

SUBCHAPTER 27E – TREATMENT OR HABILITATION RIGHTS

SECTION .0100 – PROTECTIONS REGARDING INTERVENTIONS PROCEDURES

10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE

- (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 engagement skills that are alternatives to injurious behavior to self or others;
 - (3) providing choices of activities meaningful to the clients served/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.

*History Note: Authority G.S. 122C-51; 122C-53; 143B-147;
Eff. February 1, 1991;
Amended Eff. January 1, 1992;
Temporary Amendment Eff. January 1, 2001;
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10A NCAC 27E .0102 PROHIBITED PROCEDURES

In each facility the following types of procedures shall be prohibited:

- (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;
 - (f) unpleasant tasting foodstuffs;
 - (g) contingent application of any noxious substances which include but are not limited to noise, bad smells or splashing with water; and
 - (h) any potentially physically painful procedure, excluding prescribed injections, or stimulus which is administered to the client for the purpose of reducing the frequency or intensity of a behavior.
- (2) those interventions determined by the governing body to be unacceptable for or prohibited from use in the facility.

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10A NCAC 27E .0103 GENERAL POLICIES REGARDING INTERVENTION PROCEDURES

- (a) The following procedures shall only be employed when clinically or medically indicated as a method of therapeutic treatment:
- (1) planned non-attention to specific undesirable behaviors when those behaviors are health threatening;
 - (2) contingent deprivation of any basic necessity; or
 - (3) other professionally acceptable behavior modification procedures that are not prohibited by Rule .0102 of this Section or covered by Rule .0104 of this Section.
- (b) The determination that a procedure is clinically or medically indicated, and the authorization for the use of such treatment for a specific client, shall only be made by either a physician or a licensed practicing psychologist who has been formally trained and privileged in the use of the procedure.

History Note: Authority G.S. 122C-51; 122C-53; 122C-60; 122C-62; 131E-67; 143B-147; Eff. February 1, 1991; Amended Eff. January 1, 1992; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 26, 2017.

10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL

- (a) This Rule governs the use of restrictive interventions which shall include:
- (1) seclusion;
 - (2) physical restraint;
 - (3) isolation time-out
 - (4) any combination thereof; and
 - (5) protective devices used for behavioral control.
- (b) The use of restrictive interventions shall be limited to:
- (1) emergency situations, in order to terminate a behavior or action in which a client is in imminent danger of abuse or 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
 - (2) as a planned measure of therapeutic treatment as specified in Paragraph (f) of this Rule.
- (c) Restrictive interventions shall not be employed as a means of coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions shall not be used in a manner that causes harm or abuse.
- (d) In accordance with Rule .0101 of Subchapter 27D, the governing body shall have policy that delineates the permissible use of restrictive interventions within a facility.
- (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions:
- (1) the requirement that positive and less restrictive alternatives are considered and attempted whenever possible prior to the use of more restrictive interventions;
 - (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 client's 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 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 by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being during the use of manual restraint; and
 - (D) continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention;
 - (3) the process for identifying, training, assessing competence of facility employees who may authorize and implement restrictive interventions;
 - (4) the duties and responsibilities of responsible professionals regarding the use of restrictive interventions;
 - (5) the person responsible for documentation when restrictive interventions are used;
 - (6) the person responsible for the notification of others when restrictive interventions are used; and
 - (7) the person responsible for checking the client's physical and psychological well-being and assessing the possible consequences of the use of a restrictive intervention and, in such cases there shall be procedures regarding:
 - (A) documentation if a client has a physical disability or has had surgery that would make affected nerves and bones sensitive to injury; and
 - (B) the identification and documentation of alternative emergency procedures, if needed;
 - (8) any room used for seclusion or isolation time-out shall meet the following criteria:

- (A) the room shall be designed and constructed to ensure the health, safety and well-being of the client;
 - (B) the floor space shall not be less than 50 square feet, with a ceiling height of not less than eight feet;
 - (C) the floor and wall coverings, as well as any contents of the room, shall have a one-hour fire rating and shall not produce toxic fumes if burned;
 - (D) the walls shall be kept completely free of objects;
 - (E) a lighting fixture, equipped with a minimum of a 75 watt bulb, shall be mounted in the ceiling and be screened to prevent tampering by the client;
 - (F) one door of the room shall be equipped with a window mounted in a manner which allows inspection of the entire room;
 - (G) glass in any windows shall be impact resistant and shatterproof;
 - (H) the room temperature and ventilation shall be comparable and compatible with the rest of the facility; and
 - (I) in a lockable room the lock shall be interlocked with the fire alarm system so that the door automatically unlocks when the fire alarm is activated if the room is to be used for seclusion.
- (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum:
- (A) notation of the client's physical and psychological well-being;
 - (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior;
 - (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used;
 - (D) a description of the intervention and the date, time and duration of its use;
 - (E) a description of accompanying positive methods of intervention;
 - (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions;
 - (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and
 - (H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.
- (10) The emergency use of restrictive interventions shall be limited, as follows:
- (A) a facility employee approved to administer emergency interventions may employ such procedures for up to 15 minutes without further authorization;
 - (B) the continued use of such interventions shall be authorized only by the responsible professional or another qualified professional who is approved to use and to authorize the use of the restrictive intervention based on experience and training;
 - (C) the responsible professional shall meet with and conduct an assessment that includes the physical and psychological well-being of the client and write a continuation authorization as soon as possible after the time of initial employment of the intervention. If the responsible professional or a qualified professional is not immediately available to conduct an assessment of the client, but concurs that the intervention is justified after discussion with the facility employee, continuation of the intervention may be verbally authorized until an on-site assessment of the client can be made;
 - (D) a verbal authorization shall not exceed three hours after the time of initial employment of the intervention; and
 - (E) each written order for seclusion, physical restraint or isolation time-out 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 or up to a total of 24 hours.
- (11) The following precautions and actions shall be employed whenever a client is in:
- (A) seclusion or physical restraint, including a protective device when used for the purpose or with the intent of controlling unacceptable behavior: periodic observation of the client shall

- occur at least every 15 minutes, or more often as necessary, to assure the safety of the client, attention shall be paid to the provision of regular meals, bathing and the use of the toilet; and such observation and attention shall be documented in the client record;
- (B) isolation time-out: there shall be a facility employee in attendance with no other immediate responsibility than to monitor the client who is placed in isolation time-out; there shall be continuous observation and verbal interaction with the client when appropriate; and such observation shall be documented in the client record; and
 - (C) physical restraint and may be subject to injury: a facility employee shall remain present with the client continuously.
- (12) The use of a restrictive intervention shall be discontinued immediately at any indication of risk to the client's health or safety or immediately after the client gains behavioral control. If the client is unable to gain behavioral control within the time frame specified in the authorization of the intervention, a new authorization must be obtained.
 - (13) The written approval of the designee of the governing body shall be required when the original order for a restrictive intervention is renewed for up to a total of 24 hours in accordance with the limits specified in Item (E) of Subparagraph (e)(10) of this Rule.
 - (14) Standing orders or PRN orders shall not be used to authorize the use of seclusion, physical restraint or isolation timeout.
 - (15) The use of a restrictive intervention shall be considered a restriction of the client's rights as specified in G.S. 122C-62(b) or (d). The documentation requirements in this Rule shall satisfy the requirements specified in G.S. 122C-62(e) for rights restrictions.
 - (16) When any restrictive intervention is utilized for a client, notification of others shall occur as follows:
 - (A) those to be notified as soon as possible but within 24 hours of the next working day, to include:
 - (i) the treatment or habilitation team, or its designee, after each use of the intervention; and
 - (ii) a designee of the governing body; and
 - (B) the legally responsible person of a minor client or an incompetent adult client shall be notified immediately unless she/he has requested not to be notified.
 - (17) The facility shall conduct reviews and reports on any and all use of restrictive interventions, including:
 - (A) a regular review by a designee of the governing body, and review by the Client Rights Committee, in compliance with confidentiality rules as specified in 10A NCAC 28A;
 - (B) an investigation of any unusual or possibly unwarranted patterns of utilization; and
 - (C) documentation of the following shall be maintained on a log:
 - (i) name of the client;
 - (ii) name of the responsible professional;
 - (iii) date of each intervention;
 - (iv) time of each intervention;
 - (v) type of intervention;
 - (vi) duration of each intervention;
 - (vii) reason for use of the intervention;
 - (viii) positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used;
 - (ix) debriefing and planning conducted with the client, legally responsible person, if applicable, and staff, as specified in Parts (e)(9)(F) and (G) of this Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and
 - (x) negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client.
 - (18) 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:
 - (A) the type of procedure used and the length of time employed;
 - (B) alternatives considered or employed; and
 - (C) 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 upon request.

- (19) Nothing in this Rule shall be interpreted to prohibit the use of voluntary restrictive interventions at the client's request; however, the procedures in this Rule shall apply with the exception of Subparagraph (f)(3) of this Rule.
- (f) The restrictive intervention shall be considered a planned intervention and shall be included in the client's treatment/habilitation plan whenever it is used:
- (1) more than four times, or for more than 40 hours, in a calendar month;
 - (2) in a single episode in which the original order is renewed for up to a total of 24 hours in accordance with the limit specified in Item (E) of Subparagraph (e)(10) of this Rule; or
 - (3) as a measure of therapeutic treatment designed to reduce dangerous, aggressive, self-injurious or undesirable behaviors to a level which will allow the use of less restrictive treatment or habilitation procedures.
- (g) When a restrictive intervention is used as a planned intervention, facility policy shall specify:
- (1) the requirement that a consent or approval shall be considered valid for no more than six months and that the decision to continue the specific intervention shall be based on clear and recent behavioral evidence that the intervention is having a positive impact and continues to be needed;
 - (2) prior to the initiation or continued use of any planned intervention, the following written notifications, consents and approvals shall be obtained and documented in the client record:
 - (A) approval of the plan by the responsible professional and the treatment and habilitation team, if applicable, shall be based on an assessment of the client and a review of the documentation required by Subparagraph (e)(9) and (e)(14) of this Rule if applicable;
 - (B) consent of the client or legally responsible person, after participation in treatment planning and after the specific intervention and the reason for it have been explained in accordance with 10A NCAC 27D .0201;
 - (C) notification of an advocate/client rights representative that the specific intervention has been planned for the client and the rationale for utilization of the intervention; and
 - (D) physician approval, after an initial medical examination, when the plan includes a specific intervention with reasonably foreseeable physical consequences. In such cases, periodic planned monitoring by a physician shall be incorporated into the plan.
 - (3) within 30 days of initiation of the use of a planned intervention, the Intervention Advisory Committee established in accordance with Rule .0106 of this Section, by majority vote, may recommend approval or disapproval of the plan or may abstain from making a recommendation;
 - (4) within any time during the use of a planned intervention, if requested, the Intervention Advisory Committee shall be given the opportunity to review the treatment/habilitation plan;
 - (5) if any of the persons or committees specified in Subparagraphs (h)(2) or (h)(3) of this Rule do not approve the initial use or continued use of a planned intervention, the intervention shall not be initiated or continued. Appeals regarding the resolution of any disagreement over the use of the planned intervention shall be handled in accordance with governing body policy; and
 - (6) documentation in the client record regarding the use of a planned intervention shall indicate:
 - (A) description and frequency of debriefing with the client, legally responsible person, if applicable, and staff if determined to be clinically necessary. Debriefing shall be conducted as to the level of cognitive functioning of the client;
 - (B) bi-monthly evaluation of the planned by the responsible professional who approved the planned intervention; and
 - (C) review, at least monthly, by the treatment/habilitation team that approved the planned intervention.

History Note: Authority G.S. 122C-51; 122C-53; 122C-60; 122C-62; 131E-67; 143B-147; Eff. February 1, 1991; Amended Eff. January 4, 1993; January 1, 1992; 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. March 26, 2017.

10A NCAC 27E .0105 PROTECTIVE DEVICES

(a) Whenever a protective device is utilized for a client, the governing body shall develop and implement policy to ensure that:

- (1) the necessity for the protective device has been assessed and the device is applied by a facility employee who has been trained and has demonstrated competence in the utilization of protective devices;
- (2) the use of positive and less restrictive alternatives have been reviewed and documented and the protective device selected is the appropriate measure;
- (3) the client is frequently observed and provided opportunities for toileting, exercise, etc. as needed. When a protective device limits the client's freedom of movement, the client shall be observed at least every hour. Whenever the client is restrained and subject to injury by another client, a facility employee shall remain present with the client continuously. Observations and interventions shall be documented in the client record;
- (4) protective devices are cleaned at regular intervals; and
- (5) for facilities operated by or under contract with an area program, the utilization of protective devices in the treatment/habilitation plan shall be subject to review by the Client Rights Committee, as required in 10A NCAC 27G .0504. Copies of this Rule and other pertinent rules are published as Division publication RULES FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES, APSM 30-1, and may be purchased at a cost of five dollars and seventy-five cents (\$5.75) per copy.

(b) The use of any protective device for the purpose or with the intent of controlling unacceptable behavior shall comply with the requirements of Rule .0104 of this Section.

History Note: Authority G.S. 122C-51; 122C-53; 122C-60; 143B-147; Eff. February 1, 1991; Amended Eff. January 4, 1993; January 1, 1992; 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. March 26, 2017.

10A NCAC 27E .0106 INTERVENTION ADVISORY COMMITTEES

(a) An Intervention Advisory Committee shall be established to provide additional safeguards in a facility that utilizes restrictive interventions as planned interventions as specified in Rule .0104(g) of this Section.

(b) The membership of the Intervention Advisory Committee shall include at least one person who is or has been a consumer of direct services provided by the governing body or who is a close relative of a consumer and:

- (1) for a facility operated by an area program, the Intervention Advisory Committee shall be the Client Rights Committee or a subcommittee of it, which may include other members;
- (2) for a facility that is not operated by an area program, but for which a voluntary client rights or human rights committee has been appointed by the governing body, the Intervention Advisory Committee shall be that committee or a subcommittee of it, which may include other members; or
- (3) for a facility that does not meet the conditions of Subparagraph (b)(1) or (2), the committee shall include at least three citizens who are not employees of, or members of the governing body.

(c) The Intervention Advisory Committee specified in Subparagraphs (b)(2) or (3) shall have a member or a regular independent consultant who is a professional with training and expertise in the use of the type of interventions being utilized, and who is not directly involved in the treatment or habilitation of the client.

(d) The Intervention Advisory Committee shall:

- (1) have policy that governs its operation and requirements that:
 - (A) access to client information shall be given only when necessary for committee members to perform their duties;
 - (B) committee members shall have access to client records on a need to know basis only upon the written consent of the client or his legally responsible person as specified in G.S. 122C-53(a); and
 - (C) information in the client record shall be treated as confidential information in accordance with G.S. 122C-52 through 122C-56;
- (2) receive specific training and orientation as to the charge of the committee;
- (3) be provided with copies of appropriate statutes and rules governing client rights and related issues;

- (4) be provided, when available, with copies of literature about the use of a proposed intervention and any alternatives;
- (5) maintain minutes of each meeting; and
- (6) make an annual written report to the governing body on the activities of the committee.

History Note: Authority G.S. 122C-51 through 122C-56; 143B-147; Eff. February 1, 1991; Amended Eff. January 1, 1992; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 26, 2017.

10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS

- (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.
- (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 property damage 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 must be completed by each service provider periodically (minimum annually).
- (f) Content of the training that the service provider wishes to employ must 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 persons with disabilities;
 - (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;
 - (6) recognizing the importance of and assisting in the person's involvement 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 review/request 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 restrictive interventions.
 - (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 are not 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 restrictive interventions at least one time, with positive review by the coach.
- (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions 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.
 - (2) The Division of MH/DD/SAS may request and review this documentation 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;
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10A NCAC 27E .0108 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 and have demonstrated competence at least annually.
- (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 pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.
- (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 must be completed by each service provider periodically (minimum annually).
- (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
- (g) Acceptable training programs shall include, but are not limited to, presentation of:
 - (1) refresher information on alternatives to the use of restrictive interventions;
 - (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 restrictive interventions;
 - (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 their importance and purpose; and
 - (8) documentation methods/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 review/request this documentation at any time.
- (i) Instructor Qualification 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 restrictive interventions.
 - (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.
 - (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 (j)(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 restrictive interventions at least two times with a positive review by the coach.
 - (10) Trainers shall teach a program on the use of restrictive interventions at least once annually.
 - (11) Trainers shall complete a refresher instructor training at least every two years.
- (k) 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 review/request this documentation at any time.
 - (l) 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.
 - (m) Documentation shall be the same preparation as for trainers.

*History Note: Authority G.S. 143B-147;
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 Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 26, 2017.*