PUBLIC MEETING NOTICE
AGENDA
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
COMMISSION ON BEHAVIORAL HEALTH

November 18, 2016
8:30 AM to Adjournment

Commission Members: Valarie Kinnikin; Pamela Johnson; Lisa Durette, M.D.; Noelle Lefforge, Ph.D., Asma Tahir; Lisa Ruiz-Lee; Tabitha Johnson, MFT; Thomas Hunt, M.D., Barbara Jackson

VIDEO CONFERENCE AVAILABILITY:

- **RENO – Northern Nevada Adult Mental Health Services (NNAMHS), 480 Galletti Way, Building 22 Conference Room, Sparks, Nevada**
- **LAS VEGAS – 6161 W. Charleston Blvd. Bldg. 1, West Hall Conference Room, Las Vegas, Nevada**
- **Call in: – (775) 887-5619 Conference No. 2001# Pin No. 1118#**

8:30 AM	1.	Call to Order	Chair Kinnikin
	2.	Public Comments *Public Comment will be taken during this agenda item. No action may be taken on a matter raised under this item until the matter is included on an agenda as an item on which action may be taken. The Chair of the Commission will place a five (5) minutes time limit on the time individuals may address the Commission. The Chair may elect to allow public comment on a specific agenda item when that item is being considered.*	Commissioners/Public
	3.	For Possible Action September 16, 2016 Minute	Chair Kinnikin
	4.	Informational Agency Director Reports	Commission
	5.	Informational Report on Behavioral Health Wellness and Prevention • Simplification of sub-grant process	Kyle Devine, Chief, BHWP
	6.	Informational • Seclusion and Restraint Report Update • Update on electronic transmission versus FedEx • Update on feedback provided to hospitals regarding Commission feedback.	Statewide QA/PI Manager, DPBH
	7.	Informational Local Governing Board Reports • Northern Nevada Adult Mental Health • Southern Nevada Adult Mental Health • Lake's Crossing Center	Commission

	8.	Informational Report on Aging and Disability Services Division • Reciprocity of professional staff • Waitlist concerns related to DRC and SRC	Edward Ableser, Administrator , ADSD
	9.	Informational Overview of denial of rights statutes	Julie Slabaugh, DAG
	10.	For Possible Action Discuss and possible approval of response process for Seclusion and Restraint, Denial of Rights and Death Reports	Chair Kinnikin and members
	11.	For Possible Action/Make Recommendations • Establish Bylaws Committee/appoint members	Chair Kinnikin
	12.	For Possible Action/Make Recommendations • Governor's Letter Committee Appointment	Chair Kinnikin
	13.	Informational • Update on Housing Regulations	Ellen Richardson-Adams
	14.	Informational • Review organizational charts on various Divisions/Branches with relation to Behavioral Health • Annual report on information regarding all services provided not limited to waitlists and census	Cody Phinney, Administrator
	15.	For Approval • Policy A 1.1 – Policy Development and Review Process **DRC Policies:** • Policy 36-1 – Family Preservation Program • Policy 36-2 – Respite Services • Policy 37-1 – Durable Power of Attorney for Health Care Decisions • Policy 39-1 – Community Service Health Care for Supported Living Arrangements (SLA) • Policy 41-4 – Residential Services Cost of Living Allocations • Policy 41-6 – Shared Living Arrangements • Policy 46-1 – Electronic Documentation	Commission
	16.	Identification of Future Agenda Items	Commission
	17.	Public Comments *Public Comment will be taken during this agenda item. No action may be taken on a matter raised under this item until the matter is included on an agenda as an item on which action may be taken. The Chair of the Commission will place a five (5) minutes time limit on the time individuals may address the Commission. The Chair may elect to allow public comment on a specific agenda item when that item is being considered.*	
	18.	For Possible Action Adjournment of Regular Session	Commission

		EXECUTIVE SESSION CLOSED TO THE PUBLIC	
	1.	For Possible Action Call to Order of Executive Session	Chair Kinnikin
	2.	For Possible Action Approval of Executive Session Minutes From September 16, 2016	Chair Kinnikin and Commissioners
	3.	Informational Review of Denial of Rights and Seclusion and Restraints pursuant to NRS 433.534 (4) and NRS 241.030	Chair Kinnikin
	5.	Informational Review of Death Reports	Chair Kinnikin
	6.	Identification of Discussion and Identification of Future Agenda Items	Chair Kinnikin
	7.	For Possible Action Adjournment of Executive Session	Chair Kinnikin

Denotes Possible Action Item
Agenda items may be taken out of order.

NOTE: Unless a specific time is noted, items on the agenda may be taken in any order and any agenda items not covered at this meeting may be placed on the agenda for the next scheduled meeting.

Please be advised that at the discretion of the Chair, public comments may be limited to five (5) minutes.

Members of the public who are disabled and require special accommodations or assistance at the meeting are requested to notify the Commission Secretary in writing at: Division of Public and Behavioral Health , 4150 Technology Way, 3rd Floor, Carson City, NV 89706, or by calling 775-684-2207 no later than three (3) working days prior to the meeting date.

NOTICES OF PUBLIC MEETING HAVE BEEN POSTED AT THE FOLLOWING LOCATIONS:

DRC - 1391 South Jones Boulevard, Las Vegas
LCC - 500 Galletti Way, Sparks
NNAMHS – 480 Galletti Way, Sparks
DPBH – 4126 Technology Way, 1st Floor, Carson City
DPBH – 4150 Technology Way, 1st Floor, Carson city
SNAMHS - 6161 West Charleston Blvd., Las Vegas

Division of Public and Behavioral Health website: http://dpbh.nv.gov/
Nevada Public Notice Website: https://notice.nv.gov/

COMMISSION ON BEHAVIORAL HEALTH
MINUTES
SEPTEMBER 16, 2016

VIDEO CONFERENCE MEETING LOCATIONS:

Northern Nevada Adult Mental Health Services (NNAMHS)
480 Galletti Way, Bldg. 22, Sparks, Nv

Division of Public and Behavioral Health
4150 Technology Way, Conference Room 303, Carson City, NV

Desert Regional Center
1391 South Jones Blvd., Training Room, Las Vegas, NV

COMMISSIONERS PRESENT:

Valerie Kinnikin, Chair - Las Vegas, Pamela Johnson, RN – Carson City, Barbara Jackson – Sparks, Thomas Hunt, M.D. – Las Vegas, Lisa Durette, M.D. – Las Vegas, Noelle Lefforge, Ph.D. – Las Vegas, Asma Tahir – Las Vegas, Lisa Ruiz-Lee – Las Vegas, Tabitha Johnson – Las Vegas
Krista Hales – Las Vegas

Staff and Guests

Carson City:
Cody L. Phinney, Administrator, DPBH, Tina Gerber-Winn, Robin Williams, RRC, Kyle Devine, Bureau Chief, Kate McCloskey, ADSD, Cara Paoli, ADSD, Christina Brooks, Lisa Sherych, NNAMHS, Barry Lovgren, Public, ADSD, Amy Roukie, Deputy Administrator Clinical Services,

Sparks:
Elizabeth Neighbors, DHHS, Julie Slabaugh, AG, Tom Durante, LCC, Julia M. Montoya, SRC, Eddie Ableser, MD,

Las Vegas:
Ellen Richardson-Adams, SNAMHS, Joanne Malay, SNAMHS, Rose Park,

Chair Kinnikin called the meeting t order at 9:05 am. Roll call is reflected above. It was determined that a quorum was present. Introductions were made at all three locations.

PUBLIC COMMENT:

Mr. Lovgren provided a hand out which is attached to these minutes as exhibit "A". Mr. Lovgren is concerned with Nevada's difficulty in meeting the requirements for receiving Substance Abuse Prevention and Treatment Block Grant funding.

New commissioners were provided Introductions to staff and given an overview of the Commission. Ms. Phinney introduced additional staff present at today's meeting and provided an overview of Division programs and how they relate to the Commission for new members. Chair Kinnikin requested Mr. Devine provide more information at future meetings address Mr. Lovgren' s concerns. Ms. Phinney will provide an organizational chart related to the Division programs. Ms. Phinney offered to coordinate tours of the various facilities for new commissioners is needed.

CONSENT AGENDA:

Approval of Minutes November 13, 2015

A motion was made by Ms. P. Johnson, seconded by Ms. T. Johnson and passed to accept the minutes of November 13, 2015.

Approval of Director's Reports

Dr. Durette would like for information to be disseminated in a manner, similar to DCFS, on all services provided not just limited to census and waiting lists in agency reports.

Action: Need to prepare an annual report for the Commissioners which outlie services, achievements, barriers, changes, etc., for the next Commission meeting. Kristen Rivas, DCFS

A motion was made by Ms. P. Johnson, seconded by Ms. T. Johnson and passed to accept the agency director reports as submitted.

Behavioral Health and Prevention Unit – Kyle Devine, Chief

The next year will be a year of transition. We need to develop a State Comprehensive plan that will drive what is in the Block Grants. Most grants are process based and we need an outcome based plan. We need to address items pointed out by Mr. Lovgren. We need to be more transparent and improve communication. We will work on revising the sub-grant process. We will be working on aligning funding in the future. We will work on improving data collection and reporting. We need a robust plan that is outcome based.

Action: Mr. Devine will continue to report at Commission meetings and provide comments on funding and block grant requirements being met especially focusing on the target population of pregnant women IV drug users, etc.

Seclusion and Restraint Report

Ms. Park reported for Mr. Filippelli, and provided a handout, updating seclusion and restraint activity, Exhibit "B."

Local Governing Body Reports

Ms. P. Johnson reported on LGB's for Lake's Crossing Center and Northern Nevada Adult Mental Health Services. Ms. Johnson informed Commissioners that there are only two Commissioners in the north attending these meetings. Credentialing and privileging at LCC and NNAMHS is up to date. LCC and NNAMHS is working hard to provide the necessary services with staff shortages. NNAMHS continues to work on performance improvement projects. NNAMHS CMS license is current with no upcoming surveys.

Ms. J. Malay reported for SNAMHS. A tour was given to new Commissioners. Continue to be in compliance. SNAMHS is expecting a CMS survey at any time.

Aging and Disability Services

Dr. Ableser is the new Administrator for Aging and Disability Services Division. Dr. Ableser provided an update on ADSD. Dr. Hunt related concerns regarding waitlists for DRC and SRC. Dr. Ableser offered to work with Local Governing Body's to improve reciprocity of professionals such as social workers, coming from other states to help with workforce development.

Action: Waitlist issues will be addressed by Dr. Ableser at the next Commission meeting.

Process for Seclusion and Restraint, Denial of Rights and Death Reports

Ms. Phinney provided Commissioners with the process for seclusion and restraint, denial of rights and death reports. Mr. Filippelli electronically sends out seclusion, restraint and denial if rights forms to Commissioners versus FedEx, except where there are those requiring original signatures. Mr. Filippelli will report on this process at the next meeting.

Dr. Hunt expressed concerns regarding how feedback is given to hospital if Commissioners have questions on reports. HCQC is the mechanism for any enforcement activities, however, this is more about the need to communicate regarding the review of the denial of rights. Commissioners would like to look at trends in the types and frequency in our state versus other states.

Action: Mr. Filippelli will review the process of feedback to the hospitals regarding the Commission's feedback in an effort to close the loop with the private hospitals.

Ms. Phinney suggested developing a flow chart or PowerPoint demonstrating how the process of the review of the DOR's are completed and signed off. Context with regards to the volume received by the Commissioners is needed.

Action: Ms. Phinney will report on the development of the flow chart or PowerPoint at the next meeting.

Policies:

Ms. Park provided an overview of Policy Tech. Ms. Park would like to work with Commissioners to learn how to review policies on Policy Tech. Policies can be reviewed by Commissioners and discussion and approval would be done at the Commission meeting. Commissioners were also reminded that they cannot provide feedback outside of the public meeting, therefore there should be no comments made until future meetings. Ms. Slabaugh suggested a policy be developed to grant the Administrator authority to approve policies temporarily before the Commission meeting.

Action: Ms. Park will develop a draft policy giving the Administrator authority to approve policies temporarily before Commission meetings.

A motion was made by Dr. Durette, seconded by Dr. Hunt and carried to approve the following policies:

- SP 5.1 – PASRR Program and Attachments
- Gov 1.1 – Clinical Services Hospital Governing Body
- A6.1 – Psychological First Aid Counselor Response
- A 5.3 – Quality Assurance and Performance Improvement
- A 1.1 – Policy Development and Review Process – tabled
- A 5.2 – Review of Client Death for Adult Mental Health Agencies
- SP 3.1 – Involuntary Administration of Medication in Civil Clients
- SP 3.3 – Involuntary Administration of Medication in Forensic Clients
- New – Root Cause Analysis (RCA)
- New – Sentinel Events
- DPBH Policy Concept
- DPBH Clinical Services Policy Process Algorithm

Community Housing Update

Ms. Richardson-Adams provided an update on community housing. We have drafted a regulation on Community Based requirements. Formal public workshops will be scheduled on this proposed regulation. Ms. Richardson-Adams will provide updates to the Commission at future meetings. When the regulation is approved by the Board of Health it will go to the Legislative Commission for approval. Ms. Richardson-Adams will provide information on SLA's at the next meeting.

Future Agenda Items

- Develop and appoint a Bylaws Committee
- Governor's Letter Development and committee appointment
- Draft Policy on Administrator approval for temporary policies

There was no public comment.

A motion was made, seconded and carried to adjourn the DPBH Commission on Behavioral Health. The meeting was adjourned at 11:15 am.

Exhibit "A"

Barry W. Lovgren
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Gardnerville, NV 89460
(775)265-2659
barrylovgren@yahoo.com

Public Comment to the Commission on Behavioral Health
September 16, 2016

Nevada's having some difficulty with meeting the requirements for receiving Substance Abuse Prevention and Treatment Block Grant funding.

I'm a retired State employee. The requirements for the Block Grant went into effect in 1993 when I was working for the Bureau of Alcohol and Drug Abuse (BADA), the predecessor agency to the Substance Abuse Prevention and Treatment Agency. When I left BADA in 2000 there'd been longstanding compliance with the requirements.

In 2009 I found that there'd come to be a problem with the requirement to publicize the availability of treatment and admission priority for pregnant women, and at last November's meeting of this Commission I thanked the Division for fixing it. But at that same meeting there was indication of other problems: It was reported that SAPTA wasn't collecting waiting list data, and that's required for the Block Grant.

Three months later, in February of this year, the Center for Substance Abuse Treatment (CSAT) issued the report on its technical review of SAPTA. It found that SAPTA no longer has a functional waiting list/capacity management system as required for Block Grant funding. This makes it impossible to meet the requirements that SAPTA refer a pregnant woman to a program that can admit her if she applies for treatment at a program that's full, that SAPTA ensure that interim services are provided when timely admission can't be obtained, and that waiting list data be included in the required substance abuse needs assessment. It also found that SAPTA hadn't conducted a needs assessment. Then I found that SAPTA is no longer meeting the requirement that it have funded treatment programs conduct outreach to injection drug users. Yet there had been compliance with each of these Block Grant requirements back in the 90's.

On April 26th of this year I sent a letter about this to the SAPTA Bureau Chief. On July 26th I sent a letter to the Division Administrator pointing out that to receive Block Grant funding to begin October 1st signed assurance must be given that these requirements are being met. That assurance was signed on August 30th.

Back in 2009, when this was the Mental Health and Developmental Services Commission, I told the Commission about that problem with Nevada no longer meeting the requirement to publicize the availability of substance abuse treatment and admission priority for pregnant women. The Deputy Attorney General told the Commission that it didn't have authority to address any problems specific to SAPTA, and it was another five years before the requirement to publicize services for pregnant women was met.

In 2013 this Commission was given authority to address problems specific to SAPTA when it became the Commission on Behavioral Health. I'm hoping you'll exercise that authority by seeking the transparency and accountability in government you were denied in 2009. I'm hoping you'll put on your agenda for your next meeting with DPBH an action item for a report on what's been done to meet the Block Grant requirements which had yet to be met when I sent the letter to the Division Administrator in July.

This isn't about legalisms and grant application boilerplate. This is about whether assurances, promises given by the Division Administrator, are kept. This is about spending millions of dollars on substance abuse services without first finding out what's needed. This is about the lack of outreach to get injection drug users into treatment while Nevada suffers from a heroin epidemic.

This is about babies being born with substance-related birth defects that could have been prevented had mom gotten into treatment. I got involved in this in 2009 when I found that the number of pregnant women getting substance abuse treatment had fallen to half what it had been. By 2015 it had fallen to about a third.

With funding to begin October 1st, SAPTA's plate is very full with trying to get compliance with these requirements back in place. Nevada complied with them 20 years ago and there's no excuse for not doing it now.

Exhibit "B"

Nevada Division of Public & Behavioral Health

Clinical Services Branch

Seclusion and Restraint Report

for the

Nevada Commission on Behavioral Health

Submitted by

Kevin P. Filippelli, MS, NCC

Statewide QAPI Manager

September 16, 2016

CLINICAL SERVICES

Improving Quality of Life

QAPI

Nevada Division of Public & Behavioral Health - Commission on Behavioral Health

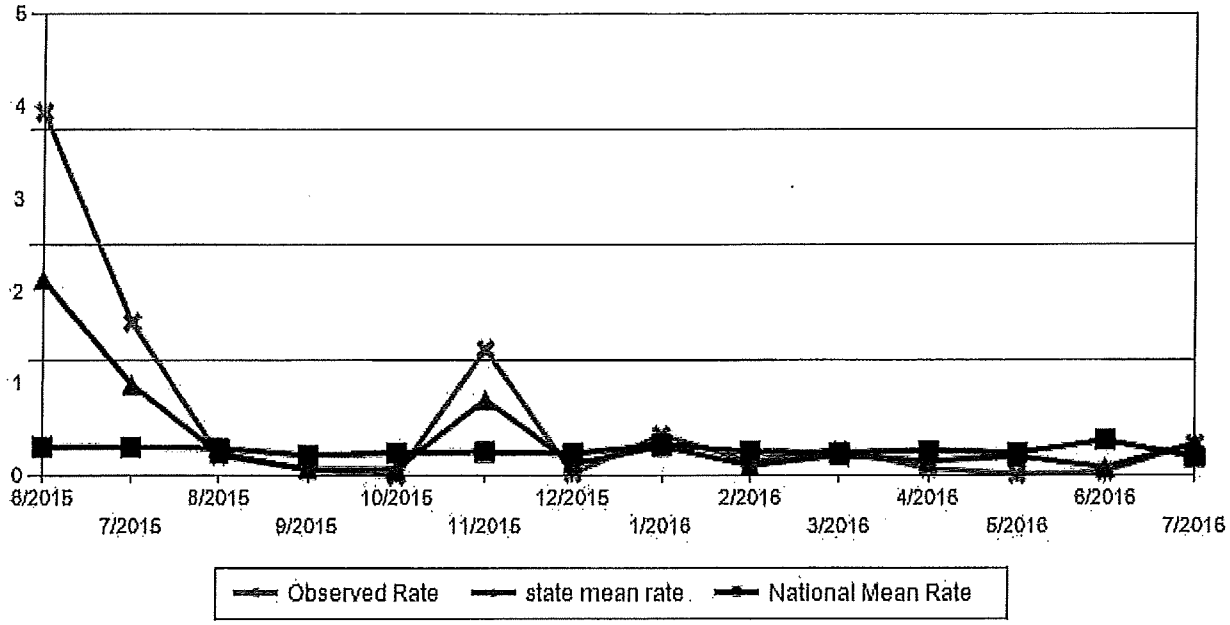
Seclusion and Restraint Report

Friday, September 16, 2016

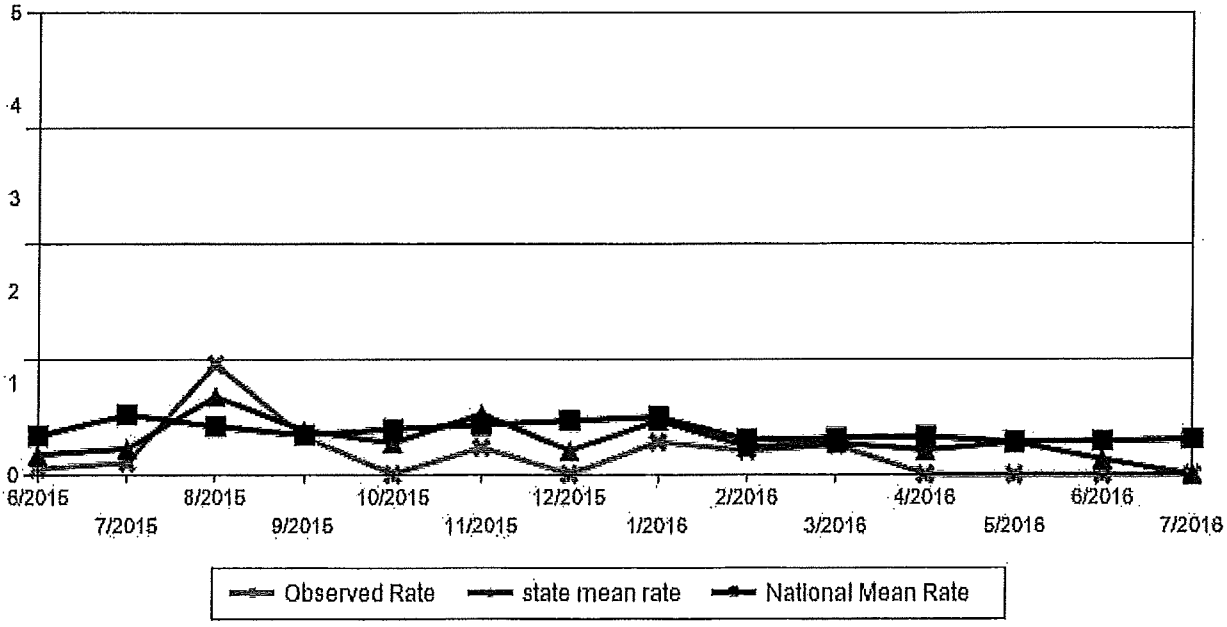
COMPARATIVE STATISTICS

NOTE: The graphs below represent the number of patient hours spent in seclusion or restrain for every 1000 inpatient hours. National Mean represents State-run inpatient psychiatric facilities serving adults 18+.

NNAMHS Seclusion Data



NNAMHS Restraint Data

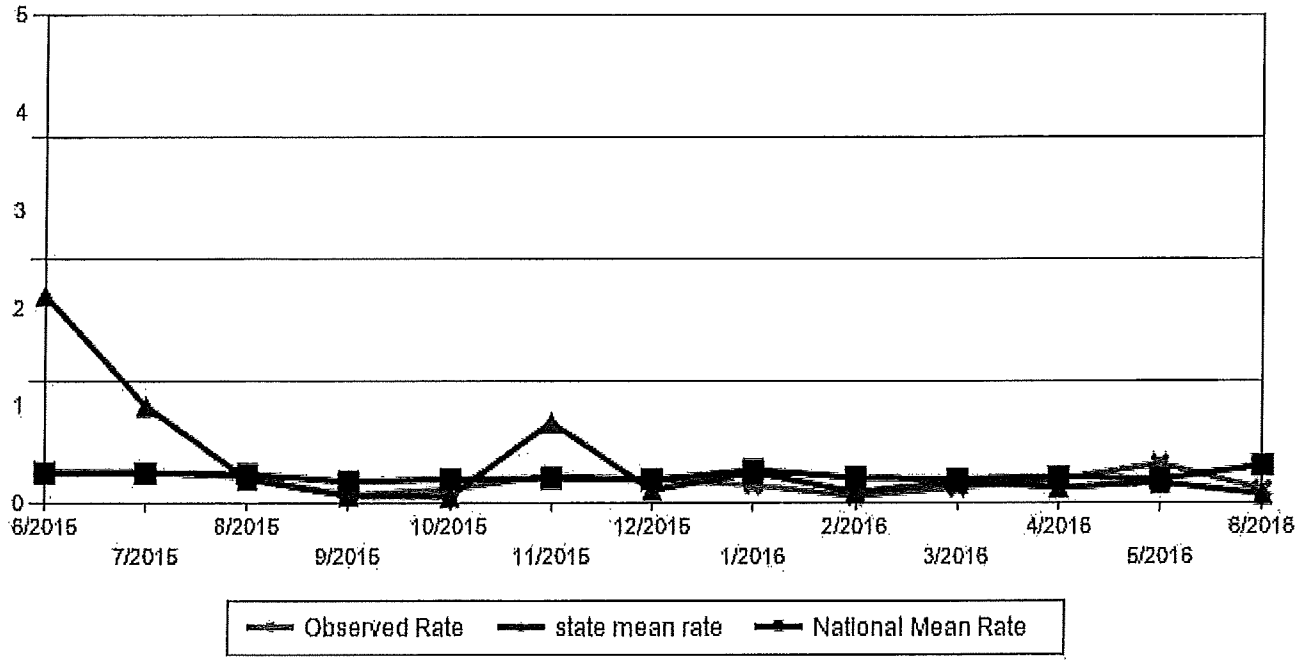


Nevada Division of Public & Behavioral Health - Commission on Behavioral Health

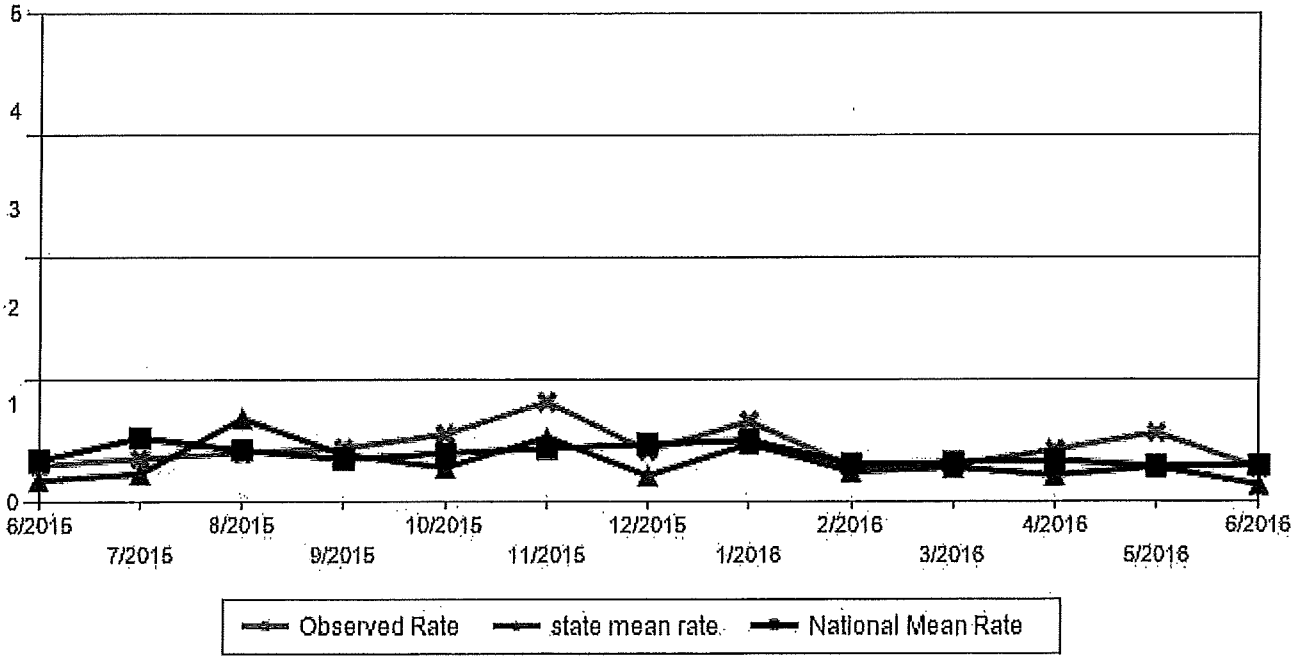
Seclusion and Restraint Report

Friday, September 16, 2016

SNAMHS Seclusion Data



SNAMHS Restraint Data



REDUCING SECLUSION AND RESTRAINT

The DPBH Clinical Services Branch is currently undertaking the following activities to reduce incidents of seclusion and restraint:

- **CPART** - DPBH has provided and will continue to provide all of its staff members with **Conflict Prevention and Response Training** (CPART) during Agency orientation. CPART is an approved curriculum of de-escalation techniques and increasingly intrusive/restrictive intervention procedures used by trained staff to re-establish and/or maintain safety in the presence of threatening or dangerous behavior. All nursing staff are required to complete CPART training during orientation and are re-trained and re-certified annually.

- **CPI** – The Division is currently piloting the *Nonviolent Crisis Intervention*® program developed by the Crisis Prevention Institute® (CPI). This program is considered the worldwide standard for crisis prevention and intervention training. With a core philosophy of providing for the care, welfare, safety, and security of everyone involved in a crisis situation, this evidence-based program's proven strategies give human service providers the skills to safely and effectively respond to anxious, hostile, or violent behavior while balancing the responsibilities of care. Budget Concept papers will be submitted to request financing for purchasing this program Division-wide.

- **PBSP** - A **Positive Behavior Support Plan** is a specialized part of the treatment plan that is written for a patient and that provides directions to all staff regarding:
  - What to on a daily basis to decrease and/or prevent the occurrence of maladaptive and/or dangerous behaviors;
  - How to reinforce the identified adaptive coping skill and/or socially acceptable behavior;
  - What to do in the event that a patient engages in a specific maladaptive behavior;
  - When to use restrictive procedures to ensure the safety of the patient and others in the environment.

  A Positive Behavior Support Plan is utilized before, after and/or in lieu of seclusion and/or restraint whenever possible. Seclusion and/or restraint procedures are reserved for emergency situations in which less restrictive techniques have failed, and the patient and/or others in the environment are in imminent danger due to a patient's behavior.

- **Increased Programing**
  - *SNAMHS Treatment Mall* - A model of person-centered care in which the development of coping and recovery awareness and skills, as well as, life skills, leisure and recreational skills are provided. Clients will receive therapeutic care in group settings with the intent of normalizing clients' daily lives and returning them to their community in a successful transition. By normalizing the routine of hospitalized clients, they will have a routine of going to various treatments offered for their rehabilitation as in a normal work or school day.
  - *NNAMHS* – Increased programming on swing shift, which, in the past, had a higher incident of S&R. Programming now includes pet therapy and music therapy, both of which have received positive feedback from patients. Adding an additional psychologist to the inpatient NNAMHS treatment team.

- **Token Economy** - The Token Economy Program has an empirically proven record of being successful in addressing a multitude of behavioral concerns. The effectiveness of the token program for the chronic psychiatric population has been extensively examined. The Token Economy Program can be perceived in terms of a systems approach toward behavioral management. A token reinforcer is an object with redeemable value, one that can be traded for an actual reinforcer of another kind of material, social or activity. The token program's theoretical basis is grounded in well-established learning theories of reinforcement motivation.

- **DPBH Quality Assessment and Performance Improvement (QAPI) Department**
  - The QAPI Team is conducting a national search of comparable State Psychiatric Hospitals to determine what processes, protocols and/or programs they are using to reduce seclusion and restraint.
  - The QAPI Team is beginning to collect data on the antecedents to episodes seclusion and restraint to determine if there are trends, commonalities or systemic issues or concerns that tend to increase or promote episodes of seclusion and restraint.

DEFINITIONS OF SECLUSION AND RESTRAINT

NEVADA REVISED STATUTES

"Chemical restraint" means the administration of drugs for the specific and exclusive purpose of controlling an acute or episodic aggressive behavior when alternative intervention techniques have failed to limit or control the behavior. The term does not include the administration of drugs on a regular basis, as prescribed by a physician, to treat the symptoms of mental, physical, emotional or behavioral disorders and for assisting a person in gaining self-control over his or her impulses. (NRS 433.5456)

"Mechanical restraint" means the use of devices, including, without limitation, mittens, straps, restraint chairs, handcuffs, belly chains and four-point restraints to limit a person's movement or hold a person immobile. (NRS 433.547)

"Physical restraint" means the use of physical contact to limit a person's movement or hold a person immobile. (NRS 433.5476)

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

According to 42 CFR Part 482, Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients' Rights; Final Rule, CMS defines seclusion and restraint as follows:

RESTRAINT: A restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

A restraint does ***not*** include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm.

SECLUSION: Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

Seclusion does ***not*** include confinement on a locked unit, ward, or other area where the patient is with others. Seclusion is not just confining a patient to an area but involuntarily confining the patient alone in a room or area where the patient is physically prevented from leaving. A situation where a patient is restricted to a room or area alone and staff are physically intervening to prevent the patient from leaving the room or area is also considered seclusion.

TIME OUT: If a patient is free to leave a ***time out*** area whenever the patient chooses, this would ***not*** be considered seclusion based on this definition. The key distinction in deciding whether an intervention is seclusion or a time out is whether the patient is physically prevented from leaving a room or area. Another distinction is the patient's level of personal control. In the case of seclusion, boundaries are placed on the patient's behavior based on the clinical determination that the patient's behavior poses a risk to the safety of the patient or others. In a ***time out***, the patient is able to respond to staff direction encouraging a time out or to independently decide that such action is needed. In a time out, the staff and patient collaboratively determine when the patient has regained self-control and is able to return to the treatment milieu. In seclusion, this judgment is made by the clinicians—that is, an agitated patient may feel that he or she should be released, even though the patient's behavior continues to be violent or self-destructive.

THE JOINT COMMISSION (TJC)

RESTRAINT:

1. Any method (chemical or physical) of restricting an individual's freedom of movement, including seclusion, physical activity, or normal access to his or her body that (1) is not a usual and customary part of a medical diagnostic or treatment procedure to which the individual or his or her legal representative has consented, (2) is not indicated to treat the individual's medical condition or symptoms, or (3) does not promote the individual's independent functioning.
2. For hospitals and rehabilitation and psychiatric distinct part units in critical access hospitals that elect The Joint Commission deemed status option: 42 CFR 482.13(e)(1) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or 42 CFR 482.13(e)(1)(i)(B) (A restraint is—) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
3. 42 CFR 482.13(e)(1)(i)(c) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

SECLUSION:

1. The involuntary confinement of an individual in a room alone, for any period of time, from which the individual is physically prevented from leaving. Seclusion does not include involuntary confinement for legally mandated but nonclinical purposes, such as the confinement of a person who is facing serious criminal charges or who is serving a criminal sentence.
2. For hospitals and rehabilitation and psychiatric distinct part units in critical access hospitals that elect The Joint Commission deemed status option: The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior. (42 CFR 482.13(e)(1)(ii))

Seclusion and Restraint Report

Friday, September 16, 2016

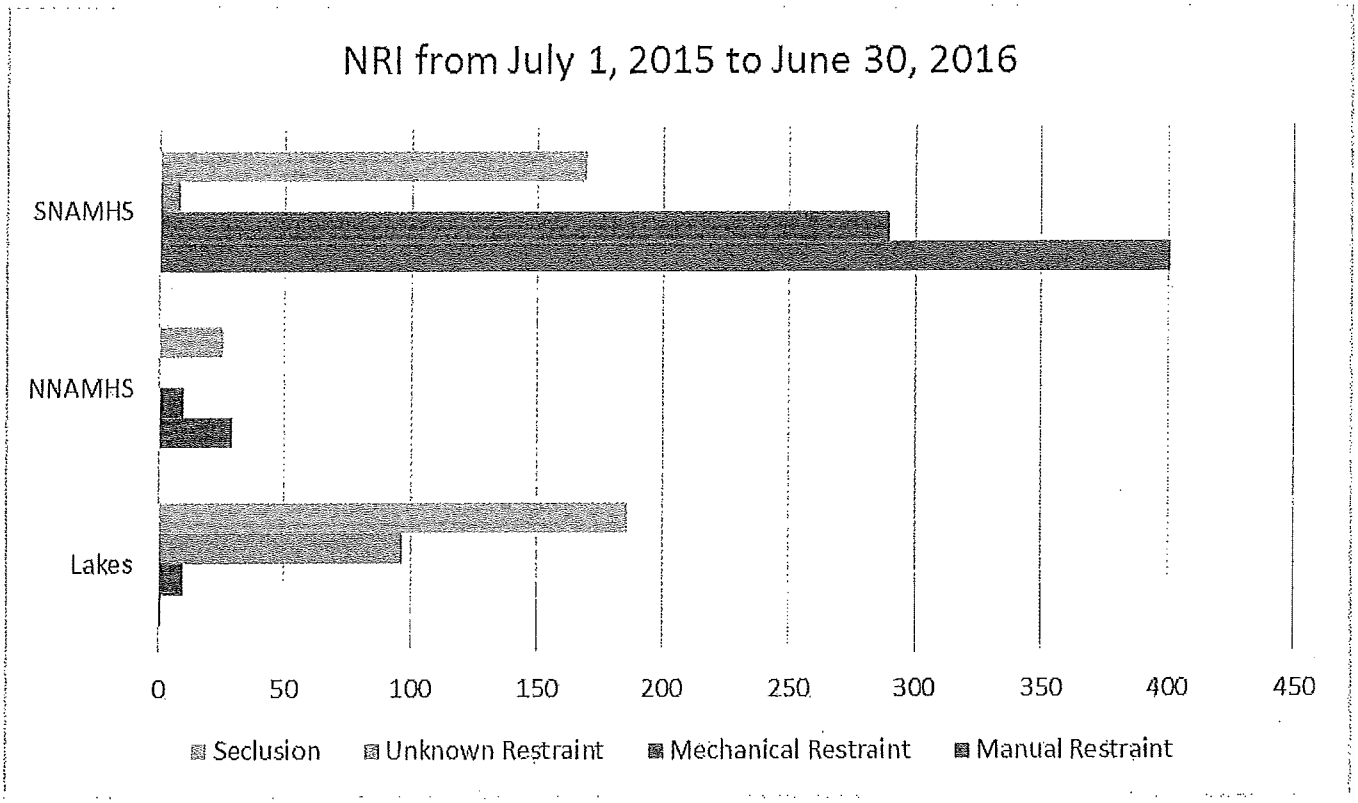
RAW DATA

Note: These facilities are of varying size and function. Comparisons between facilities should be made with extreme caution.

Tables 1 & 2: All State of Nevada Adult Hospitals

NRI from July 1, 2015 to June 30, 2016

	Manual Restraint	Mechanical Restraint	Unknown Restraint	Seclusion	Total
SNAMHS	401	290	8	169	868
NNAMHS	29	10	0	25	64
Lake's Crossing	1	10	97	186	294
Total	431	310	105	380	1226



Average Daily Census from July 1, 2015 to June 30, 2016

SNAMHS	114
NNAMHS	27
Lake's Crossing	74

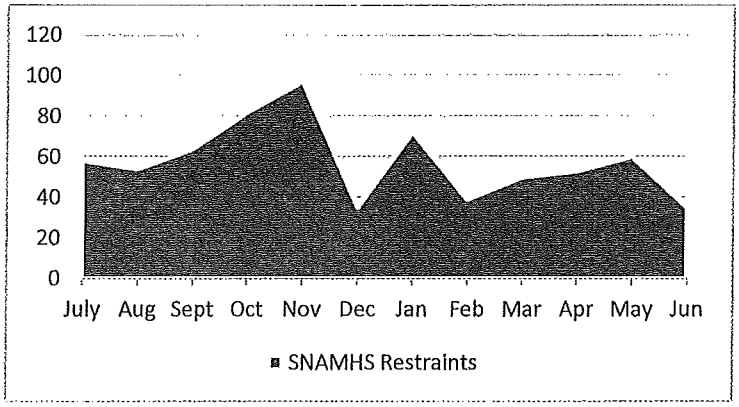
Nevada Division of Public & Behavioral Health - Commission on Behavioral Health

Seclusion and Restraint Report

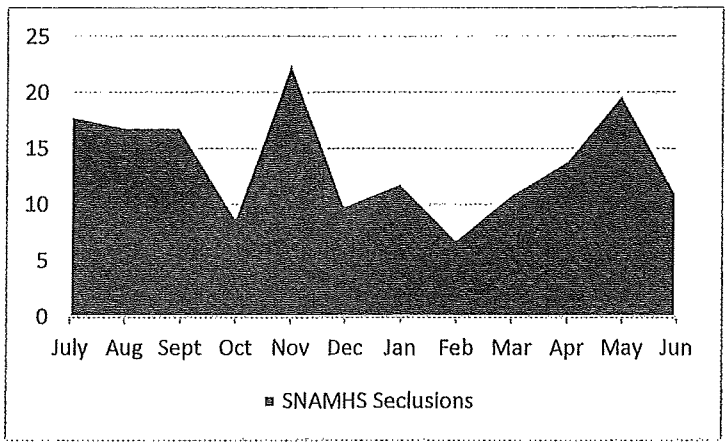
Friday, September 16, 2016

Tables 3 – 4 – 5: SNAMHS Restraints & Seclusions

SNAMHS - Restraints													
Month	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Restraints	58	54	64	82	97	35	72	39	50	53	60	35	**699**
Individuals with Multiple Events	15	18	12	18	16	11	19	8	10	15	14	9	**165**
≤4 hours	57	52	64	78	92	32	68	36	47	51	55	33	**665**
4 to 8 hours	1	2	0	3	4	2	1	2	1	3	4	2	**25**
>8 hours	0	0	0	1	1	1	3	1	2	0	1	0	**10**



SNAMHS - Seclusions													
Month	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Seclusions	18	17	17	9	23	10	12	7	11	14	20	11	**169**
Individuals with Multiple Events	3	3	1	2	5	2	4	2	1	4	4	2	**33**
≤4 hours	16	17	17	9	23	8	10	7	11	13	19	10	**160**
4 to 8 hours	2	0	0	0	0	2	1	0	0	1	1	1	**8**
>8 hours	0	0	0	0	0	0	1	0	0	0	0	0	**1**



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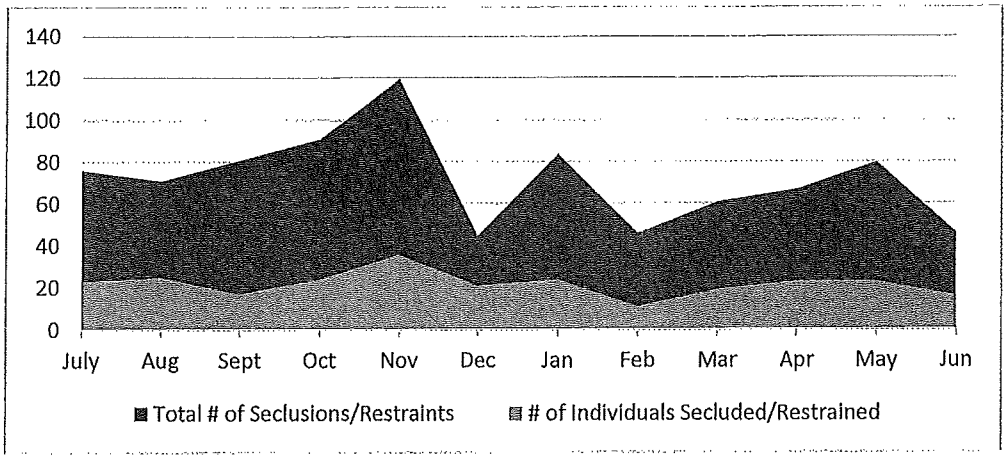
Seclusion and Restraint Report

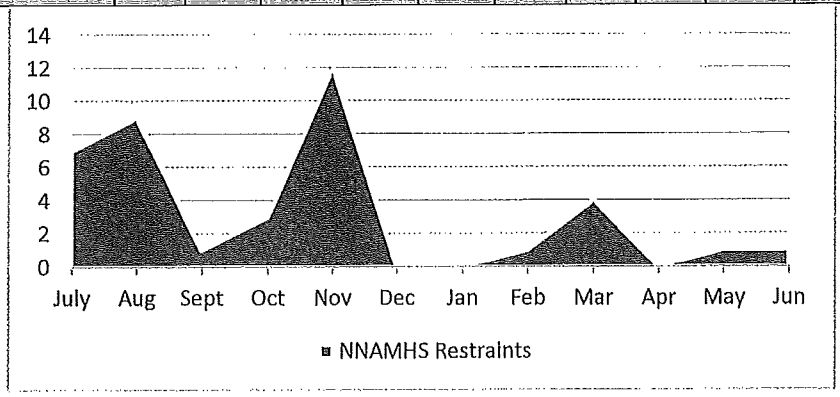
Friday, September 16, 2016

SNAMHS - Seclusions/Restraints													
Month	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Number of Individuals Secluded/Restrained	23	25	17	24	36	21	24	11	19	23	23	16	**262**
Total Number of Seclusion/Restraint Events	76	71	81	91	120	45	84	46	61	67	80	46	**868**
Events with Treatment Plan Review	51	52	38	16	1	0	0	0	0	0	0	0	**158**
Events with Progress Note Completed	74	68	81	91	120	45	83	46	61	67	80	46	**862**
Positive Behavioral Support Plan in Place at Time of Event	26	39	39	0	47	18	23	24	0	0	30	13	**259**
Events with Patient Injuries	6	8	9	7	10	4	6	3	2	5	8	5	**73**
Events with Staff Injuries	12	12	10	11	13	7	17	3	16	5	8	9	**123**



Tables 6 – 7 – 8: NNAMHS Restraints & Seclusions

NNAMHS - Restraints													
Month	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Restraints	7	9	1	3	12	0	0	1	4	0	1	1	**39**
Individuals with Multiple Events	1	1	0	1	4	0	0	0	1	0	0	0	**8**
≤4 hours	7	9	1	3	12	0	0	1	3	0	1	1	**38**
>8 hours	0	0	0	0	0	0	0	0	1	0	0	0	**1**



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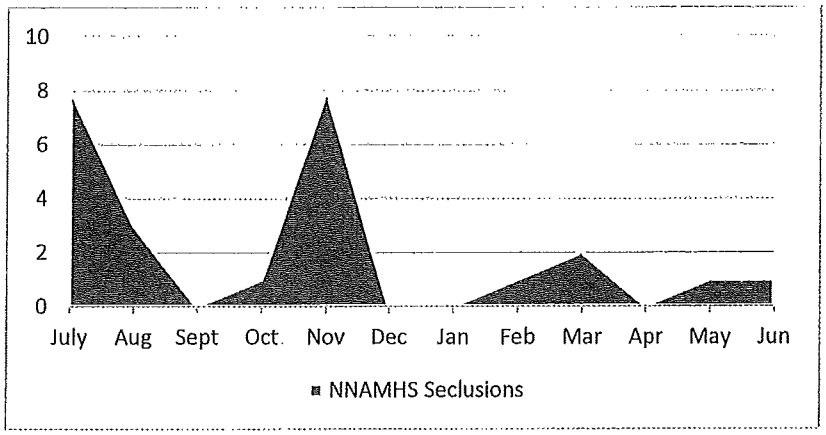
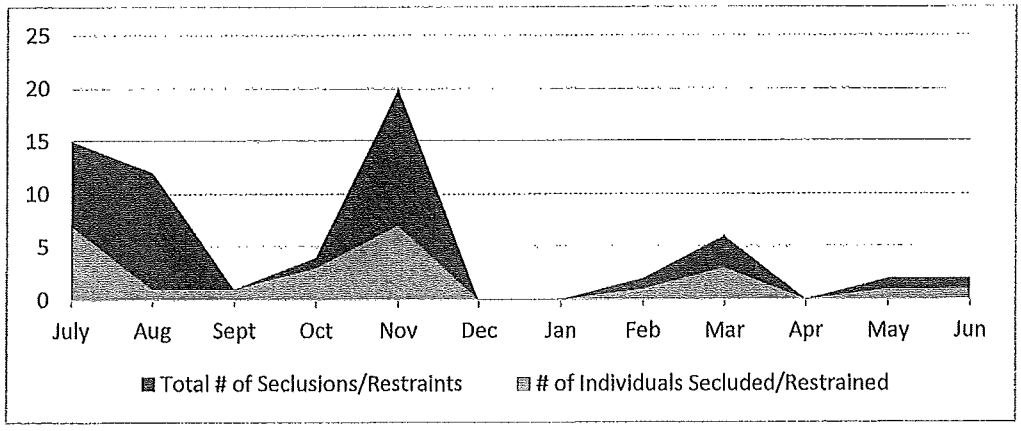
NNAMHS - Seclusions													
Month	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Seclusions	8	3	0	1	8	0	0	1	2	0	1	1	**25**
Individuals with Multiple Events	2	1	0	0	1	0	0	0	1	0	0	0	**5**
≤4 hours	8	3	0	1	7	0	0	1	2	0	1	1	**24**
4 to 8 hours	0	0	0	0	1	0	0	0	0	0	0	0	**1**



NNAMHS – Seclusions/Restraints													
Month	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Number of Individuals Secluded/Restrained	7	1	1	3	7	0	0	1	3	0	1	1	**25**
Total Number of Seclusion/Restraint Events	15	12	1	4	20	0	0	2	6	0	2	2	**64**
Events with Treatment Plan Review	5	0	0	0	0	0	0	0	0	0	0	0	**5**
Events with Progress Note Completed	12	12	0	1	20	0	0	2	6	0	2	2	**57**
Events with Patient Injuries	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Events with Staff Injuries	0	1	0	0	0	0	0	0	0	0	0	0	**1**



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Seclusion and Restraint Report

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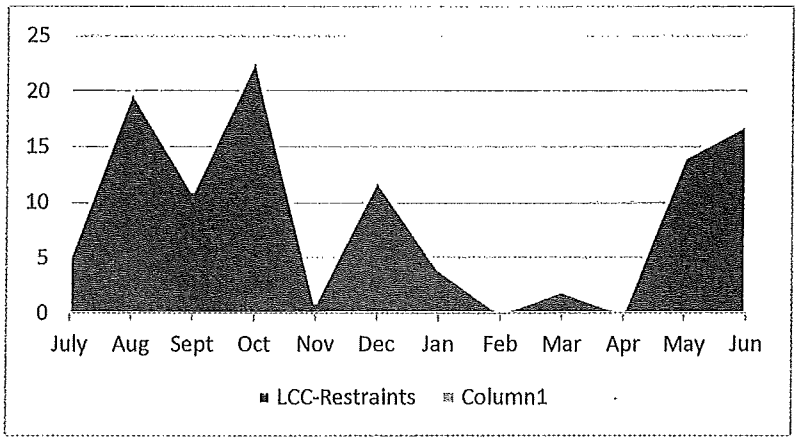
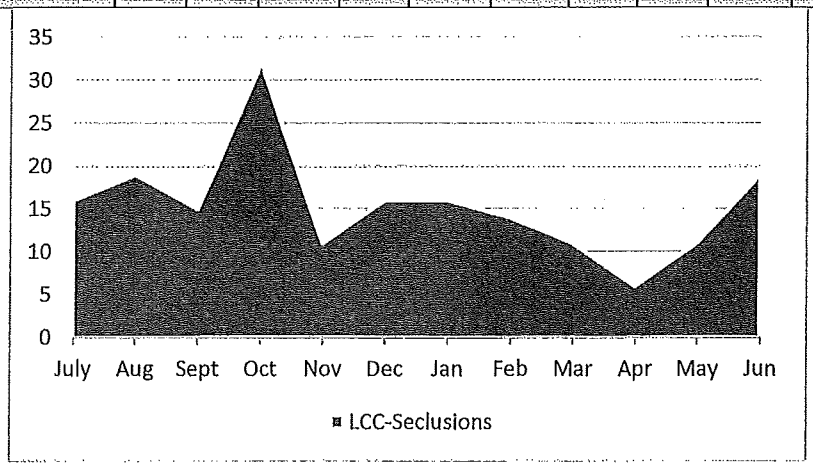
Tables 9 – 10 – 11: Lake's Crossing Restraints & Seclusions

Lake's Crossing - Restraints													
Month	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Restraints	5	20	11	23	1	12	4	0	2	0	14	17	**109**
Individuals with Multiple Events	2	5	2	5	0	1	4	0	0	0	1	2	**22**
≤4 hours	5	20	11	20	1	12	4	0	1	0	13	17	**104**
4 to 8 hours	0	0	0	0	0	0	0	0	1	0	0	0	**1**
>8 hours	0	0	0	0	0	0	0	0	0	0	1	0	**1**



Lake's Crossing - Seclusions													
Month	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Seclusions	16	19	15	32	11	16	16	14	11	6	11	19	**186**
Individuals with Multiple Events	3	6	2	12	0	1	0	2	2	0	1	3	**32**
≤4 hours	2	1	2	5	4	5	3	2	0	0	1	2	**27**
4 to 8 hours	0	3	1	0	1	2	0	2	0	0	0	0	**9**
>8 hours	12	10	12	16	6	9	13	10	11	6	10	17	**132**



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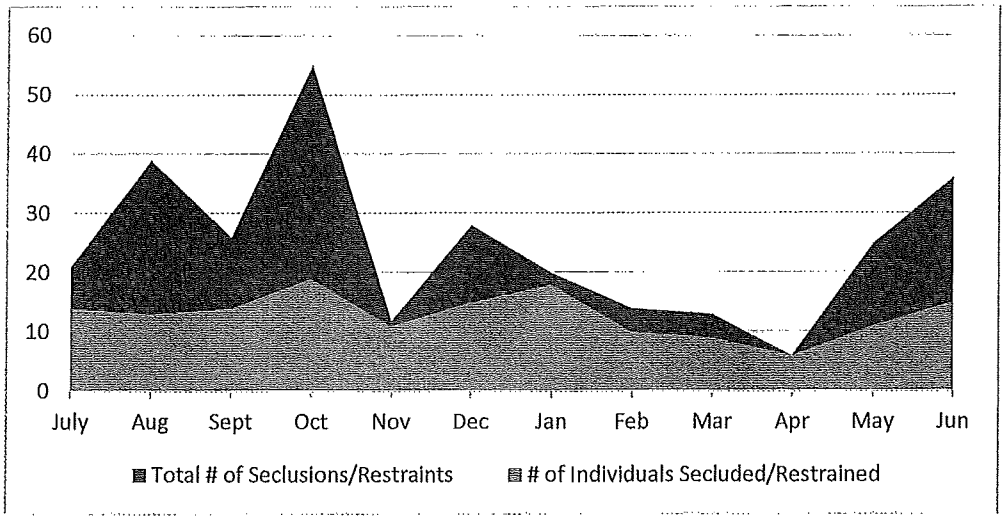
Lake's Crossing – Seclusions/Restraints													
Month	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Number of Individuals Secluded/Restrained	14	13	14	19	11	15	18	10	9	6	11	15	**155**
Total Number of Seclusion/Restraint Events	21	39	26	55	12	28	20	14	13	6	25	36	**295**
Events with Progress Note Completed	21	39	25	51	11	26	18	13	13	6	25	36	**284**