Changes to Seclusion and/or Restraint Emergency Procedures Form

Page 1

- Add "/or" to title of form
- Add "Print on gold paper. No names or HIPAA-identifiers." to first box
- Change "Patient/Client #:" to "Medical Record #:"
- Add "(Required)" under the line for Medical Record #
- Add "Transgender" and "Other" to Gender
- Add "State" and "County:" under Legal Status/Child Welfare Custody
- Add "Co-Custody" under Legal Status
- Add "Southern Hills Hospital Pavilion" to list of Facilities
- Delete "Children and Adolescents ages 9-17:" and "Children under age 9:" boxes
- Add "Day of the week and shift:"
- Add "(Required) IS THIS CHILD/YOUTH CURRENTLY ENROLLED IN SPECIALIZED FOSTER CARE?
 Yes/No (For reporting purposes only)"
- Under CONTINUATION ORDER, change "patient/client's" to "child/youth"
- Under PHYSICIAL RESTRAINT/Number of Staff Involved, change "Patient" to "Child/Youth"

Page 2

- Change "Is Patient Medically Compromised" to "Is Child/Youth Medically Compromised"
- Change "Injury to Patient/Client" to "Injury to Child/Youth"
- Change "Does the patient/client have a Personal Safety Plan?" to "Does the Child/Youth have a Personal Safety Plan (Safety Assessment and Crisis Plan)?"
- Add "Legally Responsible Individual/" before "Parent/Guardian/Custodian Notified"

NEW

Commission on Behavioral Health Seclusion and/or Restraint Emergency Procedures for Children and Youth Denial of Rights v.01.08.2020

Print on gold paper. No names or HIPAA-identifiers.	Gender: Male Female	Legal Status:
		Legal Status
Date of Admission:	Transgender Other	Parental Custody
	77-1-1-1	
Medical Record #:	Height:	Child Welfare Custody
Wiedical Record #.		State
	Weight:	County:
		☐ Youth Parole Custody
(Required)	Age:	
(Reguiren)		Co-Custody
Page Check all that and		
Race: Check all that apply	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
American Indian/Alaskan Native	Asian	☐ White (Caucasian)
Black American	Native Hawaiian/Pacific Islander	Other
Ethnicity: Hispanic Non-Hispanic Unkn	own	
Programs/Facilities:	-	
DCFS/DWTC Acute-Adolescent (AAP)	DCFS/PRTF Oasis East 12	Reno Behavioral Healthcare
☐ DCFS/DWTC RTC	DCFS/PRTF Oasis West 12	Seven Hills Behavioral Institute
DCFS/PRTF Enterprise FLH 1	DCFS/PRTF Oasis 13	Southern Hills Hospital Pavilion
DCFS/PRTF Enterprise FLH 2	DCFS/PRTF Oasis 14	Spring Mountain Treatment Center
DCFS/PRTF Enterprise FLH 3	Desert Parkway Behavioral Healthcare	West Hills Hospital/Adolescent
DCFS/PRTF Enterprise FLH 4	Montevista Hospital/Acute	West Hills Hospital/Pediatric
DCFS/PRTF North (formerly ATC)	Montevista/Adolescent Residential	Willow Springs Treatment Center
DCFS/PRTF Oasis West 11	Never Give Up Treatment Center	Other
Day of the week and shift;	La rever one op Heatment Center	Other
	DUBOLL ED INTORIOR	
(Required) IS THIS CHILD/YOUTH CURRENTLY (For reporting purposes only)	ENROLLED IN SPECIALIZED FOSTER CARE	? L Yes L No
Discussed with wheeling (TV - TN - TN)		-2,000 -000 800 1
Discussed with physician: Yes No RN		
Physician verbal/phone orders by Dr.	Date/Time;	
Physician Initials:	Date/Time:	
Order noted by:	Date/Time:	
Did RN extend order once up to the maximum allo	wable hours? UYes UNo	
CONTINUATION ORDER: The RN evaluation and	documentation for continuation orders must inclu	de a face-to face-reassessment of the child/youth
current behavior that warrants the extension of the resti	aint/seclusion.	
SECLUSION: Locked Unlocked		□ N/A
Placed in Seclusion: DATE:	TIME:	PM
Keleased from Seclusion: DATE:	TIME:	PM Total time in minutes
MECHANICAL RESTRAINT: L Cuff/Belt L Le	gs Wrists 4-point 5-point Mitts	☐ Geri Chair ☐ N/A
Other		
Placed in Restraint: DATE:	TIME: 🔲 AM 🗀	PM
receased from restraint, DATE,	IIIVIC.	LPM Lotal time in minutes
PHYSICAL RESTRAINT: CPAR- Escort Sta	nding Wrap/Basket Hold 🔲 Seated 🔲 Lying	Supine (on back) N/A
Lying Prone (on stomach) Uther Hold Imp	emented, Type and Description:	
Placed in Restraint: DATE:	TIME:	
Released from Restraint: DATE:	TIME: 🔲 AM 🗀] PM
Total Time in Minutes:	Number of Staff Involved in Restraining C	hild/Youth:
CHEMICAL RESTRAINT: DATE:	TIME: AM [PM N/A
Medication Administered:	Dose· \square	PO IM
Medication Administered:	Dose:	
Medication Administered:	Dose:	PO IM
Results After one Hour (Explain)		
Behavioral Descriptors of Events: (CHECK ALL TI	IAT APPLY)	
Attempted elopement		Pushes
Bites	☐ Imminent harm to self	
l =	☐ Imminent harm to self☐ Kicks	Scratches
Cuts	Kicks	Scratches
Cuts Hits	☐ Kicks ☐ Physical fighting	☐ Scratches ☐ Spits
Cuts Hits Imminent harm to others	Kicks	☐ Scratches ☐ Spits ☐ Threatening gestures
Cuts Hits	☐ Kicks ☐ Physical fighting ☐ Property destruction	☐ Scratches ☐ Spits
Cuts Hits Imminent harm to others	☐ Kicks ☐ Physical fighting ☐ Property destruction	☐ Scratches ☐ Spits ☐ Threatening gestures
Cuts Hits Imminent harm to others	☐ Kicks ☐ Physical fighting ☐ Property destruction	☐ Scratches ☐ Spits ☐ Threatening gestures
Cuts Hits Imminent harm to others	☐ Kicks ☐ Physical fighting ☐ Property destruction	☐ Scratches ☐ Spits ☐ Threatening gestures
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Cuts Hits Imminent harm to others	☐ Kicks ☐ Physical fighting ☐ Property destruction	☐ Scratches ☐ Spits ☐ Threatening gestures

Is Child/Youth Medically Compromised: Yes	□ No (CHECK ALL THAT APPLY)		
	☐ Pregnancy	Spinal Injury	
Morbid Obesity Seizure Precautions	Recent Vomiting	Other	
Injury to Child/Youth During Procedure: Yes	No (If You describe injury on I was to	1	
Injury to childy Found Daring Procedure. [] Tes	13 No (II Tes, describe injury and any tre	eatment)	
Staff Intervention Prior to Restraint/Seclusion (CI	HECK ALL THAT APPLY)		
☐ Ventilation of Feelings ☐ Verbal Reassurance	Environmental Change	☐ Limit Setting	
Verbal Redirection	Praise/Empathy Statement 1:1 Interaction w/Staff	Rationale/Reality States Reduction in Stimuli	ments
Timeout	Coupling Statements	[_] Reduction in Stimuli	
Describe Interventions Prior to Procedure:			
Does the Child/Youth have a Personal Safety Plan			
Was the Plan followed? Yes No	Was there a Debriefing?	Yes No	
Plan to prevent further events (Make Note of Any	Changes to the Positive/Individual Behar	vior Plan, and attach Plan):	
			
Names and Titles of Staff Involved:	E-100 - 100		
Name:		Title:	-
Names and Titles of Miles			
Names and Titles of Witnesses: Name:		Title:	
	Carrier Nation Day Day	Inte:	
Legally Responsible Individual/Parent/Guardian	/Custodian Notified		
Name of Staff Member Providing Notification:	Da	ate: Time:	_ 🗌 AM 🗌 PM
Nursing Report: Findings and Treatment:			
Signature/Title:		D .	
		Date:	
Physician's Report: Findings and Treatment:			
Signature/Title:		Date:	
Program Manager's (DCFS CPM I) Review: Findir	gs and Treatment		
,			
Complement (Trivia			
Signature/Title:		Date:	
DCFS Clinical Program Manager II's Review: Find	ings and Treatment		
Signature/Title:		Date:	
DCFS/Private Facility ADMINISTRATIVE	DOES A DA (IN HOTEL A TOP DAY		
REVIEW: Comments-	DCFS ADMINISTRATOR REVIEW: Comments-	DAG/COMMISSION REVI	EW:
	Condition		
		DAG	Date:
			Date.
DCFS Dep. Admin. / Facility Admin. Date:	Administrator Date:	Commissioner	Date:
, , , , , , , , , , , , , , , , , , , ,	Date.		
NV Commissioner of Behavioral Health Comment	<u></u>	<u> </u>	
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Commission on Behavioral Health Seclusion and Restraint Emergency Procedures for Children and Youth Denial of Rights

Date of Admission:	Gender: Mal	e 🔲 Female	Legal Status:
Patient/Client#:	Height:		☐ Parental Custody ☐ Child Welfare Custody
Age:	Weight:	-	Youth Parole Custody
Race:	Treight.		
American Indian/ Alaskan Native African American	Asian Native Hawa	iian/Other Pacific Islander	☐ White (Caucasian) ☐ Other
Ethnicity: Hispanic Non-Hispanic Unkn	OWN	mary officer racine islander	Ottler
	04414		
Programs/Facilities:	T		
☐ DCFS/ATC	☐ DCFS/OCTI-	I East 12	Reno Behavioral Healthcare
DCFS/DWTC Acute-Adolescent (AAP)	DCFS/OCTI	I West 12	Seven Hills Behavioral Institute
☐ DCFS/DWTC RTC	DCFS/OCTI	I 13	Spring Mountain Treatment Center
DCFS/FLH 1	DCFS/OCTH		West Hills Hospital/Adolescent
DCFS/FLH 2		ay Behavioral Healthcare	West Hills Hamiltol / Dedictor
DCFS/FLH 3	Montevista H	Ioonital / A suba	West Hills Hospital/Pediatric
DCFS/FLH 4			Willow Springs Treatment Center
DCFS/OCTH West 11		Adolescent Residential	Other
	Never Give L	p Treatment Center	
Children and Adolescents ages 9-17:		Children under age 9:	
Restrained for up to 2 hours		Restrained for up to 1 ho	ur
Secluded for up to 2 hours		Secluded for up to 1 hour	
Secluded and Restrained for up to 2 hours		Secluded and Restrained	for up to 1 bour
Discussed with physician: Yes No RN	initials:	Date/Time:	TO UP TO THOU
Physician verbal/phone orders by Dr.		Date/Time	No.
Physician Initials:		Date/Time:	
Order noted by:			
		Date/Time:	
Did RN extend order once up to the maximum all	owable hours?	Yes No	
CONTINUATION ORDER: The RN evaluation a	nd documentation	for continuation orders must	include a face-to face-reassessment of the
putient/client's current behavior that warrants the	extension of the re	straint/seclusion.	•
SECLUSION: Locked Unlocked			□ N/A
Placed in Seclusion: DATE:	TIME:	Пам Пр	DM
Released from Seclusion: DATE:	TIME:		M
Total Time in Minutes:			141
MECHANICAL RESTRAINT: Cuff/Belt L	age Miriete M	I noint DE noint D Miss.	The section of the se
Other	ega □ Milara □.	*-bount [] witte (☐ Geri Chair ☐ N/A
Placed in Pactraints DATE	TIL CE	C C -	
Placed in Restraint: DATE:	TIME:	∐ АМ ∐ Р	M
Released from Restraint; DATE:	HME:	LI AM L. P	M
Total Time in Minutes:			
PHYSICAL RESTRAINT: CPAR- Escort St	anding Wrap/Bask	et Hold 🔲 Seated 🔲 Lying	Supine (on back) N/A
Lying Prone (on stomach) U Other Hold Impl	lemented, Type and	l Description:	
Placed in Restraint: DATE:	TIME:	Пам Пр	M
Released from Restraint: DATE:	TIME:	ПАМ ПР	M
Total Time in Minutes:	Number of S	taff Involved in Restraining	Patient
CHEMICAL RESTRAINT: DATE:	TIME	DAM DE	
Medication Administered	IIMID,	UM [] I	°M □N/A
Medication Administered:	Dose:	<u></u>	O LIM
Medication Administered:	Dose:		PO ∐IM
Medication Administered:	Dose:		O [] IM
Results After one Hour (Explain)			
Behavioral Descriptors of Events: (CHECK ALL T	HAT APPLY)		
Attempted elopement	Imminent har	m to self	Pushes
∤ □ Bites	Kicks		Scratches
Cuts	Physical fight	ing	Spits
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I I ∤ Hits	Property dest	ruction	
Hits Imminent barm to others	Property dest	ruction	Threatening gestures
Imminent harm to others	Property dest	ruction	Threatening gestures Throwing objects at another
I =	Property dest	ruction	
Imminent harm to others	Property dest	ruction	
Imminent harm to others	Property dest	ruction	
Imminent harm to others	Property dest	ruction	
Imminent harm to others	Property dest	ruction	
Imminent harm to others	Property dest	ruction	
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Imminent harm to others	Property dest	ruction	
Imminent harm to others	Property dest	ruction	
Imminent harm to others	Property dest	ruction	

I I MOTOIG Unecity	Pregnancy	Spinal Injury	
☐ Morbid Obesity ☐ Seizure Precautions	Recent Vomiting	Other	
injury to Patient/Client During Procedure: 🗌 Ye	s 🔲 No (If Yes, Please describe injury a	nd any treatment)	
Staff Intervention Prior to Restraint/Seclusion (
Ventilation of Feelings Verbal Reassurance	☐ Environmental Change ☐ Limit Setting ☐ Praise/Empathy Statement ☐ Rationale/Reality Statement		
Verbal Redirection	1:1 Interaction w/Staff	Rationale/Reality Statements Reduction in Stimuli	
Timeout Describe Interventions Prior to Procedure:	Coupling Statements		
Does the patient/client have a Personal Safety Plawas there a Debriefing? The Yes No Plan to prevent further events (Make Note of An		owed?	
Names and Titles of Staff Involved: Name:		Title:	
Names and Titles of Witnesses:			
Name:		Title:	
arent/Guardiar/Custodian Notified Yes [No		
Name of Staff Member Providing Notification:		Date: Time: AM 🗆 P	
Nursing Report: Findings and Treatment:		Date: Time: AM P	
Signature/Title:		Date:	
Physician's Report: Findings and Treatment:	2011 41	The second secon	
Signature/Title:		Date:	
Program Manager's (DCFS CPM I) Review: Find	ings and Treatment:	A440 00 00 00 00 00 00 00 00 00 00 00 00	
		D.L.	
ignature/Title:	The state of the s	Date:	
	dings and Treatment	Date:	
Signature/Title: DCFS Clinical Program Manager II's Review: Fir Signature/Title:	dings and Treatment	Date:Date:	
OCFS Clinical Program Manager II's Review: Fir Signature/Title: OCFS/Private Facility ADMINISTRATIVE	DCFS ADMINISTRATOR REVIEW:		
DCFS Clinical Program Manager II's Review: Fir Signature/Title: DCFS/Private Facility ADMINISTRATIVE	DCFS ADMINISTRATOR REVIEW:	Date:	
OCFS Clinical Program Manager II's Review: Fir	DCFS ADMINISTRATOR REVIEW: Comments-	Date:DAG/COMMISSION REVIEW:	
OCFS Clinical Program Manager II's Review: Fir Signature/Title: OCFS/Private Facility ADMINISTRATIVE REVIEW: Comments- OCFS Dep. Admin. /Facility Admin. Date:	DCFS ADMINISTRATOR REVIEW: Comments- Administrator Date:	Date: DAG/COMMISSION REVIEW: DAG DAG Date:	
DCFS Clinical Program Manager II's Review: Fir Bignature/Title: DCFS/Private Facility ADMINISTRATIVE REVIEW: Comments-	DCFS ADMINISTRATOR REVIEW: Comments- Administrator Date:	Date: DAG/COMMISSION REVIEW: DAG DAG Date:	
OCFS Clinical Program Manager II's Review: Fire Signature/Title: OCFS/Private Facility ADMINISTRATIVE REVIEW: Comments- OCFS Dep. Admin. /Facility Admin. Date:	DCFS ADMINISTRATOR REVIEW: Comments- Administrator Date:	Date: DAG/COMMISSION REVIEW: DAG DAG Date:	