SUBCHAPTER 26D - NORTH CAROLINA DEPARTMENT OF CORRECTION: STANDARDS FOR MENTAL HEALTH AND MENTAL RETARDATION

SECTION .0100 - SCOPE AND DEFINITIONS

10A NCAC 26D .0101 SCOPE

This Subchapter sets forth standards for the delivery of mental health and mental retardation services to inmates in the custody of the Department of Correction. These standards shall apply to such services provided to inmates by the Department or by any other provider of services on a contractual basis.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0102 REQUIRED SERVICES

(a) The Department shall provide or contract for mental health and mental retardation services.
(b) Such services, which address the needs of the client as assessed by a clinician, shall include, but need not be limited to:

(1) emergency;
(2) prevention;
(3) outpatient;
(4) residential; and
(5) inpatient.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0103 DEFINITIONS

For the rules contained in this Subchapter, the following definitions apply:

(1) "Administering medication" means direct application of a medication whether by injection, inhalation, ingestion, or any other means to the client.
(2) "Admission" means acceptance of an inmate for mental health and mental retardation services in accordance with Department procedures.
(3) "Area" means one of the six geographic catchment areas designated by the Department for administrative purposes.
(4) "Area program" means a public agency providing mental health, developmental disabilities and substance abuse services for a catchment area designated by the Commission for Mental Health, Developmental Disabilities and Substance Abuse Services.
(5) "Chief of Mental Health Services" means the individual who is responsible for the development, provision and monitoring of mental health and mental retardation services in the Department's Division of Prisons. His duties include ensuring compliance with statutory and professional standards for services.
(6) "Client" means an inmate who is admitted to and is receiving mental health or mental retardation services.
(7) "Client care evaluation study" means evaluation of the quality of services by measuring actual services against specific criteria through collection of data, identification and justification of variations from criteria, analysis of unjustified variations, corrective action, and follow-up study.
(8) "Client record" means a written account of all mental health and mental retardation services provided to an inmate from the time of acceptance of the inmate as the client until termination of services. This information is documented on standard forms which are filed in a standard order in an identifiable folder.
(9) "Clinician" means a psychiatrist, physician, or psychologist.
(10) "Commission" means the Commission for Mental Health, Developmental Disabilities and Substance Abuse Services, established under Part 4 of Article 3 of G.S. 143B.

(11) "Contract agency" means an entity with which the Department contracts for a service as defined in the standards exclusive of intermittent purchase of service for an individually identified client.
(12) "Department" means the Department of Correction.
(13) "DHR" means the Department of Health and Human Services.
(14) "DHR review team" means the staff delegated by the Department of Health and Human Services to monitor the implementation of standards in accordance with the provisions of G.S. 148-19(d).
(15) "Direct care staff" means staff who provide care, treatment, or habilitation services to the client on a continual and regularly scheduled basis.
(16) "Disability group" means two or more inmates who are either mentally ill or mentally retarded.
(17) "Discharge" means the termination of mental health or mental retardation services to the client.
(18) "Dispensing medication" means issuing for the client one or more unit doses of a medication in a suitable container with appropriate labeling.
(19) "Documentation" means provision of written, dated and authenticated evidence of the delivery of services to the client or compliance with standards.
(20) "Emergency service" means a service which is provided on a 24-hour, non-scheduled basis to inmates for immediate screening and assessment of presenting problems. Crisis intervention and referral to other services are provided as indicated.
(21) "Facility" means the physical area where mental health or mental retardation services are provided, including both buildings and grounds, under the auspices of the Department.
(22) "Habilitation" means education, training, care and specialized therapies undertaken to assist a mentally retarded client in achieving or maintaining progress in developmental skills.
(23) "Habilitation plan" means an individualized, written plan for the client who is mentally retarded which includes measurable, time-specific objectives based on evaluations, observations, and other assessment data. The plan is based on the strengths and needs of the client and identifies specific staff responsibilities for implementation of the plan.
(24) "Health professional" means a staff member trained in the delivery of medical or mental health services.
(25) "Inmate" means an incarcerated individual who remains in the custody of the Department.
(26) "Inpatient service" means a service provided on a 24-hour basis. Client care is provided under the clinical direction of a physician or doctoral level psychologist. The service provides continuous, close supervision for the client with moderate to severe mental health problems.
(27) "Legend drug" means a drug that must be dispensed with a prescription.
(28) Medication" means a substance in the official "United States Pharmacopoeia" or "National Formulary" intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease or intended to affect the structure or any function of the body.
(29) "Mental health program director" means the individual who is responsible for the operation of mental health and mental retardation services for inmates.
(30) "Mental illness" means the term as defined in G.S. 122C-3.
(31) "Mental retardation" means the term as defined in G.S. 122C-3.
(32) "Nurse" means a person licensed to practice in the State of North Carolina either as a registered nurse or as a licensed practical nurse.
(33) "Officer in charge" means the correctional officer who has designated responsibility for the custody and safekeeping of inmates in the facility.
(34) "Outpatient service" means a service designed to meet the diagnostic and therapeutic needs of the client residing with the regular inmate population. Individual counseling, psychotherapy, extended testing and evaluation, and medication therapy are provided as needed.
(35) "Peer review" means the formal assessment by professional staff of the quality and efficiency of services ordered or performed by other professional staff.
(36) "Physician" means a medical doctor who is licensed to practice medicine in the State of North Carolina.
(37) "Prevention service" means a service provided to the prison population. Service activities include counseling, information, instruction, and technical assistance with the goals of preventing dysfunction and promoting well being.
(38) "Privileging" means a process by which each staff member's credentials, training and experience are examined and a determination made as to which treatment or habilitation modalities the staff member is qualified to provide.

(39) "Program evaluation" means the systematic documented assessment of program objectives to determine the effectiveness, efficiency, and scope of the system under investigation, to define its strengths and weaknesses and thereby to provide a basis for informed decision-making.

(40) "Protective device" means an intervention that provides support for a medically fragile client or enhances the safety of the client with self-injurious behavior. Such device may include geri-chairs or table top chairs to provide support and safety for the client with a major physical handicap; devices such as seizure helmets or helmets and mittens for self-injurious behaviors; or a device such as soft ties used to prevent a medically ill client from removing intravenous tubes, indwelling catheters, cardiac monitor electrodes, or similar medical devices.

(41) "Psychiatric nurse" means an individual who is licensed to practice as a registered nurse in the State of North Carolina by the North Carolina Board of Nursing and who is a graduate of an accredited master's level program in psychiatric mental health nursing with two years of nursing experience, or has a master's degree in behavioral science with two years of supervised clinical experience, or has four years of experience in psychiatric mental health nursing.

(42) "Psychiatrist" means a physician who is licensed to practice medicine in the State of North Carolina and who has completed an accredited training program in psychiatry.

(43) "Psychologist" means an individual who is licensed as a practicing psychologist or a psychological associate in the State of North Carolina or one exempt from licensure requirements who meets the supervision requirements of the North Carolina Board of Examiners of Practicing Psychologists as specified in 21 NCAC 54 .2000.

(44) "Psychotherapy" means a form of treatment of mental illness or emotional disorder which is based primarily upon verbal interaction with the client. Treatment is provided by a trained professional for the purpose of removing or modifying existing symptoms, of attenuating or reversing disturbed patterns of behavior, and of promoting positive personality growth and development.

(45) "Psychotropic medication" means medication given with the primary intention of treating mental illness. These medications include, but are not limited to, antipsychotics, antidepressants, minor tranquilizers and lithium.

(46) "Qualified mental health professional" means any one of the following: psychiatrist; psychiatric nurse; psychologist; psychiatric social worker; an individual with a master's degree in a related human service field and two years of supervised clinical experience in mental health services; or an individual with a baccalaureate degree in a related human service field and four years of supervised clinical experience in mental health services.

(47) "Qualified mental retardation professional" means an individual who holds at least a baccalaureate degree in a discipline related to developmental disabilities and who has at least one year of experience in working with mentally retarded clients.

(48) "Qualified professional" means a qualified mental health professional or a qualified mental retardation professional.

(49) "Qualified record manager" means an individual who is a graduate of a curriculum accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association and the Council on Education of the American Health Information Management Association and who is currently registered or accredited by the American Health Information Management Association.

(50) "Quality assurance" means a process for objectively and systematically monitoring and evaluating the quality, appropriateness, and effectiveness of mental health and mental retardation services provided and the degree to which those services meet the identified needs and intended goals for the client.

(51) "Release" means the completion of an inmate's active sentence and return to the community.

(52) "Research" means inquiry involving a trial or special observation made under conditions determined by the investigator to confirm or disprove a hypothesis, or to explicate some principle or effect.

(53) "Residential service" means a service provided in a designated treatment setting where 24-hour supervision is an integral part of the care, treatment, habilitation or rehabilitation provided to the client.

(54) "Responsible clinician" means the psychologist, psychiatrist, or physician designated as responsible for the client's treatment. This may include a clinician designated as on-call for the facility.

(55) "Restraint" means limitation of the client's freedom of movement with the intent of controlling behavior by mechanical devices which include, but are not limited to, cuffs, ankle straps, or sheets. For purposes of these Rules, restraint is a therapeutic modality and does not include protective devices used for medical conditions or to assist a non-ambulatory client to maintain a normative body position, or devices used for security purposes.

(56) "Seclusion" means isolating the client in a separate locked room or a room from which he cannot exit for the purpose of controlling the client's behavior. For purposes of these Rules, seclusion is a therapeutic modality and does not include segregation for administrative purposes.

(57) "Service" means an activity or interaction intended to benefit an individual who is in need of assistance, care, habilitation, intervention, rehabilitation or treatment.

(58) "Service delivery site" means any area, correctional institution, residential unit, or inpatient unit operated by the Department where mental health and mental retardation services are provided.

(59) "Social worker" means an individual who holds a master's degree in social work from an accredited school of social work and has two years of clinical social work experience in a mental health setting or who is a clinical social worker certified by the North Carolina Certification Board for Social Work.

(60) "Standards" means minimum standards for the delivery of mental health and mental retardation services to clients, prescribed by the Commission for Mental Health, Developmental Disabilities and Substance Abuse Services and codified in 10A NCAC 26D .0100 through .1600.

(61) "State facility" means a facility operated by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and which provides mental health, mental retardation or substance abuse services.

(62) "Support service" means a service provided to enhance the client's progress in his primary treatment or habilitation program.

(63) "Testing services" means the administration and interpretation of the results of standardized instruments for the assessment, diagnosis or evaluation of psychological or developmental disorders.

(64) "Treatment" means the process of providing for the physical, emotional, psychological, and social needs of the client through services.

(65) "Treatment plan" means an individualized, written plan of treatment for a mentally ill client. The plan contains time-specific goals and strategies for implementing the goals, and identifies direct care staff responsible for the provision of treatment services to the client.

(66) "Waiver" means a situation in which the Commission determines that a specific prison site is not required to comply with a specific standard. A waiver is granted according to the provisions of 10A NCAC 27G .0800.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .0200 - ORGANIZATIONAL RESPONSIBILITIES

10A NCAC 26D .0201 COORDINATION AND DELIVERY OF SERVICES

The Department shall develop and implement a plan to ensure coordination in the delivery of all mental health and mental retardation services.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0202 ORGANIZATIONAL CHART

The organizational chart of the Department shall clearly articulate the channels of responsibility in implementing and ensuring the coordination of mental health and mental retardation services.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0203 DISTRIBUTION OF STANDARDS

The Department shall distribute to all service delivery sites adequate copies of the rules of this Subchapter and any subsequent revisions to these Rules as they occur.

History Note: *Authority G.S. 148-19(d);*

Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0204 COMPLIANCE WITH RULES
(a) The Department shall conduct an annual internal evaluation of compliance with Commission standards in each service delivery site.
(b) The evaluation report shall be made available to the DHHS review team.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0205 GRIEVANCE RULE
The Department shall develop and implement a rule which identifies procedures for review and disposition of grievances regarding mental health and mental retardation services.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .0300 - REQUIRED STAFF

10A NCAC 26D .0301 PSYCHIATRIST
Each service delivery site shall employ, or contract for, the services of a psychiatrist to ensure the client's accessibility to services which require the judgment and expertise of a psychiatrist.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0302 PSYCHOLOGIST
Each service delivery site shall employ, or contract for, the services of a psychologist to ensure the client's accessibility to services which require the judgment and expertise of a psychologist.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0303 REGISTERED NURSE
Each service delivery site shall employ, or contract for, a registered nurse to ensure that the client is given the nursing care that requires the judgment and specialized skills of a registered nurse.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0304 SOCIAL WORKER
Unless exempted by the Chief of Mental Health Services based on size and mission of the facility, each service delivery site shall employ, or contract for, social work staff to ensure the client's accessibility to services which require the knowledge and expertise of a social worker.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0305 SUPPORT STAFF

Each service delivery site shall have support staff to ensure the delivery of mental health and mental retardation services to clients. This includes, but need not be limited to, clerical staff.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .0400 - ORGANIZATIONAL RELATIONS

10A NCAC 26D .0401 COORDINATION OF SERVICES

The Department shall develop and implement procedures to facilitate cooperative working relationships between the staff of mental health and mental retardation services, custody personnel, and other service staff to facilitate the provision of services for inmates who are mentally ill or mentally retarded.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0402 INFORMATION AND OUTREACH SERVICES

The Department shall provide, to correctional staff, information designed to promote awareness of mental health and mental retardation services available to inmates within the Department.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0403 AGREEMENT WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Department shall have a written agreement with the Department of Health and Human Services regarding mutual responsibilities for mental health and mental retardation services to inmates under Department supervision.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .0500 - QUALITY ASSURANCE

10A NCAC 26D .0501 SCOPE

(a) Quality assurance shall be a continuing responsibility of the Department and each service delivery site that offers mental health and mental retardation services.
(b) Quality assurance activities shall include, but need not be limited to:
- (1) clinical and professional supervision and privileging;
- (2) client care evaluation studies;
- (3) record review;
- (4) utilization and peer review;
- (5) employee education and training;
- (6) program evaluation; and
- (7) evidence of corrective action.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0502 QUALITY ASSURANCE PLAN

(a) The Department shall establish and implement a written quality assurance plan for mental health and mental retardation services that describes how quality assurance activities will be carried out.
(b) Quality assurance activities shall include, but need not be limited to, the following:

(1) an objective and systematic process for monitoring and evaluating the quality and appropriateness of client care, incorporating a review of significant incidents, which may include but need not be limited to, suicides, sudden deaths, and major assaults;
(2) a written plan of professional and clinical supervision describing such activities and how they shall be carried out;
(3) the establishment and implementation of program evaluation activities;
(4) the strategies for improving client care; and
(5) evidence of corrective action.

(c) The plan shall be reviewed annually, and may be revised at any time by the Department.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0503 QUALITY ASSURANCE COMMITTEE

(a) The Department shall have a quality assurance committee which shall be comprised of:
(1) representation from mental health and mental retardation service areas;
(2) a qualified record manager;
(3) a nurse;
(4) a psychologist;
(5) a psychiatrist; and
(6) a social worker.

(b) The purpose, scope and organization of the quality assurance committee shall be specified in the quality assurance plan, which shall include, but need not be limited to the following:
(1) the committee shall meet at least monthly;
(2) a member shall not review his own client's treatment or habilitation record; and
(3) minutes of meetings shall be recorded and shall include, but need not be limited to:
(A) date, time, attendees and absentees; and
(B) a summary of the business which was conducted.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0504 CLIENT CARE EVALUATION STUDIES

The quality assurance committee shall ensure that at least one client care evaluation study of issues, relevant to the improvement of services to clients, is completed during each fiscal year.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0505 CLIENT RECORD REVIEW

The quality assurance committee shall establish, implement and document the criteria, procedure and methodology for client record reviews for completeness and adequacy, as delineated in Section .0700 of these Rules.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0506 SUPERVISION OF MENTAL HEALTH AND MENTAL RETARDATION STAFF

(a) The Department shall implement a written plan of supervision for staff who are not qualified mental health or mental retardation professionals, as defined in Rule .0103 of this Subchapter, and who provide mental health or mental retardation services.

(b) The Department shall ensure that:

(1) each mental health staff member who provides services, and who is not qualified in that service area, shall have an individual contract of supervision with a qualified mental health professional; and
(2) each mental retardation staff member shall be supervised by, or have access to, the professional supervision of a qualified mental retardation professional.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0507 PRIVILEGING OF ALL PROFESSIONAL STAFF

(a) The Department shall ensure that the qualifications of each mental health and mental retardation professional are examined, and a determination is made as to treatment or habilitation privileges granted and supervision needed.
(b) Delineation of privileges shall be based on documented verification of the individual's competence, training, experience and licensure.
(c) The privileging process shall be reviewed and approved by the Department's quality assurance committee.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0508 EMPLOYEE EDUCATION AND TRAINING

(a) The Department shall:
(1) provide or secure orientation programs and annual continuing education and training for employees to enhance their competencies and knowledge needed to administer, manage, and deliver quality mental health and mental retardation services; and
(2) assure the maintenance of an ongoing record of all education and training activities provided or secured for employees.
(b) The education and training activities shall:
(1) address, at a minimum, the needs identified by the quality assurance process and related committees; and
(2) as deemed necessary by the Department, be provided at no expense to staff.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0509 PROGRAM EVALUATION ACTIVITIES

(a) The Department shall implement program evaluation activities.
(b) These activities shall reflect the evaluation of program quality, effectiveness and efficiency in such areas as the:
(1) impact of the program in reducing readmissions;
(2) availability and accessibility of services;
(3) impact of services upon the clients within the service area;
(4) patterns of use of service; and
(5) cost of the program operation.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0510 QUALITY ASSURANCE ANNUAL REPORT

(a) The Department shall make available, to the DHHS review team, a written annual report summarizing the activities and recommendations of the quality assurance committee.
(b) This report shall include, at a minimum, the following functional areas:
(1) client care evaluation studies;
(2) client record reviews;
(3) utilization and peer reviews;

(4) clinical supervision;
(5) employee education and training activities; and
(6) the results of program evaluation.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .0600 - FACILITIES MANAGEMENT

10A NCAC 26D .0601 SCOPE

The rules in this Section apply to each service delivery site within the Department and to any other provider of services on a contractual basis.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0602 BUILDINGS AND GROUNDS

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule expired July 1, 2015.

10A NCAC 26D .0603 SPACE REQUIREMENTS

(a) Space shall be provided to facilitate the delivery of mental health and mental retardation services.
(b) Each client in an inpatient mental health unit shall be housed in a single cell.
(c) Each client in a residential treatment program shall have a minimum of 50 square feet of living space; e.g., if two clients are housed in the living space, the minimum shall be 100 square feet.
(d) Each service delivery site shall have private space for interviews and conferences with clients.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0604 ADDITIONAL REQUIREMENTS FOR RESIDENTIAL/INPATIENT UNITS

(a) Each residential and inpatient unit providing mental health or mental retardation services shall have indoor space for group activities and gatherings.
(b) The space in which therapeutic and habilitative activities are routinely conducted shall be separate from sleeping areas.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .0700 - CLIENT RECORDS

10A NCAC 26D .0701 SCOPE

(a) The rules in this Section apply to each service delivery site and to any other provider of services on a contractual basis, unless otherwise specified in this Section.
(b) This Section applies to the management of client information which is generated by a service delivery site during the period of time that treatment or habilitation services are rendered to clients.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0702 STANDARD CLIENT RECORD

(a) The Department shall develop and maintain a standard client record for each client who receives mental health or mental retardation treatment or habilitation services.

(b) The same forms and filing format shall be utilized within each disability.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0703 RECORD REQUIREMENTS

(a) A written client record shall be maintained for each client, and shall contain, at a minimum, the following identifying information:

(1) name;
(2) record number;
(3) date of birth;
(4) race, sex, and marital status;
(5) admission date; and
(6) discharge date.

(b) Active outpatient client records shall be kept in the outpatient health record and filed at the client's assigned unit.

(c) Each inpatient program shall maintain active inpatient records which shall be kept separate from the outpatient records.

(d) The outpatient record shall be transferred to the inpatient unit.

(e) Information required in other rules in this Subchapter, including but not limited to, prescribing and administering medication, and seclusion and restraint shall be documented in the client record.

(f) All client record entries shall include the date of entry and authentication by the individual making the entry.

(g) The time of service shall be recorded, based upon the nature of the service or incident, such as, shift notes, medication administration, and accidents and injuries.

(h) All client record entries shall be legible and made in permanent ink or typewritten.

(i) Alterations in client records, which are necessary in order to correct recording errors or inaccuracies, shall:

(1) be made by the individual who recorded the entry;
(2) have a single, thin line drawn through the error or inaccurate entry with the original entry still legible;
(3) show the corrected entry legibly recorded above or near the original entry;
(4) show the type of documentation error or inaccuracy whenever the reason for the alteration is unclear; and
(5) include the date of correction and initials of recorder.

(j) Each page of the client record shall include the client's name and number.

(k) Client records shall include only those symbols and abbreviations contained in an abbreviation list approved by the Department.

(l) Notations in a client's record shall not identify another client by name.

(m) Each service delivery site shall designate, in writing, those individuals authorized to have access to client records and who may make entries in the record.

(n) Any additional information regarding the following shall be included in the client record:

(1) diagnostic tests, assessments, evaluation, consultations, referrals, support services or medical services provided;
(2) known allergies or hypersensitivities;
(3) major events, accidents or medical emergencies, involving the client;
(4) consent for, and documentation of, release of information;
(5) documentation of applied behavior modification, which includes at risk or other intrusive interventions, including authorization, duration, summaries of observation and justification;
(6) conferences or involvements with the client's family, significant others, or involved agencies or service providers;
(7) documentation of attendance in outpatient service; and
(8) results of any standardized and non-standardized evaluations, such as social, developmental, medical, psychological, vocational or educational.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0704 CONFIDENTIALITY OF CLIENT RECORD

(a) All information contained in the client record shall be considered privileged and confidential, with the exception of matters of public record, as set forth in 5 NCAC 02D .0600.
(b) The Department shall ensure confidentiality of client records during their use, transportation, and storage.
(c) The Department shall ensure that information contained in client records is released upon the written authorization of the client, in accordance with other Department Rules, or as set forth in the provisions of G.S. 122C-55(c).
(d) Employees governed by the State Personnel Act, G.S. 126, are subject to suspension, dismissal or disciplinary action for failure to comply with the rules in this Subchapter.
(e) The Department shall inform all employees, students, volunteers, and all other individuals with access to confidential information, the provisions of the rules in this Subchapter. Such individuals with access to confidential information shall sign a statement of understanding and compliance.
(f) Records shall be protected against loss, tampering, or use by unauthorized persons.
(g) Records shall be readily accessible to authorized users at all times.
(h) When consent for release of information is obtained, a time-limited consent, not to exceed one year, shall be utilized.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0705 DIAGNOSTIC CODING

The Department shall code diagnoses for clients using the following diagnostic systems:

(1) Mental illness or mental retardation shall be diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition - Revised (DSM-IV-R).
(2) Physical disorders shall be diagnosed according to Interational Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0706 CLIENT RECORD AVAILABILITY

The Department shall ensure that client records are available to professional staff for a minimum of three years following the inmate's release. This shall apply to previous incarcerations.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .0800 - SERVICE ELIGIBILITY

10A NCAC 26D .0801 SCOPE

The rules in this Section apply to each service delivery site within the Department and to any other provider of services on a contractual basis.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0802 SERVICE CRITERIA

The Department shall ensure the development of service criteria for mental health and mental retardation services. These criteria shall be communicated to inmates and staff.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0803 SCREENING

The Department shall develop a systematic means of screening each inmate referred for services to determine his need for services, and designate staff qualified to make screening determinations.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0804 WAITING LISTS

The Department shall establish criteria for prioritizing service delivery and use of waiting lists for mental health and mental retardation services.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0805 INFORMATION REGARDING AVAILABILITY TO SERVICES

The Department shall ensure that each inmate is informed how to access mental health and mental retardation services.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .0900 - TREATMENT AND HABILITATION

10A NCAC 26D .0901 SCOPE

(a) The rules in this Section apply to each service delivery site within the Department and to any other provider of services on a contractual basis.

(b) The process of treatment or habilitation shall incorporate activities and procedures that address the client's assets and needs from the point of initial contact, through active treatment or habilitation, and after discharge from treatment.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0902 ADMISSION ASSESSMENT

(a) An admission note shall be completed within 24 hours of admission which includes, but need not be limited to:

(1) reason for admission;

(2) present condition of the client reported in objective, behavioral terms, and when possible, a description of the client's condition by others;

(3) diagnostic impression, including a provisional or admitting diagnosis;

(4) determination of and request for additional referrals or special diagnostic tests, assessments or evaluations, if needed; and

(5) a preliminary individual treatment or habilitation plan.

(b) If clinically indicated, a social, educational, medical, criminal, vocational, developmental, and psychiatric history shall be completed within 30 days after admission.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0903 EVALUATION AND DIAGNOSIS

Each service delivery site shall document, for each client, any routine diagnostic tests, assessments and evaluations, or medical examinations, as well as time frames for their completion.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0904 TREATMENT OR HABILITATION PLAN

(a) Each service delivery site shall develop an individualized treatment or habilitation plan for each client based upon:

(1) an evaluation of his condition, assets and needs; and
(2) information gathered during the admission assessment process.

(b) The treatment or habilitation plan shall be documented in the client record as follows and shall:

(1) provide a systematic approach to the treatment or habilitation of the client;
(2) substantiate the appropriateness of treatment or habilitation goals;
(3) designate clinical responsibility for the development and implementation of the plan;
(4) include at least the diagnosis to ensure consistency;
(5) include time-specific measurable goals; and
(6) provide a summary of client, and if appropriate, family strengths and weaknesses.

(c) The plan shall be reviewed at least annually; and when medically or clinically indicated, the plan shall be revised accordingly.

(d) The client shall have the opportunity to participate in the development and implementation of the treatment and habilitation plan.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0905 PROGRESS NOTES

(a) Progress notes shall be recorded at least on a weekly basis in residential and inpatient services and following each scheduled appointment in outpatient services.

(b) Progress notes shall reflect the client's progress or lack of progress:

(1) in meeting goals;
(2) in staff interventions;
(3) regarding information which may have a significant impact on the client's condition; and
(4) when indicating reviews of relevant laboratory reports and actions taken.

History Note: Authority G. S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0906 TRANSFER OR DISCHARGE SUMMARY

(a) Whenever a client is transferred to a different level of service, a written transfer note by the referring unit shall accompany the client summarizing the client's condition at the time of transfer, and any recommendations for continued care.

(b) A qualified professional in the receiving unit shall evaluate the client to determine the need for continued treatment or habilitation.

(c) At the time of discharge, a discharge summary shall be completed and shall include:

(1) the reason for admission;
(2) course and progress of the client in relation to the goals and strategies in the individual treatment or habilitation plan;
(3) condition of the client at discharge;
(4) recommendations and arrangements for further services or treatment; and
(5) final diagnosis.

History Note: Authority G.S. 148-19(d);

Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0907 TREATMENT AND HABILITATION COORDINATION
(a) Coordination shall be maintained among all staff members contributing to the evaluation, planning, and treatment and habilitation efforts for each client.
(b) Each service delivery site, utilizing shifts or relief staff, shall develop mechanisms to ensure adequate communication among staff regarding clients.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .0908 RELEASE PLANNING IN RESIDENTIAL AND INPATIENT SERVICES
(a) When release of a client can be anticipated and the need for continued treatment has been identified, each client shall have a written individualized aftercare plan.
(b) The aftercare plan shall:
(1) be formulated by qualified professionals;
(2) inform the client of how and where to receive treatment or habilitation services;
(3) identify continuing treatment or habilitation needs; addressing issues, such as food, housing, and employment;
(4) indicate the need and the plan, if applicable, to involuntarily commit (inpatient or outpatient);
(5) involve the respective area program or state facility, when indicated;
(6) address the procurement and availability of medication prescribed for mental health problems for the released client, regardless of his ability to pay;
(7) address the use and coordination of generic resources in the community, which may be through Employment Security Services, Vocational Rehabilitation Services, community colleges, and YMCA; and
(8) be provided to the client.
(c) The Department shall designate a qualified professional to assist the client in establishing contact with the respective area program or state-operated facility.
(d) The designee shall be responsible for providing information to the area program or state-operated facility to ensure continuity of treatment upon the client's release.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .1000 - CLINICAL SERVICES

10A NCAC 26D .1001 SCOPE
(a) The rules in this Section apply to each service delivery site, and to any other provider of services on a contractual basis that incorporates clinical services in their activities.
(b) The provision of clinical services shall be provided by qualified mental health professionals as an essential component of the treatment or habilitation process, to include but not limited to:
(1) individual and group counseling;
(2) psychotherapy services;
(3) testing services; and
(4) specialized therapies of various kinds.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .1002 COUNSELING AND PSYCHOTHERAPY SERVICES

Individual, group and family counseling, and psychotherapy shall be provided by, or under the direct supervision of, qualified professionals who have received training in these treatment or habilitation modalities.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .1003 SPECIALIZED THERAPIES

The following shall be provided by, or under the direct supervision of, staff licensed or registered to perform these activities:

(1) medical care;
(2) physical, occupational, or language and communication therapy; and
(3) nursing care.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .1004 TESTING SERVICES

Individuals, who are privileged to utilize the particular testing instrument being administered, shall perform testing on each client, who is referred by a clinician, in the areas of:

(1) psychology;
(2) development;
(3) education; and
(4) intelligence.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .1100 - MEDICATION SERVICES

10A NCAC 26D .1101 SCOPE

(a) The rules in this Section apply to each service delivery site and to any other provider of services on a contractual basis that provide medication services.
(b) Any client who is placed on medication for problems associated with mental health and mental retardation disabilities and needs shall receive, at least, medication services that include, but need not be limited to:

(1) prescribing;
(2) dispensing;
(3) administration;
(4) storage;
(5) control; and
(6) provision of education.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .1102 DISPENSING OF MEDICATION

(a) Medication shall be dispensed, by a pharmacist or physician, in a properly labeled container in accordance with state and federal law.
(b) The medication container shall protect medication from light and moisture, and shall be in compliance with the Poison Prevention Packaging Act.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .1103 ADMINISTRATION OF MEDICATION

(a) Medication shall be administered in accordance with state and federal law.
(b) Prescription medication shall be administered in service delivery sites only on the order of an authorized prescriber.
(c) Non-prescription medications and standing orders shall be administered only on the written approval of a physician or person authorized to prescribe legend drugs.
(d) Only properly dispensed medication shall be administered.
(e) Medication shall be administered in inpatient psychiatric services only by a physician, physician assistant, or nurse.
(f) In other service delivery sites, medication may be either:

- (1) administered by program or correctional staff who have received training by the Department; or
- (2) self-administered by any client who has received instructions, from either the program's physician or designee, about:
  - (A) each medication;
  - (B) dosage;
  - (C) time of administration; and
  - (D) side effects and contraindications.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .1104 INVOLUNTARY ADMINISTRATION OF PSYCHOTROPIC MEDICATION

(a) Psychotropic medication may be administered to any non-consenting client who has a mental illness and is receiving inpatient mental health treatment if any one or more of the following conditions exist:

- (1) failure to treat the client's illness or injury would pose an imminent substantial threat of injury or death to the client or those around him; or
- (2) there is evidence that the client's condition is worsening and, if not treated, is likely to produce acute exacerbation of a chronic condition that would endanger the safety or life of the client or others; and:
  - (A) the evidence of substantial and prolonged deterioration is corroborated by medical history; and
  - (B) the source of the history is documented in the client's record.

(b) Medication refusal shall mean a client has refused to take medication within 30 minutes of the initial offer. A client who accepts medication within 30 minutes of the initial offer shall not be considered to have refused medication.
(c) Medication Refusal:

- (1) All incidents of medication refusal shall be:
  - (A) reported as promptly as possible to the psychiatrist who is treating the client; and
  - (B) documented on progress notes and the medication chart by staff responsible for administering the medication.
- (2) The administering staff shall attempt to determine the reason for refusal by questioning the client and encouraging him to accept the medication. Such shall be documented in the client's record.
- (3) A member of the treatment team shall discuss the reasons for refusal directly with the client and attempt to resolve those concerns that are the source of the refusal before a forced medication order is written.

(d) Initial Emergency Situation:

- (1) In an initial emergency situation the physician:
  - (A) may initiate procedures and write an order for administering emergency forced medication for a period not to exceed 72 hours; and
  - (B) shall document in the client's record the pertinent circumstances and rationale for the psycho-tropic medication.
- (2) Psychotropic medication may be administered if the physician determines that the condition set forth in Paragraph (a) of this Rule exists and:
  - (A) the medication is a generally accepted treatment for the client's condition;
  - (B) there is a substantial likelihood that the treatment will effectively reduce the signs and symptoms of the client's illness; and
  - (C) the proposed medication is the least intrusive of the possible treatments.

In all cases, the medication shall not exceed the dosage expected to accomplish the treatment and the client shall be monitored for adverse reactions and side effects.

(3) Continuation of emergency situation:

(A) If needed, two subsequent emergency periods of 72 hours may be authorized only after the attending psychiatrist has received the written or verbal concurrence from another psychiatrist not currently involved in the client's treatment.

(B) If the client continues to refuse medication after it is determined that psychotropic medication is still warranted, procedures for administering medication in a non-emergency situation shall be implemented.

(e) Non-Emergency Situations:

(1) If a client refuses psychotropic medication in a non-emergency situation, the attending physician shall:

(A) make every effort to determine the cause of the refusal;

(B) inform the client of indications for psychotropic medication, including benefits and risk, and the advantages and disadvantages of alternate courses of treatment; and

(C) request his or her consent.

(2) The treatment team may also assist in efforts to explain the advantages of medication to the client.

(3) The client's record shall contain documentation that efforts have been made to determine the cause of refusal and advantages of medication.

(4) The physician shall initiate a referral to the Involuntary Medication Committee if the client continues to refuse medication. The Committee shall:

(A) determine whether either of the conditions as set forth in Paragraph (a) of this Rule exists before authorizing an involuntary medication order; and

(B) apply the criteria set forth in Subparagraphs (d)(1) and (2) of this Rule in making its determination.

(C) If neither of the conditions set forth in Paragraph (a) of this Rule exists, the client shall not be involuntarily medicated.

(f) Involuntary Medication Committee:

(1) The members of the Involuntary Medication Committee shall be appointed by the Chief of Psychiatry and shall consist of a psychiatrist, a psychologist, and a mental health nurse who is a Registered Nurse.

(A) If the psychiatrist who issued the involuntary medication order is the individual who normally sits on the committee, another psychiatrist shall serve in that capacity.

(B) Other prison staff who have pertinent information that may be useful to the committee in making its determination shall be required by the committee to attend the hearing.

(2) In conducting the hearing, the committee chairman, appointed by the Chief of Psychiatry, shall ensure that the client:

(A) has received written and verbal notice of the time, date, place, and purpose of the hearing;

(B) is informed of his or her right to hear evidence providing the basis for the involuntary medication, the right to call witnesses on his or her behalf; and the right to request that the Client Representative attend the hearing as set forth in Subparagraph (g)(2) of this Rule;

(C) attends the hearing unless his or her clinical condition is such that his or her attendance is not feasible. In this case, the Committee shall:

(i) state the reasons for determining that the presence of the client is not feasible;

(ii) allow the client to be interviewed in his or her room by the client representative and one or more members of the Committee; and

(iii) allow the client representative an opportunity to present facts relevant to whether an involuntary medication order should be issued;

(D) shall be allowed a reasonable number of witnesses, to be determined by the committee chairman, or:

(i) written statements may be considered in lieu of direct testimony; and

(ii) specific client witnesses may be excluded from direct testimony if the unit superintendent or designee determines a justifiable security risk would occur if they were brought to the hearing site; and

(E) be given the opportunity to question any staff who present evidence that supports the need to involuntarily medicate.

(3) After the committee has received all relevant information, the committee shall:

(A) consider the facts and arrive at a majority decision;

(B) ensure that the authorization to involuntarily medicate shall not exceed 30 days;
(C) prepare and file in the client's record a written summary of the evidence presented and the rationale for the decision; and
(D) consult an attorney from the Attorney General's Office, assigned to represent the Department, concerning the legal propriety of forcibly administering medication in a given case.

(4) If, after the initial 30 day period, involuntary medication is still deemed necessary, the psychiatrist may again present the case to the Involuntary Medication Committee, which:
(A) shall conduct a review of the record and the reasons presented in support of continuing involuntary medication; and
(B) may then authorize the administration of involuntary medication for 90 additional days. Subsequent 90-day periods may be authorized only after similar reviews.

(g) Client Representative:

(1) If a client is recommended for forced medication on a non-emergency basis, the Chief of Psychiatry or his or her designee shall appoint a member of the treatment staff to serve as a Client Representative, whose role shall include:
(A) assisting the client in verbalizing the reasons for his or her refusal of psychotropic medications in meetings with his or her treatment team;
(B) providing this information to the Involuntary Medication Committee; and
(C) preparing a summary of the reasons for the refusal and documenting it in the client's record.

(2) The Client Representative shall appear before the Involuntary Medication Committee whenever he feels that it is in the best interest of the client or at the client's request.

(3) When reviewing a case involving the involuntary administration of medication, the Involuntary Medication Committee shall consider oral or written comments from the Client Representative.

(h) If physical force is actually employed, documentation of all actions relating to the forceful administration of medication shall be included in the client's record and reported to the Unit Superintendent on a "Use of Force Report" (DC-422).

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Readopted Eff. March 1, 2019.

10A NCAC 26D .1105 PSYCHOTROPIC MEDICATION EDUCATION

(a) To ensure the client's understanding of psychotropic medication, individual or group medication education shall be provided to each client:

(1) who is to begin receiving, or is to be maintained on, psychotropic medication; and
(2) by the prescribing physician or other person approved by the physician;

(b) Medical education that has been provided to a client shall be documented in the client's record.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Readopted Eff. March 1, 2019.

SECTION .1200 - PROTECTIONS REGARDING CERTAIN PROCEDURES

10A NCAC 26D .1201 SCOPE

The rules in this Section specify protections regarding the use of certain specified procedures, in order to promote dignity and humane care for any client receiving mental health and mental retardation services.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .1202 USE OF SECLUSION

(a) Seclusion shall be used only under one of the following conditions:

(1) on an emergency basis when it is necessary to prevent immediate harm to the client or to others; or
(2) on a non-emergency basis if that seclusion will resolve the precipitating crisis.

(b) Emergency seclusion shall last no longer than is necessary to control the client.
(c) Seclusion shall not exceed seven days without the review and approval of an internal committee in accordance with Paragraph (e) of this Rule.
(d) Observations or reviews of any client in seclusion shall be made as follows:

(1) any client placed in seclusion shall be observed no less frequently than every 30 minutes;
(2) a clinician may extend this interval up to 60 minutes if such an observation would not affect the health, safety, or welfare of the client;
(3) documentation for extending the observation shall be placed in the client's record;
(4) observations by a clinician shall be made at least daily or, if the clinician is not present at the facility, observations by a health professional shall be reported by telephone to a clinician; and
(5) reviews by an internal committee shall be made in accordance with Paragraph (e) of this Rule.

(e) Committee review:

(1) If it appears that seclusion may be indicated for a period to exceed seven days:
    (A) an internal committee consisting of a clinician, a nurse or member of the medical staff, and a member of the administrative staff shall review the use of seclusion and interview the client; and
    (B) continued use shall not exceed the initial 7 days without the approval of this committee.
(2) Following its initial review, the committee shall review the case at intervals not to exceed 30 days.

(f) If a client is placed in seclusion, his or her client record shall contain the following documentation:

(1) the rationale and authorization for the use of seclusion, including placement in seclusion pending review by the responsible clinician;
(2) a record of the observation of the client as required in Subparagraph (d)(1) of this Rule;
(3) each review by the responsible clinician as required in Subparagraph (d)(4) of this Rule, including a description of the client's behavior and all significant changes that may have occurred; and
(4) each review by the internal committee as required in Paragraph (e) of this Rule.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Readopted Eff. March 1, 2019.

10A NCAC 26D .1203 USE OF RESTRAINT

(a) Restraint shall be used only under the following circumstances:

(1) after less restrictive measures, such as counseling and seclusion, have been attempted or if clinically determined to be inappropriate or inadequate to avoid injury to self or others; and
(2) either:
    (A) upon the order of a clinician to control a client who has attempted, threatened, or accomplished harm to himself or others; or
    (B) upon the authorization of the officer-in-charge on an emergency basis if believed necessary to prevent immediate harm to the client or to others.
(3) In determining if restraint is indicated, a clinician shall consider whether the client:
    (A) has inflicted an injury to himself or to others and, if so, the nature and extent of such injury; or
    (B) threatens, through words or gestures, to inflict injury to himself or others and the nature of the threat.

(b) When a client exhibits behavior indicating the use of restraints and under the conditions of Paragraph (a) of this Rule, the following procedures shall be followed:

(1) If, in the judgment of any staff member, immediate restraint is necessary to protect the client or others, the client shall be referred immediately to a clinician for observation and treatment.
(2) If there is insufficient time to make the referral or if a clinician is not immediately available:
    (A) the staff in charge may employ emergency use of restraint;
    (B) the client shall be reviewed within four hours of the initial restraint, and a restraint may be ordered by a clinician pursuant to Paragraph (a) of this Rule. This may be accomplished by:
        (i) telephone contact between the senior health professional at the facility and the clinician; and
        (ii) if such review cannot be obtained, the client shall be released from restraint.
    (C) a restraint order shall not exceed four hours. At the expiration of the restraint order, the client shall be released from restraint unless a new order is issued; and

(D) a subsequent order for continuing restraint shall be based on:

(i) the client's present condition and behavior; and

(ii) reasons other than the original reasons for restraint, unless the order indicates the original reasons are considered applicable at the time of the subsequent order.

(c) If the client is restrained and subject to injury by another client, a professional staff member shall remain continuously present with the client. Observations and interventions shall be documented in the client record.

(d) All orders for continuation of restraint shall be reviewed and documented in intervals not to exceed four hours thereafter, either by personal examination or telephone communication between health professionals and the responsible clinician.

(e) All orders of restraint issued or approved by a clinician shall include written authorization to correctional staff or health professionals to release the client when he or she is no longer dangerous to him or herself or to others.

(f) The responsible clinician shall be notified upon release of a client from restraint.

(g) Observations or reviews of all clients in restraint shall be made as follows:

(1) observations no less frequently than every 30 minutes;

(2) observations every four hours by the responsible clinician either personally or through reports from health professionals; and

(3) reviews by an internal committee in accordance with Paragraph (h) of this Rule.

(h) Committee review: An internal committee consisting of three members of the Department's clinical and administrative staff, including at least one psychologist and one psychiatrist shall review cases in which restraints were used beyond four hours. The incident will be reviewed and include consideration of the following:

(1) the use of appropriate procedures in the decision to restrain;

(2) sufficient indications for the use of restraint; and

(3) release of the client from restraint as soon as clinically indicated based upon consideration of the factors listed in Paragraphs (a) and (b) of this Rule.

(i) When a client is placed in restraint, the client record shall contain documentation of the following:

(1) the rationale and authorization for the use of restraint, including placement in restraint pending review by the responsible clinician;

(2) a record of the observations of the client as required by Paragraph (g) of this Rule.

(3) each review by the responsible clinician as required by this Rule, including a description of the client and all significant changes that have occurred; and

(4) each review by the internal committee as required in Paragraph (h) of this Rule.

History Note: *Authority G. S. 148-19(d);*
Eff. January 4, 1994;
Readopted Eff. March 1, 2019.

10A NCAC 26D .1204 PROTECTIVE DEVICES

Whenever protective devices are used for any client, the Chief of Psychiatry shall:

(1) ensure that the:

(a) necessity for the protective device has been assessed and approved by a mental health professional;

(b) device is applied by a person who has been trained in the use of protective devices;

(c) client who is using protective devices which limits his or her freedom of movement is observed every two hours; and

(d) client is given the opportunity for toileting and exercising as needed.

(2) document the use of protective devices in the client's medical record.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Readopted Eff. March 1, 2019.

10A NCAC 26D .1205 VOLUNTARY REFERRALS AND TRANSFERS

(a) Non-emergency referrals shall be forwarded to the mental health or mental retardation professional designated to receive such referrals at the service delivery site to which the client is assigned.

(b) If the mental health or mental retardation professional determines that the client is in need of services provided at a residential or inpatient unit, the client shall be given:

(1) written notice of the reasons for the referral;
(2) the expected benefits of the treatment to be received; and
(3) his rights as described in Rule .1207 of this Section.

(c) If the client agrees to a voluntary transfer to the specified residential or inpatient unit, he will be asked to give written consent, with witness by a member of the staff.
(d) If the client refuses to sign the form, yet verbally agrees, this fact must be documented by two witnesses prior to initiating the transfer to the mental health unit.
(e) The referring mental health or mental retardation professional shall complete the necessary referral forms and arrange for the client's transfer.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .1206 INVOLUNTARY REFERRALS AND TRANSFERS
(a) Involuntary referrals and transfers to residential or inpatient units shall occur only if the attending clinician determines that:

(1) a client requires treatment services not available at his or her current service delivery site; and
(2) a transfer over the client's objections is required.

(b) Non-emergency involuntary referrals:

(1) If a qualified professional determines that the following conditions exist:
    (A) a diagnosable mental disorder; and
    (B) determination is made that outpatient services are not effective treatment for the client; and
(2) the professional has given the client a written notice of a referral for transfer and has explained to the client his or her rights in accordance with Rule .1207 of this Section; then
(3) the following steps shall be taken if the client does not voluntarily consent to the referral and transfer:
    (A) the client shall be informed of the time, date and place of a hearing;
    (B) the Chief of Psychiatry or his or her designee shall contact the hearing officer to arrange a hearing; and
    (C) a client advisor shall be appointed and a hearing conducted in accordance with the procedures specified in this Rule.

(c) Emergency involuntary referrals:

(1) Such referrals shall be implemented only:
    (A) if a client has a diagnosable mental disorder; and either:
        (i) presents a substantial risk of harm to himself or others, as manifested by recent overt acts or expressed threats of violence; or
        (ii) is so unable to care for his or her own personal health and safety as to create a substantial risk of harm to himself; and
    (B) the Chief of Psychiatry has made a determination that outpatient services are not effective treatment for the client's condition.
(2) Such referrals shall be made by the mental health staff, the unit physician, nurse, or officer in charge after consultation with the designated mental health staff of the receiving unit.
(3) The officer in charge shall authorize a transfer only under the following conditions and if the officer determines:
    (A) the emergency referral criteria have been met; and
    (B) efforts to contact the referring mental health professional have failed.

(d) A client who is transferred because he or she meets the criteria of an emergency involuntary referral shall be afforded a hearing at the receiving unit within 10 days of admission. This hearing will follow the same procedures as those required by Paragraph (b) of this Rule.
(e) Client advisors:

(1) Each client referred for a hearing shall have an advisor appointed to assist him or her in preparing for the hearing.
(2) Each area administrator or institution head shall be responsible for appointing advisors for all units within his or her jurisdiction.

(3) Client advisors shall be free to advise the client independently and to act solely in his or her behalf, and shall not be subject to any harassment, discipline, or coercion in connection with such advice for the client.

(4) Ex parte attempts to influence the decision of the hearing officer shall be prohibited.

(f) Hearing officers: The Chief of Psychiatry shall recommend and the Director of the Division of Prisons shall appoint persons to serve as hearing officers who shall:

(1) be qualified professionals who are neutral and independent;

(2) have the authority to refuse to transfer an client if they determine that such a transfer is not justified.

(3) ensure and document that an client advisor has been assigned;

(4) conduct a hearing that follows the procedures specified in this Rule in a fair and impartial manner; and

(5) determine from evidence presented whether the criteria for emergency or non-emergency referrals have been met.

(g) Hearing procedures:

(1) The hearing shall be conducted no sooner than 48 hours after the time the client is given written notice that he or she is being considered for a referral to a residential or inpatient unit; however, the client has the right to waive the 48-hour notice.

(2) The hearing officer shall determine the time, place, and site of the hearing.

(3) The hearing officer shall consider all relevant and non- repetitive evidence justifying or disputing the involuntary transfer and that:

(A) the client has a diagnosable mental disorder;

(B) the client requires services that are not currently available on an outpatient basis; and

(C) the unit to which the client is to be transferred is better able to provide the needed treatment or habilitation services than is the currently assigned housing unit.

(4) A copy of the referral form, as well as other relevant written documents, shall be entered as evidence.

(5) All written documents or verbal information are to be considered confidential, in accordance with applicable law and Department policy.

(6) The client shall not have direct access to his or her client record; however, the client advisor may:

(A) review the client's record presented at the hearing; and

(B) consult with the client about its use at the hearing and any other matters which could be relevant at the hearing, including the questioning of all witnesses.

(7) The client who is being considered for transfer or his or her advisor may question any witnesses for the State, including mental health or mental retardation professionals.

(8) The client may also present witnesses in his or her own behalf with limitations that include:

(A) a reasonable number of witnesses will be allowed at the discretion of the Hearing Officer;

(B) testimony may be received by conference telephone call if the hearing is conducted away from the client's assigned unit;

(C) written statements may be entered in lieu of direct testimony; and

(D) specific client witnesses may be excluded from direct testimony if a justifiable security risk, including threats of harm or inmate escape, as determined by a unit superintendent, or designee, would occur were they brought to the hearing site.

(9) The hearing officer shall:

(A) document the results of the hearing, summarizing the evidence presented and the rationale for his or her decision;

(B) communicate the results of the hearing to the client and staff; and

(C) ensure that a copy of relevant documents is placed in the client record.

(10) The decision to transfer involuntarily shall be valid throughout the duration of the stay at any residential or inpatient unit. There shall be a review of the need for continued treatment or habilitation every 30 days.

(11) A client may be transferred to another like unit without a rehearing; however, if he or she is discharged from residential or inpatient services, a rehearing shall be required prior to readmission to that level of service.

(12) At the request of the client, his or her case shall be reviewed by a Hearing Officer within 90 days after the initial hearing to determine whether the assignment to the residential or inpatient unit will be extended or terminated. Subsequent reviews by a Hearing Officer shall take place each 180 days if requested by the client.

(h) The receiving unit shall be responsible for notifying the client of his or her right to inform his or her family of the transfer, and such notice shall be provided within 24 hours of the admission to the receiving unit.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Readopted Eff. March 1, 2019.

10A NCAC 26D .1207 TRANSFER TO RESIDENTIAL OR INPATIENT UNITS

All inmates who are considered for transfer to a residential or inpatient unit shall have rights which include, but need not be limited to:

(1) written notice that transfer to a residential or inpatient mental health facility is being considered, including a statement of the reasons for the referral or transfer;
(2) a hearing, sufficiently after notice is given, to prepare objections, if any;
(3) opportunity to:
  (a) testify in person;
  (b) present documented evidence; and
  (c) present and question witnesses called by the State, except upon a finding not arbitrarily made, of good cause, for not permitting such presentation, confrontation, or cross-examination;
(4) a neutral and independent decision-maker who has the authority to refuse admission;
(5) a written statement by the decision-maker as to reasons for his decision to refer and transfer, with which two psychiatrists or psychologists concur;
(6) qualified and independent assistance from an advisor, not necessarily an attorney, to assist the inmate in preparing his objections;
(7) periodic review of the continuing need for treatment; and
(8) effective and timely notice of all of the above rights.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .1300 - RESEARCH PRACTICES

10A NCAC 26D .1301 SCOPE

(a) The rules in this Section apply to research activity or treatment involving direct contact with a client.
(b) An activity or treatment procedure shall be considered research when it:

(l) involves a clinical practice that is not conventional; or
(2) is a type of procedure that serves the purpose of research only, and does not include treatment designed primarily to benefit the client.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .1302 RESEARCH REVIEW BOARD

(a) Research that involves a client shall be reviewed and approved by a research review board established by the Department.
(b) The research review board shall approve, require modification, or disapprove proposed research projects subject to the approval of the Department.
(c) Individuals who are not directly associated with research projects under consideration shall comprise a majority of the review board.
(d) Each proposed research project shall be presented to a research review board as a written protocol containing the following information:

(1) identification of the project and the investigator;
(2) abstract, containing a short description of the project;
(3) statement of objectives and rationale; and
(4) description of methodology, including informed consent if necessary.

(e) Prior to the initiation of each research project, a research review board shall:
(1) conduct an initial review of the project;
(2) state the frequency with which it will review the project after it has been initiated; and
(3) hold a review prior to any major changes being made in research procedures.
(f) Written minutes of each research board's meeting shall be maintained and contain documentation that:
(1) risks to the client were minimal and reasonable for the benefits to be accrued;
(2) client participation was voluntary;
(3) unnecessary intrusion on the client was eliminated;
(4) informed consent was obtained; and
(5) compliance with confidentiality requirements as contained in Rule .0704 of these Rules.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .1303 CONDITIONS OF CLIENT PARTICIPATION
(a) Informed written consent shall be obtained from each client in a research project as follows:
(1) documentation that the client has been informed of any potential dangers that may exist, and that he understands the conditions of participation; and
(2) notice of the client's right to terminate participation at any time without prejudicing the treatment he is receiving.
(b) A copy of the dated, signed consent form shall be kept on file.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .1400 - EMERGENCY SERVICES

10A NCAC 26D .1401 SCOPE
(a) The Department shall ensure that emergency mental health and mental retardation services are available to all inmates.
(b) Emergency services provide:
(1) immediate assessment and intervention; and
(2) referral for continuing care after emergency treatment, for inmates experiencing acute emotional or behavioral problems.
(c) Emergency services consist of a variety of services which may include, but need not be limited to:
(1) crisis intervention;
(2) telephone crisis services; and
(3) medical and psychiatric back-up.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .1402 TRAINING OF STAFF
The Department shall ensure that staff who:
(1) supervise inmates have been trained to access and refer to emergency services; and
(2) provide emergency services are properly trained.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .1500 - PREVENTION SERVICES

10A NCAC 26D .1501 SCOPE

The Department shall develop a process to identify inmates who are:

(1) at risk for developing mental disorders; and

(2) provide counseling, education, instruction and protective living arrangements to enhance their ability to cope in the prison environment.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .1600 - INPATIENT SERVICES FOR INMATES WHO ARE MENTALLY ILL

10A NCAC 26D .1601 SCOPE

(a) Inpatient units for clients who are mentally ill shall provide close supervision by a qualified mental health professional on a 24-hour basis.

(b) The inpatient unit shall be designed to serve any client who requires continuous treatment for moderate or severe mental illness.

(c) Client care shall be provided under the supervision of a psychiatrist or doctoral level psychologist.

(d) Individuals who, in addition to mental illness, have other disorders such as mental retardation or substance abuse, shall be eligible for admission.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .1602 HOURS OF OPERATION

The inpatient unit shall provide services seven days per week, 12 months per year.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 26D .1603 REQUIRED SERVICES

(a) Services provided on an inpatient unit shall include, but need not be limited to:

(1) psychiatry;

(2) psychology;

(3) nursing;

(4) social work;

(5) rehabilitation; and

(6) recreational.

(b) Multi-disciplinary treatment teams shall be developed to oversee the delivery of such services.

History Note: Authority G.S. 148-19(d);
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.