10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE

10A NCAC 27E .0102 PROHIBITED PROCEDURES

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

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

10A NCAC 27E .0105 PROTECTIVE DEVICES

10A NCAC 27E .0106 INTERVENTION ADVISORY COMMITTEES

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

10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT

Current rules can be found at::

http://ncrules.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2027%20-%20mental%20health,%20community%20facilities%20and%20services/subchapter%20e/subchapter%20e%20rules.pdf

******ALL PHYSICAL TECHNIQUES HAVE SUBSEQUENTLY BEEN APPROVED BY THE STATE IN THE NCI CORE AND CORE PLUS CURRICULUM**********

All information on physical techniques retrieved from NCI Core and Core Plus Workbook

(9) Staff will demonstrate competence in describing strategies for ensuring the dignity and respect for the person with disabilities during and after the intervention. [27E .0108 (g)(3)]

Strategies for Ensuring Dignity and Respect for the Person with Disabilities during and after the Intervention

1. Explain to the person why a restrictive intervention is being implemented.

2. Explain to the person what his/her behavior should be in order not to proceed with restrictive interventions or to terminate the restrictive interventions.

3. Reassure the person that someone will be with him/her or that he/she will be observed at all times.

4. Explain to the person that certain articles of clothing are being removed for his/her protection and they will be returned as soon as he/she is released from restrictive interventions.

5. Remind the person during the procedure of behavior that is expected in order to terminate restrictive interventions.

6. Protect person's privacy by preventing other persons from viewing restrictive interventions.

7. On release, follow debriefing guidelines.

Procedures Prohibited by North Carolina State Law

Historically, there has been little regulation of the types of interventions and procedures used with people who have disabilities. When a person would do things that were harmful to themselves or others, staff struggled with ways to make them stop and learn not to repeat the behavior. Sometimes (due to its severity) staff used interventions/procedures that were, in themselves, harmful. Through advocacy efforts, certain procedures and interventions have been identified and prohibited by state law as show below. [See North Carolin Administrative Code 10NCAC .0102.]

- any intervention that would be considered corporal punishment (like spanking)
- the contingent use of painful body contact
- substances administered to induce painful bodily reactions, exclusive of Antabuse (such as ammonia capsules, hot pepper sauce)
- electric shock (excluding medically administered electroconvulsive therapy) such as use of cattle prods or remote controlled shock
- insulin shock
- unpleasant tasting foodstuffs
- contingent application of any noxious substances that include but are not limited to noise, bad smells or splashing with water

 any potentially physically painful procedure, excluding prescribed injections, or stimulus that is administered to the client for the purpose of reducing the frequency or intensity of a behavior

 restrictive interventions should never be used to punish, discipline a person, or for the convenience of staff.

(10) Staff will demonstrate competence in defining "health status check." [27E .0108 (g)(5)]

Health status checks before, during and after use of physical restraint and seclusion and isolation time out include, but are not limited to: monitoring vital indicators, physical and psychological status and comfort, and determining whether to seek medical assistance.

Definition of "health status check"

Health status is defined as the health of a person at a given time. A health status check is a process of evaluating, gathering, analyzing, and comparing an individual's health characteristics in order to determine their current state or condition of health. Health status check includes, but is not limited to: level of consciousness, speech, breathing, movement, skin color, orientation and mood (affect). To adequately assess a person's health status, staff must be aware of normal health patterns.

Physical restraint

- During the physical restraint episode, under no circumstances should direct pressure be applied to the neck, thorax, abdomen, back or pelvic area. This action is associated with asphyxia.

- The prone position (lying on the floor face down) and the flexion of the head or trunk toward the knees restrict the ability of the person to breath and should be avoided.
- Wherever possible, restraining a consumer on the floor should be avoided.
- However, if the floor is used, then this should be for the shortest period of time needed to bring the situation under control.
- The consumer needs to be medically monitored for the duration of the episode and medically reviewed after the episode.

(11) Staff will demonstrate competency in describing how to monitor vital indicators, physical status, and comfort. [27E .0108 (g)(5)]

Assessment	Normal Findings	Deviations from Normal
Breathing	Not labored Normal breathing No abnormal breath sounds	Absence of breathing Labored or difficulty breathing Rapid breathing Complains of difficulty breathing
Skin Color	Varies from light to deep brown; from ruddy pink to light pink; from yellow overtones to olive	Pale, bluish discoloration (cyanotic) yellow discoloration (jaundice) red discoloration (erythema)
Movement	No Swelling or tenderness Joints, limbs and all other body parts move smoothly	Limited range of movement Swelling, tenderness Discoloration

		Complains of pain
Consciousness	Eyes opening spontaneously and to verbal command	No response Decreased response, listless
Orientation	Oriented to person, place & time Converses	Disoriented, converses Uses inappropriate words Makes incomprehensible sounds No response
Affect/mood	Appropriate to situation	Inappropriate to situation
Speech	Verbal	Non-Verbal Stammering, loose association Illogical thought, pressured
Attitude	Cooperative	Negative, Hostile, Withdrawn

- Health status check must be performed prior to implementation of a restrictive intervention.
- During the restrictive intervention the person must also be evaluated for health status.
- Thirty minutes after the restrictive intervention the person must be reevaluated to determine if there are any health issues/complications directly related to the restrictive intervention.

(12)Staff will demonstrate competence in describing how to monitor a person's psychological status and comfort. [27E .0108 (g)(5)]

Psychological status and comfort

When a person is in crisis, his/her psychological status may change. The following is a list of characteristics you should assess to determine the support/intervention needed. Note: assess these characteristics in relation to the person's normal behavior.

Appearance and general behavior

□ Facial features, facial expressions, eye movements

□ Grooming, cleanliness, posture, dress

□ Degrees of friendliness, tearfulness

Expression of mood and affect

□ Does the person appear at ease? Frantic? Irritable?

□ Does the person have exaggerated feelings of elation?

□ How are these feelings expressed (anxious, panicky, terrified, depressed)?

□ What are his/her predominant expressions?

□ Flat affect (no facial expression)

□ Constricted affect as seen with depression

□ Rapid shifts in the expression of his/her emotions

Speech and language

□ What is the person's rate, volume, rhythm?

□ Is the person stammering or stuttering?

□ What is the flow of the person's ideas? Are they appropriate?

Motor movement and posture

□ Are the movements purposeful or repetitive (such as pacing, or hand wringing)

□ Are there any unusual movements (tics, tremors, lip smacking) or postures?

Thoughts and perceptions

□ Is the person having difficulty in concentrating?

□ Does he/she exhibit psychotic symptoms, delusions, or obsessions?

Orientation

□ Does the person know where he/she is?

□ Does the person know what is happening to him/her?

□ Does the person appear to be aware of what is going on around him/her?

(13)Staff will demonstrate competence in describing how to determine when to seek medical assistance. [27E .0108 (g)(5)]

Determining when to seek medical assistance

Medical assistance should be sought immediately for persons experiencing deviations from normal breathing, skin color, movement and consciousness. Orientation, affect/mood, speech and attitude must be assessed on an individual basis. If a person has a medical history of difficulty in these areas, there may not be a need to seek medical assistance. However, if there is an abnormality in the psychological indicators that is not usually apparent, medical assistance may be warranted. In order to properly determine if a person is truly in a physical and/or psychological health crisis, staff must first be familiar with normal baseline indicators.

A person should constantly be assessed for any signs of distress before, during and after a restrictive intervention.

(14)Staff will demonstrate competence in identifying and describing the procedures that are prohibited by NC law and rule. [27E .0108 (g)(6)]

Procedures Prohibited by North Carolina State Law

Historically, there has been little regulation of the types of interventions and procedures used with people who have disabilities. When a person would do things that were harmful to themselves or others, staff struggled with ways to make them stop and learn not to repeat the behavior. Sometimes (due to its severity) staff used interventions/procedures that were, in themselves, harmful. Through advocacy efforts, certain procedures and interventions have been

identified and prohibited by state law as show below. [See North Carolina Administrative Code 10NCAC .0102.]

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- insulin shock
- unpleasant tasting foodstuffs
- contingent application of any noxious substances that include but are not limited to noise, bad smells or splashing with water
- any potentially physically painful procedure, excluding prescribed injections, or stimulus that is administered to the client for the purpose of reducing the frequency or intensity of a behavior
- restrictive interventions should never be used to punish, discipline a person, or for the convenience of staff.

(15)Staff will demonstrate competence in performing techniques for safely avoiding or getting out of person-initiated holds. [27E .0108 (g)(3)(5)]

It is easier and safer to prevent a hold than to perform a release technique. To do this, use blocks whenever possible. Do not over-react to the person reaching out to touch you or to hold your hand. Many times he/she only wants your attention. The person's manner will give you a clue

about his/her intentions. If you feel threatened, do not hesitate to perform the release. Practice the releases so you can perform them quickly and with ease. The element of surprise and your ability to perform quickly is critical to the effectiveness of the release. Move away and consider how to calm the person.

(16)Staff will demonstrate competence in performing techniques for safely implementing physical restraint, seclusion, and isolation time out. [27E .0108 (g)(3)(5)]

Safety for everyone involved in physical and restrictive interventions is a top priority You will be expected to use only the techniques approved by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, your agency, and its Human/Client Rights Committee. If you change a technique or don't use these physical and restrictive interventions in the way you were taught, you may place the person you are working with and yourself in danger and make yourself and your agency liable for your actions. These interventions can be powerful and also dangerous if used improperly. When you use them, you take on a serious responsibility. This responsibility includes 1) knowing the person you are working with so that you can help him or her calm down, and 2) performing the physical interventions safely and only as a last resort. Most of the time, you have choices in how you handle a situation. If you choose to help the person calm down, your relationship with that person can only benefit from this choice. Most often the person you are dealing with is acting out of fear and confusion, not "meanness." This should guide your responses.

(17)Staff will demonstrate competence in describing criteria and techniques for the safe and effective release of a person in seclusion, restraint, and isolation time-out. [27E .0108 (g)(3)(5)]

1. Explain to the person why a restrictive intervention is being implemented.
2. Explain to the person what his/her behavior should be in order not to proceed with restrictive interventions or to terminate the restrictive interventions.
3. Reassure the person that someone will be with him/her or that he/she will be observed at all times.
4. Explain to the person that certain articles of clothing are being removed for his/her protection and they will be returned as soon as he/she is released from restrictive interventions.
5. Remind the person during the procedure of behavior that is expected in order to terminate restrictive interventions.
6. Protect person's privacy by preventing other persons from viewing restrictive interventions.
7. On release, follow debriefing guidelines.

(18)Staff will demonstrate competence in describing the responsibility, strategy, and protocol for effective and immediate intervention when unsafe implementation of seclusion, restraint, isolation time-out is observed. [27E .0108 (g)(3)(5-6)]

If you change a technique or don't use these physical and restrictive interventions in the way you were taught, you may place the person you are working with and yourself in danger and make yourself and your agency liable for your actions.

It is the responsibility of staff to intervene when techniques are not being done correctly or when unapproved techniques are being used. People have been seriously injured or have died because staff have stepped outside the bounds of their training and used unapproved methods. EBPI uses physical techniques of formerly labeled as NCI physical techniques that have been carefully selected and approved by the NCI Quality Assurance Team and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

(19)Staff will demonstrate competence in the debriefing of caretakers involved in an incident by [27E .0108 (g)(7):

1. **Describing the goals for debriefing; and**

2 **Describing the methods for debriefing.**

It is important that you debrief with your co-workers. This debriefing should take place as soon as everyone has calmed down. It is not intended to be faultfinding. It is intended to help recover from the incident and to prevent a similar situation in the future. It is an opportunity for everyone to talk about what they saw, heard, thought and felt. It is like putting a puzzle together, and everyone involved has a piece of the puzzle. Oftentimes you and your co-workers may feel confusion, disappointment, anger and fear over the incident. This is normal and to be expected. Help everyone talk about their feelings. Some folks may have difficulty discussing their feelings, and it may take some

time to feel safe enough in the group to talk. The goal of this is to create a safe group for people to look clearly and carefully at what happened. If at all possible, the person receiving the physical restraint should be part of this process.

□ Talk about what was going on just before anyone noticed a problem starting. Use your training in prevention and alternatives to aggression to assess the environment. Look at time of day, room temperature, noise levels, the manner of other people in the area. What was everyone doing?, etc.

□ Talk about the person who became upset. What do you and your coworkers know about the person? (his/her daily routine, what he/she likes and does not like to do, what makes this person frightened, confused, or angry)

How does this person react when he/she is upset? What did you and your co-workers notice about the person before the incident? (was he/she tired, not feeling well, angry at another person, wanting something)

□ Talk about what happened. Ask each person to describe what they saw, heard, thought and felt as the incident began and what they did. Remember, you as a group are putting this puzzle picture of the incident together. Sometimes the smallest piece of information may be just what is needed. (such as the person was hungry and impatient to eat, he/she got upset because there are loud noises and raised voices, the person was hearing voices that were frightening him/her, the person was made to do something they did not want to do.)

• Talk through what each person did. Examine each step of the incident and look for possible things that may have caused the incident to escalate, missed opportunities for calming the situation and how the techniques were performed.

• Finally, talk about what might be done in the future to prevent the incident from happening again. Look for solutions in the environment, the person, the people around the area and your co-workers. Any new information/understandings should be documented and shared with all co-workers who provide supports to the person. This should be shared with the person if at all possible. Maintaining a safe environment can often become a goal around which staff and person (s) supported/treated can form an alliance.

The designated staff should complete any forms or reports that are appropriate to document the incident.

(20)Staff will demonstrate competence in debriefing of persons involved in, or witnesses to, an incident by: [27E .0108 (g)(7)]

1. **Describing the goals for debriefing; and**

2. **Describing the methods for debriefing.**

Your goal here is to find out what and why the incident happened from the person's point of view and begin to rebuild your relationship. At a later time you can help the person deal with the consequences of his/her actions.

During debriefing, staff should use a calm tone of voice, be non-judgmental, and focus on helping the person develop skills and strategies to minimize future crisis episodes. The person may have difficulty putting into words what happened from his/her point of view. If the person is reluctant, it may help for you to describe what you saw, heard and thought. You may have to come back to the person several times to get the whole picture. If the person does not have the skills to tell you what happened, you might try

gestures, role playing, or other ways to communicate without words to see if that will help you get the information. The person may never be able to tell you what he/she thought happened. You will then have to rely on your co-worker's observations and your personal understanding of what has happened.

(21)Staff will demonstrate competence in identifying the documentation requirements and how to maintain the required documentation. [27E .0108 (g)(8)]

After a crisis situation, you will need to notify people and document what happened according to your agency's policies. Your documentation should describe what happened before, during and after the event. Include a description of the person's behavior leading up to the event, efforts on the part of staff to use positive ways to avoid the escalation, a description of the intervention itself, when and how the event ended, and how staff assisted the person in "debriefing" or gaining closure over the event.

Reporting and Documentation

- ☐ Procedures for notifying supervisor, advocacy, nurse, psychologist, etc.
- ☐ Accident/Incident Form
- ☐ Restriction of Rights Form
- ☐ Mechanical Restraint Form
- ☐ Progress Notes

*Use the Client Incident Report to document summary of debriefing.

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PHYSICAL INTERVENTIONS

Blocking Punches

Blocking is a defensive move to stop a person from assaulting someone physically, such as punching, grabbing, or choking you. It is important to assess the situation and decide whether you are actually dealing with a physical assault or just someone trying to touch you, your clothing or something in your hand.

Ask yourself

Some people might ask, "How do I have time to ask these questions when someone is taking a punch at me?" Good question! It is important to ask your- self questions on an ongoing basis. Jumping into an altercation without assessing the situation can cause escalation and injury to the person and to you. What does the person intend, and what harm can he/she do? In each situation it is important to continue to make assessments about this. If you think that the person doesn't intend to harm and/or is not able to do harm, it greatly reduces the level of control you will need to use to maintain safety. Some other questions you may need to ask yourself are:

_ Does the person have a history of striking out once and then ending the confrontation?

_ What might you have missed or not understood about the person before the striking out?

_ Is your behavior and manner helping or hurting the situation? That is, are you behaving in a way that will help calm things down or that can further upset the person?

_ Assess the situation. Can you handle this alone? Do you need to clear the area of other people? Could your appearance make you more of a target?

If you are unsure of the answers to these questions, **backing off** can buy you and the person time to figure out the best solution for everyone involved.

There are two acceptable ways to block a punch:

(A) one arm block with arm in an "L" position or

(B) two arm block with arms crossed forearm over forearm.

NOTE: To prevent injury to yourself and the other person, use the soft part of your forearm. Close your hand into a fist to tighten the muscles of your fore- arm and to protect your fingers. This encourages you to respond defensively. Maintain proper body alignment to keep your balance and flexibility. Keep feet about shoulder width apart, with your knees slightly flexed. Bending your knees helps absorb the impact of the punch and also allows you to move quicker. Keep your head up and your eyes on the person. Do not allow your arms to block your vision.

Considerations

_ Whenever possible, know the people you are serving/supporting. Know what they like and don't like. Know how they want to be approached. Know what scares them and what makes them angry.

_ Know that when people feel that they are not being listened to, they may strike out as a means of punctuating a sentence you have not heard. Is the person communicating, "No!," "Go away!," "I'm afraid!," "I'm hurt!"

_ If a person is upset or agitated, talking softly to the person can be very powerful. *Listening* instead of *telling* is an excellent way to help a person calm down.

_ Remember, your objective is to block the punch and RE-ASSESS. Move out of the range of the person. Controlling the situation should include ways of defusing further violence and seeking to help the person calm down.

_ Agitation may last for hours, but actual physical outbursts are usually momentary.

_ Thoughtful interventions may include blocking, backing off, assessing the situation, conversation and debriefing with the person.

THE OVERHEAD PUNCH

A punch that begins with the person's arm extended over the head and moves with a downward thrust.

A. The block...

The procedure...

*1. Raise the same arm overhead in an L shaped position (arm bent and locked at the elbow) with the fist closed above the forehead.

2. Place the same foot forward to maintain balance.

*3. Intercept the punch on the inside of the forearm. Don't hit out towards the person.

4. Step out of range of the person and consider how to calm the situation.

Considerations

- *If you see the knuckles on the hand of your blocking arm, your arm is positioned correctly.*
- *Your goal is to stop the punch.*
- *Do not obstruct your vision with your hands or arms.*

THE HOOK PUNCH

A hook punch begins at the side of the body and moves in a circular motion towards the staff.

A. The block...Method A

The procedure...

*1. Raise the same arm in front of body across the midline, with arm in an upright L-shaped position with fist closed.

2. Have the same foot forward to maintain balance.

*3. Intercept the punch on the inside of the forearm. Be careful not to hit toward the person.

4. Step out of range of the person and consider how to calm the situation.

Considerations

- *If you can see your thumb and forefinger on the hand of your blocking arm, you have the arm positioned correctly.*
- *Do not hit out or downward toward this punch. Your goal is to stop the punch.*

THE STRAIGHT PUNCH

A shoulder level punch that begins at the chest area and moves toward the staff 's head and face. The arm is fully extended when the punch is delivered.

A. The block...

The procedure...

*1 Raise the same arm in front of body at the midline, with the arm in an upright L shaped position with the fist closed.

2. Have the same foot forward to maintain balance.

*3. Intercept the punch on the inside of the forearm. As you intercept the punch, move the punch away from the face across the midline, keeping eyes on the person. Don't hit toward the person.

4. Step out of range of the person and consider how to calm the situation.

Considerations

- *Do not hit out at the punch or open the arm in the upright "L" until the punch passes to the side.*
- *The goal is to redirect the punch away from the face*

THE UPPERCUT PUNCH

A punch that begins low, around the knee area, and moves in an upward thrust aimed at the stomach or groin area.

The procedure...

*1. Cross the forearms, near the wrists in a downward scissors (arms slightly bent and rigid). Have the same arm on top with the fists closed.

2. Have the same foot forward with the knees bent.

*3. Keep the back straight, and the head up.

*4. Intercept the punch inside the scissors near the wrists. Don't hit back.

5. Step out of range of the person and consider how to calm the situation.

Blocks to therapeutic holds

As a last resort, a block from these positions allows you to place the person in a therapeutic hold.

Considerations

- *The uppercut is a very powerful punch because it has body weight behind it.*
- *Make sure your elbows are rigid as you stop the punch.*
- *Move away and consider how to calm the situation.*

Simple Holds/Releases

It is easier and safer to prevent a hold than to perform a release technique. To do this, use blocks whenever possible. Do not over-react to the person reaching out to touch you or to hold your hand. Many times he/she only wants your attention. The person's manner will give you a clue about his/her intentions. If you feel threatened, do not hesitate to perform the release.

Practice the releases so you can perform them quickly and with ease. The element of surprise and your ability to perform quickly is critical to the effectiveness of the release.

This section includes releases from three simple holds. These are:

1. Arm grabs
2. Hair pulls
3. Bites

Ask yourself

- ☐ *"Is this person just touching me or is there intent to harm?"*
- ☐ *Move away and consider how to calm the person.*

ARM GRAB-ROLL

The key to gaining release from an arm grab is noting the position of the person's thumb(s). All of the arm grab releases break the hold by either rolling or pulling against the person's thumb.

The release...

*1. Close your hand making a fist.

*2. Roll your wrist against the person's thumb in a circular motion over the back of the person's hand.

Considerations

□ *The same principle applies in all arm grabs. The thumb is the weakest part of the hand, so your movements will always be made against the thumb.*

□ *Use your body weight to gain release from a strong grip.*

ONE HANDED OR TWO HANDED ARM GRAB-PULL UP

The one-handed arm grab pull-up is used when the one arm grab roll method will not work.

The release...

*1. Close held hand making a fist.

*2. Grasp held hand with free hand as close to the wrist as possible.

*3. Bend elbow while pulling against the person's thumb.

*4. Pull straight toward the shoulder of the held hand. (Do not pull arm across your body.)·

Ask yourself

□ *Is this person just touching or is there an intent to harm?*

□ *Could I calm the person and prevent escalation by allowing the person to hold my arm or hand?*

□ *This technique is usually used when you have determined that the arm grab roll method will not work.*

□ *This movement is weakest when your palm is facing down. Rotate your held hand so that your thumb is on top, then pull up.*

□ *Move away and consider ways to calm the person.*

□ *You can use this technique most effectively when the person is beginning to grasp your wrist. It can be done quietly without drawing attention to what you are doing.*

RELEASE FROM HAIRPULLS

Prevention...

Use appropriate block to prevent hair pulls.

ONE HANDED HAIR PULL-FRONT

It is very important to apply downward pressure immediately to the person's hand(s) to prevent a stronger grip, reduce the possibility of losing hair, and provide for an easier release.

The release...

*1. Place one hand over the other on top of the person's knuckles.

*2. Apply pressure until grip loosens.

*3. Slide top hand down securing the wrist while maintaining pressure on knuckles with the other hand.

*4. Bend forward at the waist, maintain a secure hold on the wrist, slide the person's hand from your head before stepping back.

Considerations

- *Ask the person to let go of your hair. Be calm, but firm. Do not let your voice add to an escalation of the situation. You may have to ask more than once. If you do not feel the person's fingers relaxing, then use release technique.*
- *Do not lean into the person as you gain release.*
- *Performing this technique leaves you briefly vulnerable to a kick or being kneed.*
- *Step away and consider ways to calm the person*

ONE HANDED HAIR PULL–BACK

The release...

*1. Press down firmly on the person's knuckles, hand over hand until the grip loosens.

*2.Using fingers of bottom hand, locate the person's thumb position.

*3. Slide the top hand down, securing the wrist while maintaining pressure on the knuckles with the other hand.

4. Bend at the waist.

* 5. Turn away from the thumb or free hand.

6. Continue turning, stand straight up facing the person, maintaining a grasp on the wrist Release the wrist and step back.

HAIR PULL INVOLVING LONG HAIR

Long hair often presents special problems for staff. The release is often more difficult to apply. It is possible to gain release with little injury.

The release...

*1. Grasp your own hair between the person's hand and your head to stop the pull.

*2. With a free hand, grasp above the person's hand (the one he/she is pulling hair with) and move firmly and quickly using downward motion, pulling his/her hand from your hair.

3. Step back and consider how to calm the person.

Considerations

□ *Ask the person to let go of your hair. Be calm, but firm. Do not let your voice add to an escalation of the situation. You may have to ask more than once. If you do not feel the person's fingers relaxing, then use release technique.*

- *This release is equally effective with belts, beards, ties, and loose clothing.*
- *If release is not gained, use hair pull assist technique.*

BITE RELEASE

When someone bites you, your natural tendency is to pull away. This may actually increase the intensity of the bite. Do not over react. Once bitten, move into the bite not away from it.

The release...

*1. Press the body part being bitten into the person's mouth creating a seal.

*2. Hold the person's nostrils together cutting off the air supply (causes person to breathe through the mouth, thereby releasing the bite.)

ASSESS PERSON'S CONDITION.

Considerations*

- *Upon release, move away from the person and consider ways to calm the situation.*
- *Practice universal precautions immediately.*

CAUTION:

NEVER PULL OR JERK AWAY FROM BITE.

Complex Holds/Releases

Complex holds can lead to life threatening situations. Try to prevent the person from applying the hold by moving or blocking. It is much easier and safer to prevent a hold than to perform a release. The releases are most effective when you use surprise and quickness to your advantage.

Using your body weight along with the release technique is essential for an effective release. This section describes techniques for release of the following holds:

1. Chokes
2. Bear hugs
3. Full Nelsons
4. Headlocks

FRONT CHOKE PREVENTION

Quick, immediate action is essential. When being choked you must protect your windpipe by quickly tucking your chin. This tucking not only decreases the available space for the person to choke, it also contracts the muscles around your windpipe.

The prevention...

*1. Close hands making fist.

*2. Bring them up between the person's arms in an L-shaped position.

*3. Moving your arms outward to spread person's arms.

4. Move away.

Considerations

- *Tuck chin to prevent choke.*
- *Step back and consider ways to calm the person*

THE FRONT CHOKE WEDGE

Quick, immediate action is essential. When being choked you must protect your windpipe by quickly tucking your chin. This tucking not only decreases the available space for the person to choke, it also contracts the muscles around your windpipe.

The release...

*1. Tuck chin.

*2. Wedge one arm over the person's arm.

*3. Raise other arm high over your head (prevents hitting person's face when turning).

*4. Make a turn toward wedged arm, bringing raised arm down across person's arms.

5. Wrap the person's arms tightly under the armpit, placing other arm on top as a block.

*6. Release; or turn and face person, while maintaining control. Then back away.

BACK CHOKE FAKE

Quick, immediate action is essential. When being choked you must protect your windpipe by quickly tucking your chin. This tucking not only decreases the available space for the person to choke, it also contracts the muscles around your windpipe.

The release...

*1. Tuck chin.

*2. Fake a distractive body movement.

*3. Raise one arm HIGH above head. With arm straight up in the air, turn in the direction of raised arm (prevents hitting person's face when turning).

4. Wrap person's arms tightly under armpit.

5. Bring free arm over top to block.

*6. Release and move quickly away from the person.

UPPER BEAR HUG

The person applies the hold from behind and above the elbows.

The release...

*1. Place thumbs under person's forearms near the wrists, palms facing, thumbs up.

*2. Turn head to either side maintaining an upright body position.

*3. Lift up on person's wrists while dropping out of the hold.

*4. Move quickly away from the person.

5. Turn and face the person.

Considerations

- *Turn and face the person*
- *Move away quickly and consider ways to calm the person.*
- *If they lift you off the ground, stay calm and call for help. Have your feet ready to land when they let go of you.*

LOWER BEAR HUG

The person applies hold from behind and below the elbows. To release a bear hug care should be taken to grasp the person's entire thumb or finger with your hand. If you grasp only the finger-tip you may injure person.

The release...

*1. When contact is felt, slide arms to back of hips.

*2. Lean forward and/or stepping/rocking while freeing arms.

*3. Continue leaning or stepping/rocking as you grasp-the person's thumb(s)/finger(s) at the base, not at the tip (right with right, left with left).

*4. Gradually pull back on person's thumbs or fingers at the base of the thumbs or fingers, until release is gained, extending arms outward.

*5. Move quickly away from the person.

6. Turn and face the person.

Considerations

- *Turn and face the person.*
- *If they lift you off the ground, stay calm, call for help. Have your feet ready to land when they let go of you. Move away and consider ways to calm the person.*

HEADLOCK

A headlock is a form of a choke, therefore the first thing you must do is protect your windpipe by tucking your chin.

The release…

*1. Tuck chin.

*2. Place hand on the person's wrist that is under your neck. Note: This is important because it prevents tightening of hold.

*3. Place other hand on back of person's elbow.

*4. Turning face into person's side.

*5. Step back causing the person's elbow to move over your head, while maintaining control of wrist.

*6. Step back, releasing person's arm.

Considerations

- *Be prepared to stabilize the person if he/she loses his/her balance.*
- *Move away and consider ways to calm the person*

BACK CHOKE TO HEADLOCK RELEASE

Quick immediate action is essential; therefore the first thing you must do is protect your windpipe by tucking your chin.

The release...

*1. Quickly secure the outside of the person's forearm just above the wrist and just below the elbow, pulling person's arm away from your throat.

*2. Attempt to tuck your chin toward person's wrist and get air.

*3. Bend forward from waist, step back and behind person's legs with the leg closest to the person.

*4. Continue with headlock release from this point.

Considerations

- *Be prepared to stabilize the person if he/she loses his/her balance.*
- *Move away and consider ways to calm the person.*

FULL NELSON—PREVENTION

A Full Nelson can be very dangerous because the person could cause serious injury to your neck. Try to prevent this hold by using the prevention techniques described in the following pages. Call for help if you are unable to prevent the hold and proceed with the release.

The prevention...

*1. When you feel hands from behind coming between your body and your arms, bring elbows tight to sides, move away.

2. Turn and face person.

THE FULL NELSON

A Full Nelson can be very dangerous because the person could cause serious injury to your neck. Call for help immediately!

The release...

*1. Stand still.

*2.Grasp person's entire thumb(s) or any other finger(s), not tips.

*3. Gradually pull back on thumb(s)/finger(s) until release is gained, extending arms outward.

4. Turn and face the person. Move away and consider ways to calm the person.

BASE PLUS

OPTIONAL TECHNIQUES

The following techniques are optional techniques that may be added to the North Carolina Interventions core curriculum based on the needs of the people being served by a facility. Human rights/client rights committee approval is required for inclusion of any optional technique.

Steps indicated with an asterick (*) are considered critical to the safe execution of the technique. Trainees must demonstrate the technique as described in order to be considered competent in that technique.

Therapeutic Holds

Therapeutic holds are considered physical restraints and are closely monitored by your agency and the state. By law, physical restraint may only be used as a last resort and never as a means of intimidation or punishment. The therapeutic hold is a technique to physically restrain a person who may be out of control or assaultive (defined here as in imminent danger to self or others). The hold restricts the bodily movement of the person; therefore it must be used with caution. Your knowledge of the person and assessment of your abilities will determine your success in using this hold. Documentation and debriefing after this intervention are **REQUIRED**. Follow your agency's policies and procedure

There are certain precautions to think about when using a therapeutic hold:

1. Although the amount of physical control needed depends on how severe the person's behavior is, your physical abilities and speed are also important considerations.
2. The hold should be adjusted so that you are only using as much strength as needed. This is called *controlling strength*. Use less strength as the person relaxes and calms down, or more strength if needed.
3. While the person is in the hold, a person trained in CPR needs to make frequent checks of his/her physical condition. Close observations of breathing and circulation to the hands and fingers are important.
4. Care should be taken to avoid injury from:

a. Head butts: lean back and step slightly to the side of the secured person.

b. Kicks: keep close and try to begin walking the person.

c. Scratches: keep person's hands tightly secured to their sides.

Placing a person in a therapeutic hold may provide all the control that is needed. Your first consideration must be to release and back off as soon as the person is calm or meets criteria for release. You and your co-workers may need to consider several options depending on the intensity of the situation.

Ask yourself

- *Is there imminent danger to the person or others that would call for this physical restraint?*
- *What do I know about this person when he/she becomes agitated, upset or frightened?*
- *Can I maintain safety without using physical restraint?*
- *Have I considered other less restrictive interventions? Have I been alert to this person's signs of increasing upset?*
- *Do I know what works to help this person calm down. If I don't, have I tried to get someone there who does? Have I tried to talk calmly with the person?*
- *Will it help to give the person some space or time?*
- *Can I safely restrain the person in a therapeutic hold by myself?*
- *Is help available if I need it?*
- *Are there other people in the immediate area who need to be cleared out of the way? Is there help to do this?*

THE NEVERS !

NEVER CROSS THE PERSON'S ARMS OVER HIS/HER CHEST, THIS CAN RESTRICT BREATHING, CRUSH THE CHEST, AND/OR CAUSE DEATH.

NEVER HYPER-EXTEND THE PERSON'S ARMS (PULLING THE ARMS OF THE PERSON, SO THAT HIS/HER ELBOWS CROSS OVER EACH OTHER), THIS CAN CAUSE INJURY TO THE PERSON'S SHOULDERS.

BOTH OF THESE ACTIONS ARE VERY UNSAFE!

*******ALL PHYSICAL TECHNIQUES HAVE BEEN APPROVED THROUGH THE STATE AND FORMER NCI QUALITY ASSURANCE COMMITTEE AND RETRIEVED FROM NCI Participant Workbooks (2003) – Prevention; Core and Core Plus (Public Domain)**********

THE OVERHEAD BLOCK TO THERAPEUTIC HOLD

METHOD A: ONE ARM BLOCK

The procedure...

*1. Block the punch.

*2. Secure the wrist by placing the thumb under and closing the fingers over the back of the wrist. Caution: Do not twist arm or wrist.

*3. Adjust person's arm to their shoulder level.

*4. Place the free arm in an L-shaped position on the back of the person's arm.

*5. Slide other arm in L-shape position across shoulders as you step behind and beyond the person.

*6. Hold the person's arm fully extended and use your other arm to pin his free arm from the shoulder down to the front center of his body with an open hand.

*7.Lower his extended arm over his pinned arm.

*8.Transfer the wrist you are holding to your open hand.

*8. With your now free hand, grasp the person's free wrist. Place your hands under the person's elbows. Secure the person's arms at his/her hip/waist level, below the base of the ribcage, keeping a firm grasp on wrists. Keep your elbows locked to the person's sides and maintain body contact.

9. While maintaining good body contact, shift your weight to one foot and place the other foot between the person's feet. Place the other foot directly behind causing the person to lean back slightly.

Considerations

- *Use only the amount of control necessary to provide safety for everyone.*
- *Respond clearly and immediately to any cues that the person is becoming less physically threatening. Do this by talking supportively to the person and relaxing your grip. Begin to plan your release.*
- *Hyper-extension of the person's arms in the therapeutic hold is NOT ALLOWED. It is not just a comfort issue, but a critical safety issue for the other person. During a struggle, locking your elbows to your sides can prevent hyper-extension. If you find you are holding the person's arms so that the person's elbows are crossed, stop immediately, and bring the arms down to the person's waist or release the hold entirely.*
- *If the person has a history of asthma, congestive heart failure, Down syndrome or any other breathing difficulties (cystic fibrosis), the therapeutic hold may be restricted or not allowed Knowing the person's medical history is vitally important.*

THE HOOK OR STRAIGHT PUNCH

*1. Block the punch.

*2. Secure the wrist by dropping the thumb down and raising the elbow at the same time. The thumb goes under the wrist, fingers go over the wrist.

3. Adjust person's arm to their shoulder level.

4. Continue with steps 4 - 9 as shown on the previous pages to carry out the therapeutic hold safely.

THE UPPERCUT

The procedure.....

*1. Block the punch. (See the uppercut punch in Blocking Punches.)

*2. Secure the wrist with the top hand by placing the thumb under and closing the fingers over the wrist, (keep bottom hand in place).

*3. Bring the person's arm to their shoulder level. Drop the block.

4. Continue with steps 4-9, Method A or B, as shown on the previous pages to safely carry out the therapeutic hold.

Considerations

- *Keep your head out of head butting range.*

THERAPEUTIC HOLD WRAP

The procedure:

*1. Approach the other person from behind and position your body close to the other person's body. Your feet should be on the outside of the other person's feet, with knees bent.

*2.Position arms in an upright L-shaped position, elbows pointed to the floor. Make contact using your forearm between attacker's shoulder and elbow.

*3. Move arms inward into a scissors position.

*4. Continue to pin, slide hands downward and secure the other person just above the wrists.

5. While maintaining good body contact, shift your weight to one foot and place the other foot between the person's feet. Place the other foot directly behind causing the person to lean back slightly.

Considerations

- *If the person has loose shoulders, be wary of hype-extending their arms.*
- *Never pin elbow over elbow.*
- *Keep your head out of head butting range*

TWO HANDED HAIR PULL–FRONT

Prevention: Use a double L-shaped block to prevent the two handed front hair pull.

The release...

*1. Place hand over person's knuckles. (Stop the pull.)

*2. Press down firmly with heel of hands until grip loosens.

*3. Bend forward, drop one shoulder and move hands off head in the direction you are facing.

*4. Step back.

Considerations

□ *Ask the person to let go of your hair. Be calm but firm. Do not let your voice add to an escalation of the situation. You may have to ask more than once. If you do not feel the person's fingers relaxing, then use release technique.*

□ *Move away and consider ways to calm the person*

TWO HANDED HAIR PULL–BACK

The release...

*1. Press firmly on person's knuckles with flat hands, fingers open and straight. Apply pressure until grip loosens.

*2. Maintaining pressure on knuckles, drop one shoulder. Turn under person's arms.

3. Release and move away.

Considerations

□ *Ask the person to let go of your hair. Be calm, but firm. Do not let your voice add to an escalation of the situation. You may have to ask more than once. If you do not feel the person's fingers relaxing, then use the release technique.*

- *Performing this technique leaves you briefly vulnerable to a kick or being "kneed".*
- *Move away and consider ways to calm the person*

LIMITED CONTROL WALK

The procedure...

*1. Staff approaches the person from the side and slightly to the rear.

*2. Place hand closest to the person slightly above person's elbow and other hand on person's wrist.

*3. Place arm in an L-shaped position. Using a cupped hand above the person's elbow, Use slight pressure forward to prompt walking.

4. Use the secured arm to block any punch the person might throw with his free arm. Release the hold and move away and monitor for safety

Considerations

- *Be Respectful! Remember moving away can be a valid means of de-escalating the situation. This is not a moment for power struggles. In a physical confrontation, everyone loses. The other person loses dignity and self-control. You lose time and energy, and your relationship can be damaged.*
- *Only use when touching the person will not escalate the situation and/or require physical support.*
- *Don't mistake avoidance (pulling or stepping away from you) for aggression. The person may not want to go with you but may also be de-escalating.*
- *Be aware that when you choose a method of control rather than getting the person's agreement, this can harm your relationship with the person.*
- *Relax your appearance by opening your hands, talking softly, etc. It is important that your manner not be provoking.*

- *When you keep your responses to the minimum needed to maintain safety, you help promote a safe, conflict-free environment.*
- *As you approach the person, talk to him/her quietly. Discuss where you would like the person to go. Suggest that the two of you go together. Ask if they are ready to go at this moment.*
- *Look for opportunities to back off from touching the person above the elbow and wrist. Or you may redefine the touch as warm support, ie. moving the hand to the shoulder for a soft pat.*

THERAPEUTIC WALK TO CHAIR

The procedure...

*1. The staff places the person in a therapeutic hold and moves the person toward the chair using one of the previously learned walk procedures, or have helper bring chair in from the rear..

2. The person is walked around the chair until his back is toward the chair.

*3. Person is placed in the chair while the staff maintains the therapeutic hold.

*4. The staff places one knee on floor pressing shoulder in back of chair for support.

*5. The staff moves his head to one side to avoid head butts by the person.

ADDITIONAL INFORMATION: Staff may provide additional support for the chair by pressing one knee into the back of the chair while balancing his weight on the other knee.

Considerations

- *Make sure the chair being used is sturdy.*
- *If the person is extremely resistive, other techniques are better choices and may be safer.*
- *Size, strength, and relative level of resistance of the person is an important consideration. Do not put a person who weighs over 100 pounds in a chair. A large adult can break the back of the chair, and cause additional danger to both parties.*
- *Make sure knee is to the chair not the person*
- *Release the person slowly, move away, and consider ways to calm him/her.*

THERAPEUTIC HOLD IN CHAIR WITH ASSISTANCE

The procedure…

*1. Staff completes "therapeutic walk to chair" and indicates need for help. Helper can bring chair to staff and place behind staff, holding chair for support while staff sits person in chair.

*2. Helper approaches from rear, positioning self beside the person.

*3. Helper kneels with closest leg maintained in upright position beside person's leg and helper's other knee is positioned on floor to maintain balance.

*4. Helper places hand/arm closest to person across person's legs above the knees and other hand/arm below the knees for control.

Considerations:

- *Make sure the chair being used is sturdy.*
- *If the person is extremely resistive, other techniques are better choices.*
- *Make sure the person is not actively struggling.*
- *Size of the person is an important consideration. Do not put a person who weighs over 100 pounds in a chair.*
- *Release the person slowly, move away, and consider ways to calm him/her.*

ONE PERSON THERAPEUTIC WALK

The procedure...

*1. Staff places person in a therapeutic hold.

*2. While maintaining close body contact (upper body should not move), adjust the back foot up for balance.

*3. Staff moves foot that has been placed between person's feet to outside rear of person's foot, at the heel.

*4. Staff, keeping leg straight as though in a cast, (to prevent kneeing the person), leans the person back slightly, while lifting the person's foot at the heel causing the person to step forward. (Walking the person backward may be required to go through doorways or to position the person in a chair.)

*5. Staff maintains close body contact from shoulder to hip to designated area.

CAUTION: STAFF MUST NOT USE KNEE TO FORCE PERSON TO WALK OR TO LIFT PERSON OFF THE FLOOR.

Ask yourself

- *Must the person walk at this moment in time?*
- *Could talking softly with the person or waiting a moment or two lead to the person cooperating with you?*
- *Could the use of this technique lead to further escalation?*
- *Could you back down? Could releasing the therapeutic hold or moving to the limited control walk de-escalate the situation?*
- *Can you safely handle this situation alone? Is help readily available if you need it?*

□ *Is there anything in the immediate environment which would get in the way of your moving forward with the person? (furniture, other people, space) If you are unsure of the answers to these questions, waiting can buy you and the person time to figure out the best solution for everyone involved.*

On occasion, the person may try to sit down or pick his/her feet off the floor. If this should happen, turn to the side and kneel down with the person, making sure that the knee closest to the person lands before the person's rear end

TWO PERSON THERAPEUTIC WALK

The procedure...

*1. Staff places person in therapeutic hold, and indicates the need for help.

*2. Helper approaches from rear to person's open side and places foot that is closest to person beside staff 's foot (which is between the person's feet) and hip against staff 's hip creating a seal.

*3. Helper then places inside arm around the person and places open hand on person's hipbone. Hand is placed flat on person's hipbone, with fingers pointed to floor, covering the person's fingers to keep them from scratching, and pulls back slightly..

*4. Helper secures person's wrist nearest him with free hand by placing his hand at a point above staff 's hand and sliding downward to secure wrist.

*5. Once staff feels the "bump" indicating that the helper has secured the person's wrist, the staff releases grasp on that wrist, and proceeds to secure hold by placing opened hand on person's hipbone, fingers pointed to the floor covering person's fingers to keep them from scratching, and pulling back slightly.

*6. Staff in charge looks at partner and says "Ready." Helper indicates ready by nodding.

*7. Staff says, "Walk." Staff and helper take the first step with their outside feet.

*8. Inside foot comes out as walk begins. While maintaining good body contact, person is walked to designated area.

Considerations

□ Most of the time the person will begin to walk with you. Forced walking is very rare. Sometimes it will take a few minutes to encourage the person to begin the walk. Seldom is there a need to rush. You already have the person stabilized in the therapeutic hold. □ Talk softly and calmly with the person to avoid escalation. □ When releasing the person, release in a slow reassuring manner. □ Move away and consider ways to calm the person.

PREPARING FOR CLOSURE

Your goals are to help the person remain safe without the need for external controls and to help calm the person so that the restrictive intervention can end.

□ Once the person is restrained, insure that the person is safe within the intervention (breathing freely, no apparent circulation problems and not subject to injury from things like ground surfaces).

□ With people who are consistently acting in unsafe, aggressive and threatening ways, it is best not to talk much during the physical intervention other than ensure that the person is not having physical distress.

□ Staff should be alert to signs that the person is beginning to calm down and resistance is slowing down.

□ Release of physical control should be done gradually. Do not release as soon as the struggling stops. Release one part of the body at a time or allow one staff member to exit at a time.

□ Though the person was "safe" physically during the correct performance of the restrictive intervention, the procedure itself can be a frightening and humiliating experience.

□ Staff should consider ways to begin rebuilding the relationship with the person. As soon as possible look for an opportunity to talk quietly with the person to begin this rebuilding process.

□ Make sure you check with the person about any skin burns, bruises or other soreness as soon as possible. Then check with any of your co-workers involved in the restrictive intervention.

V367

Supplemental Documents

Incident and Response Training – 10/26/21
Curriculum and Sign In Sheets attached.

Copy of Pre/Post Test given to staff

Site Directors Training Certificate

Updated IRIS incident print-out for DC#8

INCIDENT RESPONSE AND REPORTING

Attendees: **ALL STAFF MEETING: TUESDAY, October 26, 2021 @ 0900**

Employee Name	Employee Signature
Ludenia Archie	Ludenia Archie
JADE WILLIAMS	Jade W
Shanika Howell	Shanika Howell
Stacy Harris	Stacy Harris
Misty Hill	Misty Hill
Janice Ledbetter	Janice Ledbetter
George Jackson	George Jackson
Candise Mores	
Michael Kirby	Michael Kirby RN

INCIDENT RESPONSE AND REPORTING

Attendees: **ALL STAFF MEETING: TUESDAY, October 26, 2021 @ 1900**

Employee Name	Employee Signature
Sydney Pellegrini	Sydney Pellegrini
Lavonda Hunter	Lavonda Hunter
Edith Franz	Edith Franz BSIOP
My Cottle	My Cottle
Holly Chapman	Holly Chapman
Sarah Martin	Sarah Martin
Eric Hopper	Eric Hopper
Heidi Hinchey	Heidi Hinchey

Attendees: **ALL STAFF MEETING: Friday, November 19, 2021 @ 0830**

Employee Name	Employee Signature
Tommie Philbeck	Tommie Philbeck
Sharon Kelley	Sharon Kelley
Howard M. Moore III "Tripp"	Howard M. Moore III "Tripp"
Teresa Richardson	Teresa Richardson
Jonathan Gerald	Jonathan Gerald

PHOENIX COUNSELING CENTER INCIDENT REPORTING TRAINING

PHOENIX
COUNSELING CENTER
Where Help, Hope and Compassion Come Together.

Reporting Guidelines for:

- *Adverse Events*
- *Critical Incidents*

WHY IS IT IMPORTANT FOR THE AGENCY TO REPORT INCIDENTS?

Reporting and documenting incidents within the agency ensures that services we provide are addressed quickly. The purpose is to analyze trends, to prevent future occurrences and improve the service system.

DEFINITION: INCIDENT

- An "incident," as defined in 10A NCAC 27G .0103(b)(32), is "any thing happening which is not consistent with the routine operation of a facility or service or the routine care of a consumer and that is likely to lead to adverse effects upon a consumer."
- There are three levels of response to incidents, based on the potential or actual severity of the event

CRISIS SERVICES

- All crisis providers are expected to report incidents that occur during the provision of crisis services
- For Mobile Crisis providers, this includes incidents that occur between the time they receive the request for crisis services and during their face-to-face contact with the consumer
- For Facility Based Crisis providers this includes incidents that occur when a consumer is on their premises or in their care.

REPORTING GUIDELINES

Documentation of all incidents:

- All incidents should be documented and analyzed as part of the provider's quality assurance and improvement processes.
- Complete all required sections on Adverse Event or Critical Incident form. Give as much information as known about an incident even if the incident occurred when the individual was not under your active care.

TIMELINE FOR SUBMITTING REPORTS

- All reports must be received by Jennifer Adams within 24 hours. Keep your supervisor informed but do not delay submission.
- Any needed review will be headed by QM or administration. This timeline is necessary to ensure state deadlines can be met by the company.
- If an incident should happen on a weekend, the incident should be received by the next business day.

ADVERSE EVENT (LEVEL 1) REPORTNG

- *Includes any incident as defined in 10A NCAC 27G .0602, which does not meet the definition of a Level II or III incident.*
- *Level I incidents are events that in isolated numbers do not significantly threaten the health or safety of an individual, but could indicate systematic problems if they occur frequently.*
- *Level I incidents are to be documented on the ADVERSE EVENT form.*
- *Adverse Events are documented and tracked through PCC's internal system only.*
- *Report within 24 hours*

EXAMPLES OF AN ADVERSE EVENT (LEVEL I)

- *Any injury that only requires first aid*
- *When a consumer is transported to hospital for medical clearance or needs to be evaluated for a non life threatening medical condition*
- *Any aggressive or destructive act that does not involve a report to law enforcement*
- *Inappropriate sexual behavior that does not involve a report to law enforcement*
- *Any medication error that does not threaten the individual's health or safety*
- *Any other Adverse Event t is outside standard operating procedure and which the employee or supervisor feels appropriate*

CRITICAL INCIDENTS

- *Critical Incidents are more serious and must be reported not only within PCC's internal system but also to NC Division of MH/DD/SAS.*
- *Critical Incidents are reported at 2 levels (Level II & Level III)*
- *Critical Incidents must be submitted on a CRITICAL INCIDENT form.*

LEVEL II

- Includes an incident, as defined in 10A NCAC 27G .0602, which involves a consumer death due to natural causes or terminal illness,

Or

- An incident which results in a threat to a consumer's health or safety or a threat to the health or safety of others due to consumer behavior

EXAMPLES OF LEVEL II CRITICAL INCIDENTS

- Consumer death due to terminal illness or other natural causes
- Any injury that requires more than first aid
- Any medication error that threatens the individual's health or safety
- Any suicidal behavior that does not result in death or psychological impairment

LEVEL III

Includes any incident, as defined in 10A NCAC 27G .060, that results in

- (1) a death, sexual assault or permanent physical or psychological impairment to a consumer
- (2) a substantial risk of death, or permanent physical or psychological impairment to a consumer
- (3)a death, sexual assault or permanent physical or psychological impairment caused by a consumer
- (4) a substantial risk of death or permanent physical or psychological impairment caused by a consumer or
- (5) a threat caused by a consumer to a person's safety.

EXAMPLES OF LEVEL III CRITICAL INCIDENTS

- *Any death due to*
  - *Suicide*
  - *Violence/homicide*
  - *Accident*
  - *Unknown cause*
  - *Death occurring within 7 days of seclusion or restraint*
- *Any incident that caused permanent physical or psychological impairment to a consumer*

IMPORTANT THINGS TO REMEMBER!

- *All reports must be received within 24 hours*
- *Make sure you are using the correct form. You can get forms from QM Coordinator, Jennifer Adams or your supervisor.*
- *Whether documenting an adverse event or a critical incident, always complete all appropriate areas. It is important to be descriptive when documenting!*
- *An Adverse Event does not have to involve a consumer*

INCIDENT REPORT SUBMISSION

- *In person to Jennifer Adams @ Gaston Outpatient, 2505 Court Drive, Gastonia, NC 28054 or mailbox in staff breakroom.*
- *Send HIPPA compliant email to: jennifer.adams@phoenixcc.us*
- *Fax to 704-854-4860*
- *You can also submit to your immediate supervisor as your supervisor will follow these same guidelines.*

IF YOU HAVE ANY QUESTIONS PLEASE FEEL FREE TO CONTACT ME!

Jennifer Adams

Quality Management Coordinator

704-842-6384

Jennifer.adams@phoenixcc.us

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Phoenix Counseling Center
Incident Reporting Training

Pre & Post Test

Date:_____ Name:_____

1. What is the importance for reporting incidents?

2. All incident reports should be submitted within
   a. 72 hours
   b. 48 hours
   c. 24 hours

3. True or False
   Facility Bases Crisis providers are expected to report incidents that occur when a consumer is on their premises or in their care.

4. Give two examples of an Adverse Event.

5. Level II & Level III incidents should be documented on
   a. Critical Incident Form
   b. Adverse Event Form
   c. Death Form

6. True or False
   Adverse Events are tracked internally and reported to NC Division of MH/DD/SAS

7. What is considered an Adverse Event?
   a. Consumer death due to natural causes
   b. Consumer transported to hospital for medical clearance
   c. Consumer death due to terminal illness

8. What is the definition of an "incident"?

9. A consumer falls in the hallway and only needs a band aid. What form is to be completed?
   a. Critical Incident Form
   b. Do not need to report
   c. Adverse Event Form

10. True or False
    There is only one way to submit an incident report and that is by email only.

11. True or False
    An Adverse Event should only involve a consumer.

12. Give an example of a Level III Critical Incident

13. True or False
    Any medication error that does not threaten the individual's health and safety should be documented as an Adverse Event.

14. True or False
    Whether documenting an Adverse Event or Critical Incident, always complete all appropriate areas. It is important to be descriptive when documenting.

15. True or False
    You should always keep your supervisor informed but do not delay submission of incident report.

PHOENIX COUNSELING CENTER
CERTIFICATE OF TRAINING PROVIDED

AWARDED TO:

Jerry Utt

For being Committed to Quality and Successfully Completing the Annual Safety Training

Awarded on

3/15/2021

PHOENIX
COUNSELING CENTER
Where Help, Hope and Compassion Come Together

Training Received:

- Emergency Preparedness Policy, Procedure, and Plans
- Critical Incident and Adverse Event Reporting
- Infectious Diseases and Blood Borne Pathogens
- Customer Services Training
- Active Shooter Training

Jennifer Adams

PCC Safety Officer

North Carolina Incident Response Improvement System

Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Date of Incident: 12/24/2021

Date Last Submitted: 3/18/2022

PROVIDER INFORMATION

Corporation: Phoenix Counseling Center

NAME

Name and Title of Person completing this form: Jennifer Adams

TITLE

QM Coodinator

Local Facility/Unit/Group Home

NPI Number:

Name: Cleveland Crisis and Recovery Center

Cottage Name:

License Number: MHL___-____

Director:

Physical Address: 609 N. Washington Street

Mailing Address:

City: Shelby **Zip Code:** 28150

Phone Number: (704) 751-3693

Fax Number: (___) ___-____

E mail address: jennifer.adams@phoenixcc.us

Plan/Service: LME-MCO

Pre-paid Health Plan:

[redacted]

County where services provided:	Cleveland
Host LME:	PATHWAYS
County of Residence:	Cleveland
Home LME:	PATHWAYS

INCIDENT INFORMATION

Date and Location

Date of Incident: 12/24/2021 ☐ **Unable to determine at this time**

Time of Incident: 10:00 PM

Date Provider Learned of Incident: 12/28/2021

Location of the Incident: Community

Other People Involed:

☑ Other

3/18/2022 Driver of the vehicle... who is unknown

Does this incident include an allegation against the facility? No

Service Type Provided

At the time of the incident:

Was the consumer under the care of the reporting provider at the time of the incident? No

Was a Licensed Residential Service being provided at the time of the incident? No

Did the incident occur while the consumer was on these premises? No

Was a Non-Residential Licensed Service being provided? No

Did the incident occur while the consumer was on these premises?

Was an Un-Licensed Service being provided at the time of the incident? No

Did the incident occur while the consumer was on these premises?

CONSUMER INFORMATION

First MI Last

Consumer's Name: [redacted]

Address where Incident Occurred: ☑ Address unknown

Address1:

Address2:

City:

State: **Zip:**

Location: Community

LME Client Record Number: [redacted]

Medicaid ID:

CNDS ID:

Consumer's Date of Birth: [redacted] ☐ Date of Birth unknown

Gender: Male

Race/Ethnicity: White

Height: [redacted] ☐ Unknown

Weight: [redacted] ☐ Unknown

Dates of Last 2 Medical Exams: ☑ None ☑ None

Services Funded by: State Funds Only

Diagnosis

DSM-IV	292.89	Amphetamine Intoxication
DSM-IV	305.20	Cannabis Abuse
DSM-IV	305.60	Cocaine Abuse

Current Medications:

12/29/2021 N/A

Medical Diagnosis:

[redacted]

N/A

Has consumer been adjudicated incompetent?	No
Is consumer receiving ICF-MR/DD services?	No
Does consumer recieve Innovations Waiver?	No
Self-Directed Waiver?	No
Is this person in the Money Follows the Person program?	No
Does consumer have TBI (Traumatic Brain Injury)?	No
Has this person ever hit his/her head or been hit in the head, including being told that he or she has/had a concussion?	Unknown
Has the person ever had a loss of consciousness or experienced a period of being dazed and/or confused because of the injury to the head?	Unknown
How old were you the first time you were knocked out or loss consciousness?	

VETERAN

Have this person or a family member ever served in the Active Duty, Guard or Reserve Armed Services?	Unknown
If yes, has this person ever served in a Combat Zone?	Unknown

Treatments

Did this incident result in or is it likely to result in permanent physical or psychological impairment?	No
Has this incident resulted in or is it likely to result in a danger to or concern to the community or a report in a newspaper, television or other media?	Yes
Was the consumer treated by a licensed health care professional for the incident?	Unknow

If hospitalized ...

was it for a medical condition?	Unknown
was it for a MH/DD/SAS issue?	Unknown

Is the consumer enrolled in an opioid treatment program, (methadone maintenance)? No

Mental Health Services

Did the consumer receive mental health services? Yes

Licensed Residential Services

☑ YP485 (.5000) - Facility Based Crisis Program - Non-Medicaid

Licensed Services

Non-Licensed Services

When did the consumer last receive a mental health service? 12/23/2021

Did the consumer express any suicidal ideation during the last mental health service? No

Did the consumer express any homicidal ideation during the last mental health service? No

Developmental Disability Services

Did the consumer receive developmental disability treatment/habilitation services? No

Licensed Residential Services

Licensed Services

Non-Licensed Services

When did the consumer last receive a development disability service?

Did the consumer express any suicidal ideation during the last development disability service?

Did the consumer express any homicidal ideation during the last development disability service?

Substance Abuse Services

Did the consumer receive substance abuse services? Yes

Licensed Residential Services

☑ H0012HB (.3400) - Substance Abuse Non-Medical Community Residential Treatment - Adult

Licensed Services

Non-Licensed Services

When did the consumer last receive a substance abuse service? 12/23/2021

Did the consumer express any suicidal ideation during the last substance abuse service? No

Did the consumer express any homicidal ideation during the last substance abuse service? No

Hospital Discharge

[redacted]

Date of last discharge from a State facility/hospital

Name of State Facility/Hospital

Date of last discharge from a Non-State facility/hospital Unknown

Name of Non-State Facility/Hospital

Associated Incident Reports

Have other Incident Reports been submitted for this incident because more than one consumer was involved / affected by this incident? No

How many other consumers required, or will require, incident reports for this same incident?

DEATH INFORMATION

Manner of Death:

Cause of Death: Accident

Did death occur within 14 days of discharge from a State Operated Facility? No

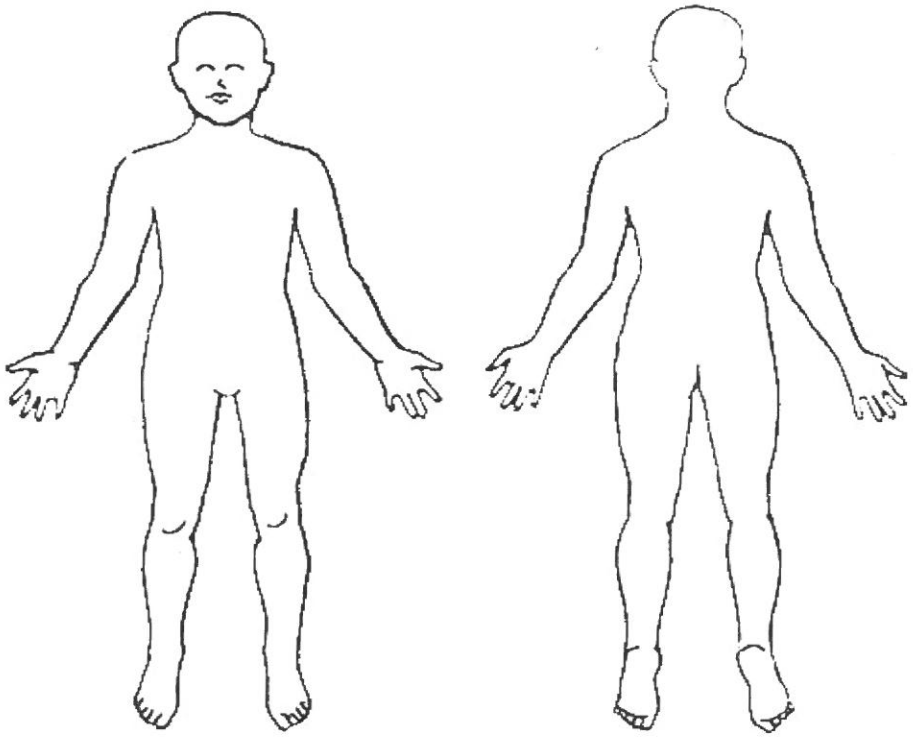
Did death occur within 7 days of Restrictive Intervention?* No

* Note: If you previously answered 'Yes' to this question, and the Restrictive Intervention section of this incident report is no longer required, be sure to uncheck it on the 'Type of Incident' menu after saving the information provided in this section.

Associated Injuries:

☑ Unknown

Associated Body Parts:



12/29/2021 Unknown

Due To:

☑ Motor Vehicle Accident

INCIDENT COMMENTS

Orgnization	Title	Author	Date	Text
LME	MCO/LME	djackson57	1/3/2022	Incident reviewed.
Advocacy	CSCR Review	[redacted]	12/29/2021	Please attach a copy of the OCME Report and/or Death Certificate when received.
Provider		Provider	12/29/2021	Per newspaper report from Laurens, SC, On Christmas Eve night, consumer died after being hit by a car. He was walking Northbound on SC-49 around 10:00 pm. According to Chief Deputy Coroner Paul Canupp, Consumer died from blunt force trauma.

SUPERVISOR ACTIONS

Level of Incident:

Level III

Describe the cause of this incident:

12/29/2021 No one knows the cause of this incident as the crash is currently still under investigation.

Incident Prevention:

12/29/2021 This accident and death is still currently still under investigation.

Incident Submission:

Name of Supervisor Authorizing Report: Jerry Utt

Title of Supervisor Authorizing Report: Facility Director

Phone #: (704) 751-3693 **Email Address:** jerry@phoenixcc.us

The following checked agencies will be automatically notified of this incident by the NC-IRIS system based on the details provided in this document.

- ☑ Local Management Entity Where Services Provided
- ☑ Local Management Entity Where Consumer Resides
- ☑ DMH/DD/SAS Quality Management
- ☑ DMH/DD/SAS Customer Service and Community Rights
- ☑ DHSR Complaint Intake Unit
- ☑ DHSR Mental Health Licensure

When re-submitting the Incident Report, please enter your explanation here:

3/18/2022 Clarification no clinical evidence of TBI. That information was provided by the consumer. That diagnosis was given by a qualified professional based upon self report by consumer however, there is no history of prior TBI found in his medical record.

☑ By checking this box, I attest that the information contained in this Incident Report is true and an accurate representation of the incident.

V512

Supplemental Documents

Early Discharge Policy and Procedure

QM Reporting Form

Consumer Early Discharge Form

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POLICY AND PROCEDURE

Title: Early Discharge from Facility-Based Crisis **Responsible Department:** Clinical Operations **Last Revision:** **Board Reviews:**	**Policy Number:** **Effective Date:** **Board Chair:**_____ **Date:**_____ **CEO:**_____ **Date:**_____ **Last Board Review:**

I. POLICY:

Phoenix Counseling Center shall appropriately review all consumers' status prior to allowing an early discharge from Facility-Based Crisis.

II. PROCEDURES:

A. Voluntary Consumers are consumers that have made a voluntary choice to enter PCC's facility-based crisis program for Crisis Interventions. Voluntary consumers may request to leave before their discharge date. The below procedures outline the requirements and allowances around Early Discharge.

1.) Consumer will request in writing their request for early discharge via the Request for Early Discharge form with Dated Signature and time of the request.
2.) Clinicians or Qualified Professionals(QP) can assess consumers for stability and in the event that they feel they are stable enough for early discharge they will route the discharge request form to the Nurse. The Nurse will contact the physician/extender to set up a time for them to see the consumer to either approve/disapprove the consumer's request for early discharge.
3.) It is required that the consumer see the physician/extender prior to any early discharge release.
4.) If the clinician or QP does not feel that the consumer is stable enough for early discharge, then the consumer will see a physician/extender at the time of their next rounding to be assessed for stability and orders will be given at that time.
5.) If staff and/or physician/extender feels that the consumer could potentially cause harm to self or others, the consumer can be held for up to 72 hours while a petition for involuntary commitment is completed.
6.) All Consumers must have a discharge plan. For Early Discharge, the consumer's discharge plan should include resources that are available to the consumer in the event a consumer has an additional crisis post-discharge.

B. Involuntary Consumer

An involuntary Consumer is a consumer that has either been transported to PCC for an IVC

first evaluation or an individual who has presented to the intake area and assessment has determined that a first evaluation is needed. PCC staff will then complete the first evaluation and physician completes the second evaluation. After a determination that IVC is warranted, the required information is then sent to the magistrate's office.

1.) Consumers admitted for treatment under involuntary commitment may not be discharged until a second examination is completed by a physician.
2.) In the event the physician determines there are insufficient findings that the consumer meets commitment criteria after the conclusion of the second exam, the physician will indicate this on the 24 Hour Facility Examination and an order given to discharge the consumer.
3.) In the event that the consumer chooses to stay after insufficient findings for upholding the Involuntary Commitment the consumer can consent to voluntary treatment. The consumer will be assessed by staff and physician for stability and compliance to treatment and discharged at the discretion of the treating physician.
4.) Any consumer under involuntary commitment must be seen by the physician/extender before discharge prior to the initial court hearing.
5.) All Consumers must have a discharge plan. For Early Discharge, the consumer's discharge plan should include resources that are available to the consumer in the event a consumer has an additional crisis post-discharge.

Quality Management Process

1.) All Early Discharges shall have a secondary review by the supervisor of the crisis unit within 24 hours of the early discharge. This will be done to ensure that all appropriate protocols have been followed and that all appropriate follow up has been done. The supervisor will complete a note to indicate they have completed the review.
2.) The Crisis Supervisor will complete the Quality Management Early Discharge Reporting Form and forward to Quality Management weekly.

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Quality Management Early Discharge Reporting Form

Date of Early Discharge	Client Name	Client ID	Physician Name	Date seen by Doc?	Date of Secondary Review

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Request for Discharge

122C-211. Admission.

(b) In 24-hour facility the application shall acknowledge that the applicant may be held by the facility for a period of 72 hours after any written request for release that the applicant may make and shall acknowledge the the 24 hour facility may have the legal right to petition for involuntary commitment of the applicant during that period. At the time of application the facility shall tell the applicant about procedures for discharge.

122C-212.Discharges

(b) An individual who has been voluntarily admitted to a 24-hour facility may be held for 72 hours after his written application for discharge is submitted.

I _____ am requesting to be discharged from inpatient treatment at the Crisis Recovery Center. I understand the above laws, and that I am required to see the physician for final approval of discharge.

Client Signature _____ _____

Date/Time

RN Staffing: _____ _____

Date/Time

Clinician/Staff _____ _____

Date/Time

Physician/Extender _____ _____

Date/Time

Physician/Extender please circle:

APPROVED **DENIED**