressive, dangerous or self-injurious behavior to a level which will allow the use of less intrusive treatment/habilitation procedures. Such interventions include the use of:

(1) seclusion, physical restraint or isolation time-out employed as a measure of therapeutic treatment;

(2) seclusion, physical restraint or isolation time-out used on an emergency basis more than 40 hours in a calendar month or one episode in which the original order is renewed for up to a total of 24 hours in accordance with the limits specified in Subparagraph (l)(8) of Rule .0206 of this Section;

(3) unpleasant tasting substances;

(4) planned non-attention to specific undesirable behaviors when the target behavior is health threatening;

(5) contingent deprivation of any basic necessity;

(6) contingent application of any noxious substances which include but are not limited to noise, bad smells or splashing with water; and

(7) any potentially physically painful procedure or stimulus which is administered to the client for the purpose of reducing the frequency or intensity of a behavior.

(c) Such interventions shall never be the sole treatment modality for the elimination of target behavior.

(d) The intervention shall always be accompanied by positive treatment or habilitation methods which shall include, but not be limited to:

(1) the deliberate teaching and reinforcement of behaviors which are non-injurious;

(2) the improvement of conditions associated with non-injurious behaviors such as an enriched educational and social environment; and

(3) the alteration or elimination of environmental conditions which are reliably correlated with self-injury.

(e) Prior to the implementation of any planned use of the intervention the following written approvals and notifications shall be obtained. Documentation in the client record shall include:

(1) approval of the plan by the treatment/habilitation team;

(2) that each client whose treatment/habilitation plan includes interventions with reasonably foreseeable physical consequences shall receive an initial medical examination and periodic planned monitoring by a physician;

(3) that the treatment/habilitation team shall inform the internal client advocate that the intervention has been planned for the client and the rationale for utilization of the intervention;

(4) the treatment/habilitation team shall explain the intervention and the reason for the intervention to the client and the legally responsible person, if applicable;

(5) the prior written consent of the client or his legally responsible person shall be obtained except for those situations specified in Rule .0206(g)(1) in this Section. If the client or legally responsible person refuses the intervention, the State Facility Director shall follow the right to refuse treatment procedures as specified in this Subchapter;

(6) that the plan shall be reviewed and approved by a review committee, designated by the State Facility Director, which shall include that:

(A) at least one member of the review committee shall be qualified through experience and training to utilize the planned intervention; and

(B) no member of the review committee shall be a member of the client's treatment team;

(7) that the treatment/habilitation plan may be reviewed and approved by the State Facility Director; and

(8) if any of the persons or committees specified in Subparagraphs (e)(1), (2), (4), (5) or (6) of this Rule do not approve the continued use of a planned intervention, the planned intervention shall be terminated. The State Facility Director shall establish an appeal mechanism for the resolution of any disagreement over the use of the intervention.

(f) Neither the consents nor the approvals specified in Paragraph (e) of this Rule shall be valid for more than six months. The treatment/habilitation team shall re-evaluate the use of the intervention and obtain the client's and legally responsible person's consent for continued use of the intervention at least every six months.

(g) The plan shall be reviewed at the meeting of the Human Rights Committee following each evaluation within the constraints of 10A NCAC 28A .0209. The Committee, by majority vote, may recommend approval or disapproval of the plan to the State Facility Director or may abstain from making a recommendation. If the State Facility Director does not agree with the decision of the Committee, the Committee may appeal the issue to the Division in accordance with the provisions of 10A NCAC 28A .0208.
(h) The intervention shall be used only when the treatment/habilitation team has determined and documented in the client record the following:

(1) that the client is engaging in behaviors that are likely to result in injury to self or others;
(2) that other methods of treatment or habilitation employing less intrusive interventions are not appropriate;
(3) the frequency, intensity and duration of the target behavior, and the behavior's probable antecedents and consequences; and
(4) it is likely that the intervention will enable the client to stop the target behavior.

(i) The treatment/habilitation team shall designate a state facility employee to maintain written records on the application of the intervention and accompanying positive procedures. These records shall include the following:

(1) data which reflect the frequency, intensity and duration with which the targeted behavior occurs (scientific sampling procedures are acceptable);
(2) data which reflect the frequency, intensity and duration of the intervention and any accompanying positive procedures; and
(3) data which reflect the state facility employees who administered the interventions.

(j) The interventions shall be evaluated at least weekly by the treatment team or its designee and at least monthly by the State Facility Director. The designee of the State Facility Director shall not be a member of the client's treatment/habilitation team. Reviews shall be documented in the client record.
(k) During the use of the intervention, the Human Rights Committee shall be given the opportunity to review the treatment/ habilitation plan within the constraints of 10A NCAC 28A .0209.

History Note: *Authority G.S. 122C-51; 122C-53; 122C-60; 122C-62; 143B-147;*
Eff. November 1, 1993;
Amended Eff. October 1, 2004; July 1, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

10A NCAC 28D .0209 TRAINING: EMPHASIS ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS

(a) Facilities shall implement policies and practices that emphasize the use of alternatives to seclusion, physical restraint and isolation time-out.
(b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others, or to property is prevented.
(c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.
(d) The training shall be competency based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(e) Formal refresher training shall be completed at least annually by each service provider.
(f) Content of the training that the service provider plans to use shall be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
(g) Staff shall demonstrate competence in the following core areas:

(1) knowledge and understanding of the people being served;
(2) recognizing and interpreting human behavior;
(3) recognizing the effect of internal and external stressors that may affect people with disabilities;
(4) strategies for building positive relationships with people with disabilities;
(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;
(6) recognizing the importance, and assisting people with disabilities in making decisions about their life;

(7) skills in assessing individual risk for escalating behavior;
(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and
(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).

(h) Service providers shall maintain documentation of initial and refresher training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where they attended; and
(C) instructor's name.
(2) The Division of MH/DD/SAS may request and review this documentation at any time.

(i) Instructor Qualifications and Training Requirements:
(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for seclusion, physical restraint and isolation time-out.
(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but not be limited to presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(D) documentation procedures.
(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for physical restraint, seclusion and isolation time-out at least one time, with a positive review by the coach.
(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for seclusion, physical restraint and isolation time-out at least once annually.
(8) Trainers shall complete a refresher instructor training at least every two years.

(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where attended; and
(C) instructor's name; and
(2) The Division of MH/DD/SAS may request and review this documentation at any time.

(k) Qualifications of Coaches:
(1) Coaches shall meet all preparation requirements as a trainer.
(2) Coaches shall teach at least three times the course which is being coached.
(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.

(l) Documentation shall be the same preparation as for trainers.

History Note: *Authority G.S 143B-147;*
Temporary Adoption Eff. February 1, 2001;
Temporary Adoption Expired October 13, 2001;
Amended Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

10A NCAC 28D .0210 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT

(a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that

staff authorized to employ and terminate these procedures are retrained at least annually and have demonstrated competence.

(b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers, shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated.

(c) A prerequisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for seclusion, physical restraint and isolation time-out.

(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.

(e) Formal refresher training shall be completed by each service provider periodically (minimum annually).

(f) Content of the training that the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.

(g) Acceptable training programs shall include, but not be limited to, presentation of:

(1) refresher information on alternatives to the use of seclusion, physical restraint and isolation time-out;

(2) guidelines on when to intervene (understanding imminent danger to self and others);

(3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);

(4) strategies for the safe implementation of seclusion, physical restraint and isolation time-out;

(5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;

(6) prohibited procedures;

(7) debriefing strategies, including importance and purpose; and

(8) documentation methods and procedures.

(h) Service providers shall maintain documentation of initial and refresher training for at least three years.

(1) Documentation shall include:

(A) who participated in the training and the outcomes (pass/fail);

(B) when and where they attended; and

(C) instructor's name.

(2) The Division of MH/DD/SAS may request and review this documentation at any time.

(i) Instructor Qualifications and Training Requirements:

(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for seclusion, physical restraint and isolation time-out.

(2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out.

(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.

(4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(6) of this Rule.

(5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(6) of this Rule.

(6) Acceptable instructor training programs shall include, but not be limited to, presentation of:

(A) understanding the adult learner;

(B) methods for teaching content of the course;

(C) evaluation of trainee performance; and

(D) documentation procedures.

(7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule.

(8) Trainers shall be currently trained in CPR.

(9) Trainers shall have coached experience in teaching the use of seclusion, physical restraint and isolation time-out at least two times with a positive review by the coach.

(10) Trainers shall teach a program on the use of seclusion, physical restraint and isolation time-out at least once annually.

(11) Trainers shall complete a refresher instructor training at least every two years.

(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.

(1) Documentation shall include:

(A) who participated in the training and the outcome (pass/fail);

(B) when and where they attended; and

(C) instructor's name.

(2) The Division of MH/DD/SAS may request and review this documentation at any time.

(k) Qualifications of Coaches:

(1) Coaches shall meet all preparation requirements as a trainer.

(2) Coaches shall teach at least three times the course which is being coached.

(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.

(l) Documentation shall be the same preparation as for trainers.

History Note: *Authority G.S 143B-147;*
Temporary Adoption Eff. February 1, 2001;
Temporary Adoption Expired October 13, 2001;
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

SECTION .0300 - RIGHT TO REFUSE TREATMENT

10A NCAC 28D .0301 THERAPEUTIC AND DIAGNOSTIC PROCEDURES

(a) In addition to the treatment procedures specified in G.S. 122C-57(f), other intrusive procedures which are not routine medical diagnostic or treatment procedures shall require the express and informed written consent of the client or his legally responsible person prior to their initiation except in medical emergencies. Such procedures shall include but are not limited to the following:

(1) procedures that introduce radioactive dyes;

(2) hyperalimentation;

(3) endoscopy;

(4) lumbar puncture;

(5) prescribing and administration of the following drugs:

(A) Antabuse;

(B) Clonodine when used for non-FDA approved uses; and

(C) Depo-Provera when used for non-FDA approved uses; and

(6) neuroleptic drug therapy following the diagnosis of tardive dyskinesia or after the symptoms of tardive dyskinesia have appeared as observed by using a standardized abnormal involuntary movement rating scale.

(b) Non-emergency surgery, and other therapeutic and diagnostic procedures as specified in Paragraph (a) of this Rule, shall not be performed on a client unless the client or his legally responsible person has been provided with sufficient information concerning the proposed procedure in order to make an educated decision about the treatment measure and has consented in writing.

(c) Emergency surgery may be performed on a client without consent as specified in Paragraph (b) of this Rule only when:

(1) immediate action is necessary to preserve the life or health of the client;

(2) the client is unconscious or otherwise incapacitated so as to be incapable of giving consent;

(3) in the case of a minor or incompetent adult client, the consent of the legally responsible person cannot be obtained within the time necessitated by the nature of the medical emergency, subject to the provisions of G.S. 90-21.1 et seq.; and

(4) the attending physician and a second physician certify in writing that the situation requires emergency surgery.

History Note: *Authority G.S. 90-21.1; 90-21.13; 122C-51; 122C-57; 131E-67; 143B-147;*
Eff. October 1, 1984;
Amended Eff. April 1, 1990; July 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

10A NCAC 28D .0302 INTRUSIVE INTERVENTIONS

When a client or his legally responsible person refuses treatment or habilitation utilizing interventions specified in Section .0200 of this Subchapter in a non-emergency situation, the following process shall be followed for both voluntary and involuntary clients:

(1) The responsible professional shall speak to the client or legally responsible person, if applicable, and attempt to explain his assessment of the client's condition, the reasons for recommending the intervention, the benefits and risks, and the advantages and disadvantages of alternative courses of action. If the client or his legally responsible person still refuses to participate and the responsible professional still believes that these interventions are a necessary part of the client's treatment or habilitation plan:
   (a) The responsible professional shall tell the client and the legally responsible person, if applicable, that the matter will be discussed at a meeting of the client's treatment/habilitation team;
   (b) If the client's condition permits, the responsible professional shall invite the client and the legally responsible person, if applicable, to attend the meeting of the treatment/habilitation team; and
   (c) The responsible professional shall suggest that the client and the legally responsible person, if applicable, discuss the matter with a person of his own choosing such as a relative, friend, or internal client advocate.

(2) If a voluntary client or his legally responsible person still refuses the intervention after the process in Paragraph (1) of this Rule has been followed and if the use of the intervention is still determined to be essential to the treatment or habilitation of the voluntary client by the treatment/habilitation team and no alternative procedures are appropriate, the treatment/habilitation team shall make a determination as to whether the client meets the requirements for involuntary commitment.
   (a) If the client meets the requirements for involuntary commitment, as specified in G.S. Chapter 122C, Article 5, the treatment/habilitation team may make a written recommendation to the State Facility Director requesting the initiation of commitment proceedings.
   (b) If the client does not meet the requirements for involuntary commitment, as specified in G.S. Chapter 122C, Article 5, the treatment/habilitation team may make a written recommendation to the State Facility Director requesting the discharge of the client.
   (c) The State Facility Director may designate a group to investigate the circumstances and to recommend appropriate action. Such a group shall include, but not be limited to, representatives from the Human Rights Committee, client advocates, and qualified professionals in supervisory positions.

(3) Interventions as specified in Rules .0203 through .0206 of this Subchapter shall not be administered to a voluntary client in a non-emergency situation if the client or his legally responsible person refuses the intervention.

(4) If an involuntary client or his legally responsible person, if applicable, refuses treatment or habilitation utilizing interventions specified in Rules .0203 through .0206 of this Subchapter in a non-emergency situation, after the process in Paragraph (1) of this Rule has been followed and if the use of the intervention is still determined to be essential to the treatment or habilitation of the involuntary client by the treatment/habilitation team and no alternative approaches are appropriate, the treatment/habilitation team shall meet to review the involuntary client's or his legally responsible person's response and assess the need for the intervention as follows:
   (a) If the client or legally responsible person is present, the treatment/habilitation team shall attempt to formulate a treatment or habilitation plan that is acceptable to both the client or legally responsible person and the treatment/habilitation team. The client or legally responsible person may agree to participate in the treatment or habilitation program

unconditionally or under certain conditions that are acceptable to the treatment/habilitation team.

(b) If the client or legally responsible person is not present, the treatment/habilitation team shall review its previous recommendations and the client's response and shall document their decision in the client record.

(5) If, after reassessing the need for the interventions, the treatment/habilitation team still believes that the interventions are a necessary part of the involuntary client's treatment or habilitation plan and the client or his legally responsible person, if applicable, still refuses, the client's treating physician and another physician, who may be the Clinical Director or his designee, shall interview the client and review the record. If both physicians determine that the intervention is essential, in accordance with G.S. 122C-57(e), the intervention may be administered as part of the client's documented individualized treatment or habilitation plan.

(6) The treating physician shall document the decision relative to the utilization of the intervention in the client record. Such documentation shall also include consideration of negative effects related to the specific treatment/habilitation measure.

History Note: *Authority G.S. 122C-51; 122C-57; 131E-67; 143B-147;*
Eff. October 1, 1984;
Amended Eff. April 1, 1990; July 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

SECTION .0400 - REFUSAL OF PSYCHOTROPIC MEDICATION

10A NCAC 28D .0401 ADMINISTRATION OF MEDICATIONS IN AN EMERGENCY

(a) For the purposes of the rules in this Section, "emergency" means a situation in which a client is in imminent danger of causing physical harm to self or other persons unless there is rapid intervention by the state facility employee in the form of the administration of psychotropic medication.

(b) When a client in a state facility refuses psychotropic medication in a situation that constitutes an emergency, the Director of Clinical Services may authorize administration of the psychotropic medication upon written certification that psychotropic medication is essential in order to prevent the client from causing imminent physical harm to self or other persons.

(c) If it is impossible to comply with the procedure in Paragraph (b) of this Rule without jeopardizing the life of the client or other persons, the medication may be administered upon a physician's written or verbal order.

(d) In any situation falling within Paragraph (b) or (c) of this Rule, the physician authorizing the psychotropic medication shall immediately document the authorization with such documentation including a statement describing the circumstances making the medication necessary and setting forth the reasons why lesser intrusive alternative measures would not have been adequate.

(e) Within 24 hours, or when imminent danger has passed or upon expiration of the physician's order, whichever comes first, the use of psychotropic medication shall be re-evaluated by the physician. Continuation of the administration of psychotropic medication in an emergency after the re-evaluation by the physician shall be permitted for up to 48 hours after written approval by the Clinical Director. If the emergency no longer exists then the procedures specified in Rules .0403 and .0404 of this Section shall apply.

(f) The occurrence of three emergency episodes within a 30-day period where psychotropic medications are administered shall constitute the need for the treatment team to review the treatment/habilitation plan. The treatment team shall develop a plan to respond to future crisis situations.

History Note: *Authority G.S. 122C-51; 122C-57; 131E-67; 143B-147;*
Eff. October 1, 1984;
Amended Eff. July 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

10A NCAC 28D .0402 BEST INTEREST TEST

(a) The responsible professional shall document in the client record that the administration of psychotropic medication against the client's will is in the best interest of the client. "Psychotropic medication administration is in the best interest of the client" means that:

(1) the client presents an imminent physical threat to himself, other clients, or state facility employee (Behavior constituting such threat shall be explicitly documented in the client record);

(2) the client is incapable without medication of participating in any treatment or habilitation plan available at the state facility that will give him a realistic opportunity of improving his condition; or

(3) although it is possible to devise a treatment or habilitation plan without psychotropic medication which will give the client a realistic opportunity of improving his condition, there is a significant possibility that the client will harm himself or others before improvement of his condition is realized if medication is not administered.

(b) In addition, the following factors shall be considered when determining if psychotropic medication administration is in the best interest of the client, and the responsible professional shall document such considerations in the client record:

(1) the client's reason for refusing medication;

(2) the existence of any less intrusive treatments; and

(3) the risks involved and severity of side effects associated with administration of the proposed medication.

History Note: *Authority G.S. 122C-51; 122C-57; 131E-67; 143B-147;*
Eff. October 1, 1984;
Amended Eff. April 1, 1990; July 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

10A NCAC 28D .0403 REFUSAL IN STATE FACILITIES OTHER THAN MR CENTERS

(a) This Rule applies to all state facilities with the exception of mental retardation centers. Mental retardation centers shall comply with Rule .0404 of this Section.

(b) In the case of an emergency, procedures specified in Rule .0401 of this Section shall apply.

(c) In the case of a client's refusal of psychotropic medication in a non-emergency, the best interest test as specified in Rule .0402 of this Section shall apply. A court order issued regarding the administration of medication for forensic patients would take precedence over this Rule.

(d) Administration to Involuntary Clients.

(1) When an involuntary client or his legally responsible person refuses psychotropic medication in a situation that is not an emergency, the following procedures are required:

(A) The attending physician shall speak to the client or legally responsible person, if applicable, and attempt to explain his assessment of the client's condition, the reasons for prescribing the medication, the benefits and risks of taking the medication, and the advantages and disadvantages of alternative courses of action. If the client or his legally responsible person still refuses and the physician still believes that psychotropic medication administration is in the best interest of the client as specified in Rule .0402 of this Section:

(i) the physician shall tell the client and the legally responsible person, if applicable, that the matter will be discussed at a meeting of the client's treatment team;

(ii) if the client's clinical condition permits, the physician shall invite the client and the legally responsible person, if applicable, to attend the meeting of the treatment team; and

(iii) the physician shall suggest that the client and the legally responsible person, if applicable, discuss the matter with a person of his own choosing, such as a relative, friend, guardian or client advocate.

(B) The treatment team shall meet to review the client's or legally responsible person's response and assess the need for psychotropic medication.

(i) If the client or legally responsible person is present, the treatment team shall attempt to formulate a treatment or habilitation plan that is acceptable to both

the client or legally responsible person and the treatment team. The client or legally responsible person may agree to take medication unconditionally or under certain conditions that are acceptable to the treatment team.

(ii) If the client or legally responsible person is not present, the treatment team shall review its previous recommendations and the client's response and shall document their decision in the client record.

(C) If, after assessing the need, the treatment team still believes that psychotropic medication administration is in the best interest of the client as specified in Rule .0402 of this Section and the client or legally responsible person still refuses administration of the prescribed medication, the Director of Clinical Services or his physician designee, who is not a member of the client's treatment team, shall interview the client and review the record, and may approve the administration of the medication over the objection of the client and legally responsible person.

(2) Such refusal shall be documented in the client record.

(e) Administration to Voluntary Clients.

(1) When a voluntary client in a state facility refuses psychotropic medication in a non-emergency situation, the medication shall not be administered to:

(A) a competent adult client without the client's consent;

(B) an incompetent adult client without consent of the legally responsible person; or

(C) a minor client without the consent of the legally responsible person.

(2) Such refusal shall be documented in the client record.

(f) Independent Psychiatric Evaluation.

(1) Whenever the Director of Clinical Services is asked to review a psychotropic medication decision, the Director of Clinical Services may retain an independent psychiatric consultant to evaluate the client's need for psychotropic medication. The use of a psychiatric consultant may be particularly indicated in cases where there is a disagreement between the prescribing physician and other members of the treatment team.

(2) If the client is evaluated by an independent psychiatric consultant, the Director of Clinical Services shall file a report in the client record indicating:

(A) the recommendation of the consultant; and

(B) why the Director of Clinical Services made a decision to follow, or not to follow, the consultant's recommendation.

(g) Case Review by the Director of Clinical Services.

(1) The Director of Clinical Services or his physician designee shall review each week the treatment or habilitation program of each client who is refusing to accept psychotropic medication administration voluntarily to determine:

(A) whether the client is still receiving the prescribed medication;

(B) whether psychotropic medication is still in the best interest of the client as specified in Rule .0402 of this Section; and

(C) whether the other components of the client's treatment or habilitation plan are being implemented.

(2) The Director of Clinical Services (not his designee) shall review quarterly the treatment or habilitation program of each client who is refusing to accept psychotropic medication administration voluntarily to determine:

(A) whether the client is still receiving the prescribed medication;

(B) whether psychotropic medication is still in the best interest of the client as defined in Rule .0402 of this Section; and

(C) whether the other components of the client's treatment or habilitation plan are being implemented.

(h) Documentation.

(1) Each step of the procedures outlined in Paragraphs (d) through (g) of this Rule shall be documented in the client record.

(2) Whenever the client or his legally responsible person has refused the administration of psychotropic medication and later agrees to such administration, the documentation of consent, either verbal or written, shall be included in the client record.

(i) A client's willingness to accept medications administered by mouth in lieu of accepting medications administered by an intramuscular route does not necessarily constitute consent. The responsible professional shall ensure that the client is indeed willing to accept the medication and is not responding to coercion.
(j) Statistical Record. The State Facility Director shall maintain a statistical record of the use of psychotropic medication against the client's will which shall include, but not be limited to, the number of administrations by client, unit of like grouping, responsible physician, and client characteristics. The statistical record shall be made available to the Division Director and Human Rights Committee on a monthly basis.

History Note: *Authority G.S. 122C-51; 122C-57; 131E-67; 143B-147;*
Eff. October 1, 1984;
Amended Eff. April 1, 1990; July 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

10A NCAC 28D .0404 REFUSAL IN REGIONAL MENTAL RETARDATION CENTERS
(a) This Rule applies to mental retardation centers. All other state facilities shall comply with Rule .0403 of this Section.
(b) In the case of an emergency, procedures specified in Rule .0401 of this Section shall apply.
(c) In the case of a client's refusal of psychotropic medication in a non-emergency, the best interest test as specified in Rule .0402 of this Section shall apply.
(d) Medication Refusal Incident Defined.
(1) A medication refusal incident is defined as any behavior on the part of the client, be it verbal or non-verbal, or legally responsible person, which is judged to be an attempt to communicate an unwillingness to have psychotropic medication administered to the client.
(2) Given the characteristics of the mentally retarded population, some very commonplace acts that may not necessarily constitute refusal should be considered. These may include:
(A) passivity or the lack of active participation in various activities which may require physical prompting such as hand over hand manipulation in order to learn a particular skill or complete a particular task;
(B) spitting out medication because of objectionable texture or taste (Therefore, disguising the texture or taste of psychotropic medication with a pleasant tasting vehicle such as applesauce or pudding may not necessarily be considered administration against the client's will.); or
(C) tantrums, self-injurious behavior, aggressive acts, etc. which would not automatically be judged to represent a client's attempt to refuse medication. However, it is recognized these behaviors in some cases may indeed be the only form of communication a client may have with which to express his or her refusal.
(e) Administration of Medication in Non-Emergency Situations. When a minor or adult client or his legally responsible person refuses psychotropic medication in a situation that is not an emergency, the following procedures are required:
(1) If a state facility employee suspects that a client may be attempting to refuse psychotropic medication, the state facility employee shall notify the client's qualified mental retardation professional (QMRP) and the client's internal advocate.
(2) If the QMRP agrees that the client may be attempting to refuse psychotropic medication, the QMRP shall notify the client's internal advocate and shall assemble the client's treatment team, including the treating physician, to assess the refusal incident.
(A) In the case of a client who is suspected of refusing, the team shall make a decision as to whether the client's behaviors, be they verbal or non-verbal, are true indications of refusal. In those instances where behavior is determined not to be refusal, authorization for the continued administration of the psychotropic medication may be given.
(B) In those cases where behaviors are judged to be refusal or when refusal originates with the competent adult client or with the client's legally responsible person, the client when possible or appropriate and the legally responsible person shall be invited to meet with the team to resolve the issue.
(C) The physician shall explain the reasons for prescribing the medication, the benefits and risks of taking the medication and the advantages and disadvantages of alternate courses

of action. The team shall make every effort to develop a habilitation plan or specific form of treatment that would be agreeable to the client or his legally responsible person and still be consistent with the treatment needs of the client.

(3) In those cases where an agreement cannot be reached between the treatment team, including the physician, and the legally responsible person, and the team, including the physician, still feels that psychotropic medication administration is in the best interest of the client, the issue shall be referred to the State Facility Review Committee appointed by the State Facility Director.

(A) The composition of this committee should include a complement of professionals, including the Medical Director (or his designated physician) and Human Rights Committee representatives. The internal client advocate shall be invited to represent the client's interest but not be considered a member of the State Facility Review Committee. The Committee should not include state facility employees providing direct services to the client refusing the psychotropic medication. In any event, the confidentiality regulations as codified in 10A NCAC 26B shall be followed.

(B) As with the treatment team, the State Facility Review Committee shall involve the client and the legally responsible person where appropriate in an attempt to arrive at a mutually acceptable solution.

(C) If agreement is reached between the legally responsible person and the State Facility Review Committee, no further proceedings are necessary. If agreement cannot be reached the State Facility Review Committee shall forward its recommendations concerning any changes in treatment or support of existing treatment methods to the Center Director.

(4) If the State Facility Director receives recommendations concerning any changes in treatment or support of existing treatment methods regarding a specific client who has refused psychotropic medications and this recommendation is still unacceptable to the legally responsible person, the Center Director shall have, as the last alternative, the authority to discharge the client under G.S. 122C-57(d). In those cases where the Center Director makes the decision to discharge the client, information shall be provided to the legally responsible person regarding the grievance procedures as specified in 10A NCAC 26B .0203, .0204, and .0205.

(f) Documentation. Each step of the procedure outlined in Paragraphs (d) through (e) of this Rule shall be documented in the client record.

(g) Statistical Record. The State Facility Director shall maintain a statistical record of the use of psychotropic medication against the client's will which shall include, but not be limited to, the number of administrations by client, unit of like grouping, responsible physician, and client characteristics. The statistical record shall be made available to the Division Director and Human Rights Committee on a monthly basis.

History Note: *Authority G.S. 122C-51; 122C-57; 122C-242; 143B-147;*
Eff. October 1, 1984;
Amended Eff. April 1, 1990; July 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.