

## AGENCY DIRECTORS' REPORT

AGENCY: Rural Regional Center

SUBMITTED BY: Robin Williams DATE: 9/16/2016

Reporting Period: 6/30/2016

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### STAFFING

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Positions filled: MHC II, Carson; Developmental Specialist, Carson; 2 Developmental Specialists, Elko; Developmental Specialist, Winnemucca; Developmental Specialist, Gardnerville;

Vacancies: .5 AA I, Carson; .75 AA II, Carson

Difficulties filling: Recruiting in rural areas is always difficult due to shortage of professional staff and competition with other state and county agencies

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### CASELOADS/WAITING LISTS

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**Program: Targeted Case Management (June 2016)**

Caseload: 718 (190 youth, 528 adults)

Waiting List: N/A

**Program: Family Support**

Caseload: 116 (June 2016)

Waiting List: 0 (June 2016)

**Program: Supported Living Arrangement**

Caseload: 348 (20 youth, 328 adults) (June 2016)

Waiting List: 3 (June 2016)

**Program: Respite**

Caseload: 99 (June 2016)

Waiting List: 21 (June 2016)

**Program: Jobs & Day Training**

Caseload: 238 (0 youth, 238 adults) (June 2016)

Waiting List: 2 (June 2016)

**Program: Autism**

Caseload: 1 (1 youth, 0 adults) (June 2016)

Waitlist: Transferred to ATAP July 1, 2011

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### PROGRAMS

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New Programs: 24-hour Supported Living Arrangement opened in Fernley, NV; this is the first time we have been able to offer this service in this area

Program Changes: Click here to enter text.

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### Service Needs/Recommendations

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Offering services throughout rural Nevada continues to remain challenging due to difficulties in finding providers.

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### Agency Concerns/Issues

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Rural Regional Center is in the process of completing certification for a new provider, who can provide employment and supported living services in Lyon and Douglas counties. This will enable us to offer these supports for the first time in these areas.

# AGENCY DIRECTORS' REPORT

AGENCY: SNAMHS

SUBMITTED BY: OP Administration

DATE: 7/1/16

Reporting Period: July 2016

## STAFFING

Positions filled: 635.02 FTE

Vacancies: 124.55 FTE

Difficulties filling: 77.02 FTE Clinical Social Workers – 4.98 FTE, Licensed Psychologist – 5.00 FTE,

Psychiatric Nurses – 36.51, Senior Psychiatrists – 30.53

## CASELOADS/WAITING LISTS

**Program: SLA+Shelter+ISLA**

Caseload: 438

Waiting List: 3

**Program: Group Care + Sp. Needs**

Caseload: 263

Waiting List: 5

**Program: PACT**

Caseload: 69

Waiting List: 0

**Program: Medication Clinic**

Caseload: 3192

Waiting List: 240

**Program: Counseling**

Caseload: 379

Waiting List: 5

**Program: Service Coord. + Intensive**

Caseload: 485

Waiting List: 12

**Program: MHC**

Caseload: 68

Waiting List: 0

**Program: IP**

Caseload: licensed beds; 211

Waiting List: See ER Data

**Program: AOT**

Caseload: 71

Waiting List: 0

**Program: Co-Occurring Program**

Caseload: 48

Waiting List: 0

**Program: Residential**

Caseload: 731

Waiting List: 8

**Program: Laughlin Mesquite Med Clin**

Caseload: 183

Waiting List: 23

**Program: Laughlin Mesquite SC**

Caseload: 36

Waiting List: 1

**Program: Laughlin Mesquite OP Coun**

Caseload: 158

Waiting List: 3

# AGENCY DIRECTORS' REPORT

AGENCY: SNAMHS

SUBMITTED BY: OP Services

DATE: 9/2/016

Reporting Period: September 2016

## STAFFING

Positions filled: 628.04 FTE

Vacancies: 131.53 FTE

Difficulties filling: 81.51 FTE (Clinical Social Workers – 4.98 FTE, Licensed Psychologist – 5.00 FTE,  
Psychiatric Nurses – 41.00, Senior Psychiatrists – 30.53)

## CASELOADS/WAITING LISTS

Program: SLA+Shelter+ISLA

Caseload: 430

Waiting List: 3

Program: Group Care + Sp. Needs

Caseload: 263

Waiting List: 8

Program: PACT

Caseload: 70

Waiting List: 0

Program: Medication Clinic

Caseload: 3136

Waiting List: 251

Program: Counseling

Caseload: 404

Waiting List: 4

Program: Service Coord. + Intensive

Caseload: 488

Waiting List: 15

Program: MHC

Caseload: 66

Waiting List: 0

Program: IP

Caseload: licensed beds: 211

Waiting List: See ER Data

Program: AOT

Caseload: 75

Waiting List: 0

Program: Co-Occurring Program<sup>1</sup>

Caseload: 46

Waiting List: 2

Program: Residential

Caseload: 728

Waiting List: 11

Program: Laughlin Mesquite Med Clin

Caseload: 193

Waiting List: 5

Program: Laughlin Mesquite SC

Caseload: 38

Waiting List: 1

Program: Laughlin Mesquite OP Coun

Caseload: 163

Waiting List: 3

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**PROGRAMS**

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**Service Needs/Recommendations**

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**Agency Concerns/Issues**

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## AGENCY DIRECTORS' REPORT

AGENCY: Lake's Crossing Center

SUBMITTED BY: Tom Durante, LCSW    DATE: 8/28/2016

**Reporting Period: 8/28/2016**

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### STAFFING

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**Positions filled:** Over the past three months, Lake's Crossing has filled one Forensic Specialist, two Nurses, one Clinical Social Worker, and two Administrative Assistants. We currently have 98 filled positions.

**Vacancies:** We currently have 18 vacant positions. These include a clinical social worker, nurses, forensic specialists, quality improvement, and administrative assistants.

**Difficulties filling:** We have a particularly difficult time filling nursing and social work positions.

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### CASELOADS/WAITING LISTS

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**Program:      Inpatient**

Caseload: 75

Waiting List: Offered bed; 11

**Program: Outpatient**

Caseload:    7

Waiting List: 0

**Program: Outpatient Competency Evaluations**

Caseload: Complete approximately 100 a month

text.

Waiting List:

**Program:** [Click here to enter text.](#)

Caseload: [Click here to enter](#)

Waiting List: [Click here to enter text.](#)

**Program:**

**Program:** [Click here to enter text.](#)

Caseload:

Caseload: [Click here to enter text.](#)

Waiting List:

Waiting List:

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### PROGRAMS

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**New Programs:** No new programs

**Program Changes:** The major construction work of the past year is complete which allows for programming on the inpatient unit to return to a normal schedule. There will soon be additional construction projects including an ADA compliance project and duct work to complete, but these activities should have minimal impact on client services.

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### Service Needs/Recommendations

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Our outpatient services continue to grow. We now have four clients that have been granted conditional release and are living in the community with private providers monitoring their progress, each on a 24/7 basis. As more clients are committed under the 178.461 statute, and these clients become eligible for conditional release, resources to provide community support will be needed. Also, the demand for outpatient competency assessments in Washoe County continues to grow. We now complete nearly 100 outpatient evaluations a month between competency, risk assessments, and mental health evaluations. We have weekly contacts with the forensic facility in Las Vegas, Stein Hospital, as we plan for admissions from Clark County and assess Stein's

needs for assistance with admissions and which facility is best suited for each client. The communication between the two forensic hospitals is assisted through the new State Wide Forensic Coordinator.

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### **Agency Concerns/Issues**

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The agency's ability to fill positions remains a concern. Nursing, forensic, and social work positions have been difficult to fill and it appears that the State's ability to be competitive with salaries affects our retention and recruitment efforts. We have had several long term staff members retire recently which has contributed to a work force that is newer and less experienced. Also of concern is the number of commitments for inpatient services. We have been successful in meeting the requirements of the recent Consent Decree (there is currently no wait list). However, as we monitor the number of commitments across the state there is concern that we may not be able to keep up with the pace without additional beds in the future.

## AGENCY DIRECTORS' REPORT

AGENCY: Sierra Regional Center

SUBMITTED BY: Julian Montoya    DATE: 9/16/2016

**Reporting Period: 6/30/2016**

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### **STAFFING**

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Positions filled: Administrative Assistant I, Certified Program Manager II, Certified Program Planner, 2 Developmental Specialist I, 3 Developmental Specialist II, 2 Developmental Specialist III, Maintenance Repair Specialist 1, Mental Health Counselor III, Quality Assurance Specialist III

Vacancies: Accounting Assistant II, 2 *Developmental Specialist III*, *Psychologist 1*,

Difficulties filling: All regional centers are experiencing difficulties finding and hiring Psychologists state-wide.

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### **CASELOADS/WAITING LISTS**

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**Program: Targeted Case Management (June 2016)**

Caseload: 1340 (415 youth, 925 adults)

Waiting List: N/A

**Program: Family Support**

Caseload: 222 (June 2016)

Waiting List: 0 (June 2016)

**Program: Supported Living Arrangement**

Caseload: 663 (57 youth, 606 adults) (June 2016)

Waiting List: 58 (June 2016)

**Program: Respite**

Caseload: 217 (June 2016)

Waiting List: 0 (June 2016)

**Program: Jobs & Day raining**

Caseload: 434 (0 youth, 434 adults) (June 2016)

Waiting List: 36 (March 2016)

**Program: Autism**

Caseload: 2 (2 youth, 0 adults (June 2016)

Waitlist: Transferred to ATAP July 1, 2011

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### **PROGRAMS**

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New Programs: AB 307 pilot home opened on August 15<sup>th</sup> with 2 youths that we serve. SRC is working with the provider, Medicaid, and other partners in this pilot program that runs until 2019.

Program Changes: None

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### **Service Needs/Recommendations**

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AB 307 pilot home project which targets the need for increased behavioral supports for youth with co-occurring Intellectual Disability and Mental Health/Behavioral disorder opened on August 15<sup>th</sup>, 2016. SRC has also identified the need to increase our efforts to recruit more Host Home providers for the people we serve.

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### **Agency Concerns/Issues**

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SRC has identified the need to work with JDT providers to increase capacity for supported employment in our community. The CMS final ruling will require DS to work with our JDT providers in re-vamping their programs to be more community based (as opposed to facility based). Our current JDT structure (facility based) does limit the number of people they

can serve – our goal is to move toward a more community based service system. (2) DS providers express concern about the current provider rate and report that it is impacting their ability to recruit qualified employees. The 24 hour SLA providers report a high turnover rate which impacts consistency of supports offered to individual's served. (3) DS is experiencing a major shift in rental increase for homes and apartments in the Washoe County area. As major companies such as Tesla and Switch come into the area with an increased need for a labor force, prices have increased making it difficult to find homes that are aligned with what DS can support.

## AGENCY DIRECTORS' REPORT

AGENCY: NNAMHS    SUBMITTED BY: Lisa Sherych    DATE: 8/31/2016

**Reporting Period: 8/31/2016**

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### STAFFING

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Positions filled: Clinical Program Manager I, Psychiatric Nurse 2, Accounting Assistant 2, Mid-Level Medical Practitioner, Mental Health Technician 3, Psychiatric Nurse 2, Accounting Assistant 1, Custodial Supervisor 2, Substance Abuse Counselor 2, Agency Manager, and Custodial Worker I

Vacancies: Senior Psychiatrist (x2), Senior Psychiatrist (0.51 FTE), Microbiologist 4, Psychiatric Nurse 2 (x9), Psychiatric Nurse 2 -- 0.51 FTE (x3), Vocational Habilitation Trainee, Psychiatric Nurse 3, Mental Health Technician 3 (x2), Maintenance Repair Worker 2, Grounds Maintenance Worker 4, Custodial Worker 1, Supply Technician 2, Psychiatric Caseworker 2 (x2), Mental Health Technician 4, Administrative Assistant 2, Clinical Social Worker 2, Licensed Psychologist 1, Pharmacy Technician 2 (0.51), Pharmacy Technician 2, Psychological Assistant, Pharmacist 1, Laboratory Technician 1 (0.5), and Mental Health Counselor

Difficulties filling: Licensed Psychologist, Mental Health Technician, Senior Psychiatrist, and Psychiatric Nurse

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### CASELOADS/WAITING LISTS

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**Program: Med Clinic**

Caseload: 1,859

Waiting List: 90

**Program: PACT**

Caseload: 82

Waiting List: 10

**Program: Mental Health Court**

Caseload: 129

Waiting List: 0

**Program: SLA**

Caseload: 258

Waiting List: 4

**Program: OP Counseling**

Caseload: 128

Waiting List: 23

**Program: Service Coordination**

Caseload: 163

Waiting List: 45

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### PROGRAMS

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**New Programs:** We have hired a new part-time Substance Abuse Counselor II for the Inpatient Units. She is a Certified Alcohol and Drug Counselor (CADC) with seven years' experience in outpatient settings including: Juvenile Detention, High School, Rural Nevada Co-Occurring Services, Drug Court, and Foster Home Care. In addition, we've engaged a contract Licensed Social Worker to assist with discharge planning and case management services on the Inpatient Units, allowing clinical social workers more time to provide direct clinical assessment and treatment. The new rotation of UNR residents is in place and efforts continue to attract additional psychiatrists and psychologists. We continue to hold meetings with stakeholders, including the District Court/Family Division, to move forward with an Assisted Outpatient Treatment Program for the North.

**Program Changes:** Lisa Sherych assumed Agency Manager responsibilities in June 2016 with Tom Durante returning to Lake's Crossing Center. Treatment teams have been reorganized within the Inpatient Units for consistency of staff with patients. In addition, treatment team meetings have been expanded to include representatives from each discipline. Dr. Terri Pittenger has been named Clinical Program Manager, replacing Dr. Michelle Burke who transferred to Outpatient Services to work with the AOT

program. There have been expanded meetings with Outpatient Services to ensure the smooth transition of discharged Inpatient clients to Outpatient providers.

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### **Service Needs/Recommendations**

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A large housing provider closed its operation, which impacted residential placements and discharges from the hospital. The Agency continues to have difficulty recruiting psychiatrists and nurses. We continue to fill open positions with contract staff, but find few applicants for the State positions. More applicants might be attracted if the compensation level at the State was comparable with that of community providers.

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### **Agency Concerns/Issues**

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The list of individuals in community emergency rooms waiting for admission to behavioral health services continues to be an issue. Dini-Townsend provides services primarily to individuals with no other resources to access community providers. The wait list is affected by several issues; there are clients who could receive services at a private facility, but they are referred to Dini-Townsend as needing a high level of care/intervention. Our length of stay has trended downward, but there are outliers with long inpatient stays who affect the average length of stay when they are discharged. Contributing to the length of stay is the difficulty of finding appropriate housing in the community for patients who may no longer need an Inpatient level of care; these clients need structured community housing and support to live successfully outside the hospital.

## AGENCY MANAGER'S REPORT

**AGENCY:** Desert Regional Center    **SUBMITTED BY:** Leslie Brown    **DATE:** 8/31/16  
**Reporting Period:** 6/30/2016

### STAFFING

Positions filled: 318  
Vacancies: 26  
Difficulties filling:

### CASELOADS/WAITING LISTS

**Program: Service Coordination**

Caseload: 4522  
Waitlist: N/A

**Program: Residential Support**

Caseload: 1152  
Waitlist: 288

**Program: Jobs and Day Training**

Caseload: 1833  
Waitlist: 415

**Program: Family Support**

Caseload: 2873  
Waitlist: 506

**Program: Autism**

Caseload: 10  
Waitlist: N/A

**Program: Development Center ICF/MR**

Caseload: 46  
Waitlist: 52

### PROGRAMS

At the close of FY 2016, DRC has succeeded in adding a total of 71 consumers to Supported Living Arrangement Services. In February 2016, the Interim Finance Committee approved a work program for DRC which permitted the funding for these placements. This total represents a combination of 24 hour awake Supervised SLA supports, Intermittent SLA supports, and Self-directed Services. Effective 7/1/16, DRC will offer services to individuals on all service waitlists (as of 8/3/16, 250 consumers on the JDT waitlist were offered services, 40 on 24 hour SLA waitlist, 40 on Intermittent SLA waitlist, and 40 on Self Directed Waitlist). DRC is collaborating with Sierra Regional Center, DFS, DCFS, and community partners to establish a pilot residential program for children who meet specific criteria in an effort to provide evidenced-based, wrap around services with the goal of reunification with family (per AB 307; Legislation which passed during the 2015 NV Legislative Session).

Program Changes:

### Service Needs/Recommendations

The DRC ICF/ID continues to be at capacity at 48 consumers and the waitlist is currently at approximately 46. There remains the need for an intensive level of residential care for individuals who have been unsuccessful in community placement. Further, DRC has numerous individuals in out-of-state residential treatment centers due to the lack of options/available beds in Nevada. There is a need for additional intensive residential options for both adults and children in Nevada (for individuals who have been unsuccessful in community-funding placement and/or require ICF/ID).

## Agency Concerns/Issues

The ADSD Administrator, Jane Gruner, announced her retirement effective 8/12/16. The DHHS Director, Mr. Whitley, appointed Dr. Edward Ableser as the new ADSD Administrator effective 8/22/16.

The Harmony Case Management system for Developmental Services remains a top priority for the agency. The portion of the system that was developed for Targeted Case Management and Quality Assurance for DRC staff was rolled out 7/1/16. All DRC employees who will use the system have received training. Service providers have received training on all functions except for fiscal which is still in development. Go Live dates for Harmony overall have been delayed several times with different functions (Case Management, QA, Fiscal, Incident Reporting) going on line in different phases. Targeted Case Management activities are now being documented in the system by all Service Coordinators. Providers do not yet have access/use of the system. DRC will begin partial use of the Incident Reporting/Serious Occurrence Reporting system on 9/1/16. In the future, Denial of Rights forms and RADs will be input into Harmony and become a paperless system. At that point, DRC will need to discuss with the Commission the method/type of reports/data desired concerning RADs.

The Annual HCQC Survey for the ICF/ID took place in April 2016 with minimal deficiencies requiring correction. HCQC accepted DRC's plan of correction and completed the annual survey.

DRC continues its collaboration with sister agencies via monthly DCFS/DPBH/DS meetings with current efforts focused on establishing/updating a MOU.

DRC has been collaborating with DETR in educating Service Coordinators and individuals served about WIOA. DRC must adhere to WIOA beginning in July when referring consumers to jobs and day training programs which includes ensuring that referrals and assessments through BVR are complete prior to center-based or supported employment.

## AGENCY DIRECTORS' REPORT

AGENCY: Rural Clinics/Community Health Services    SUBMITTED BY: Tina Gerber-Winn, MSW    DATE: 8/31/2016

**Reporting Period: 8/31/2016**

### **STAFFING**

Positions filled: Community Health Services hired a Grants and Projects Analyst II.

Vacancies: Community Health Services (CHS) currently has one opening for an AAIIV, along with one Community Health Nurse II, one Community Health Nurse III and two Community Health Nurse IV positions. There is also an opening for a Health Resource Analyst II position within CHS. Rural Clinics has openings for an AAll, a Clinical Social Worker III, a Licensed Psychologist I, five Mental Health Counselor II, two Psychiatric Caseworker II, two Psychiatric Nurse II and a Psychiatric Nurse III.

Difficulties filling: Positions that have been open for at least 90 days – Community Health Nurse II, III, IV; Health Resource Analyst II; Mental Health Counselor II (two positions); Psychiatric Nurse II (two positions); Licensed Psychologist I and Psychiatric Caseworker II.

### **CASELOADS/WAITING LISTS**

#### **Program: Outpatient Counseling**

Caseload: 281 youth; 1082 adult

Waiting List: 18 youth; 135 adult

#### **Program: Residential Supports**

Caseload: 1 youth; 44 adult

Waiting List: 0 youth; 0 adult

#### **Program: Service Coordination**

Caseload: 22 youth; 316 adult

Waiting List: 2 youth; 16 adult

#### **Program: Psychosocial Rehabilitation**

Caseload: 9 youth; 118 adult

Waiting List: 1 youth; 0 adult

#### **Program: Medication Clinic**

Caseload: 216 youth; 1386 adult

Waiting List: 14 youth; 96 adult

#### **Program: N/A**

Caseload: N/A

Waiting List: N/A

### **PROGRAMS**

Collaboration with Nevada Rural Hospital Partners, now on its fifth month, has enabled Rural Clinics (RC) to provide clinical assessments to patients in rural emergency rooms, referring 47% of assessed clients back to community services as opposed to inpatient psychiatric admission. Development of MOST/FASTT continues in rural counties; RC is working with several counties to develop forensic programs specific to their needs. New collaboration with Dept. of Welfare and Supportive Services will provide access to welfare staff at our clinics in Winnemucca and Douglas County. Community Health Services has applied for a family planning grant opportunity through the Office of Population Affairs.

### **Service Needs/Recommendations**

None at this time.

### **Agency Concerns/Issues**

Continued difficulty with recruiting/retaining clinical staff and nurses in the rural areas of the state. As indicated above, there are five Mental Health Counselor openings, a vacancy rate of 24% for the position. There are seven vacant nursing positions (three within Rural Clinics, four within Community Health Services) for vacancy rates of 19% and 27%, respectively.

*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



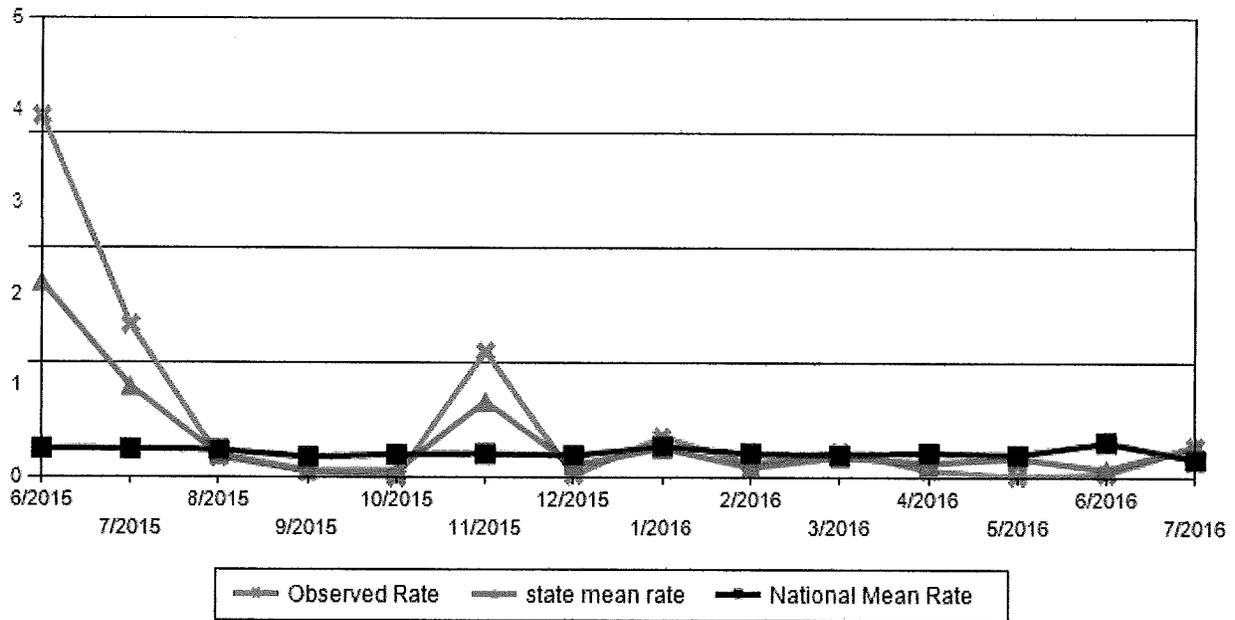
# Seclusion and Restraint Report

Friday, September 16, 2016

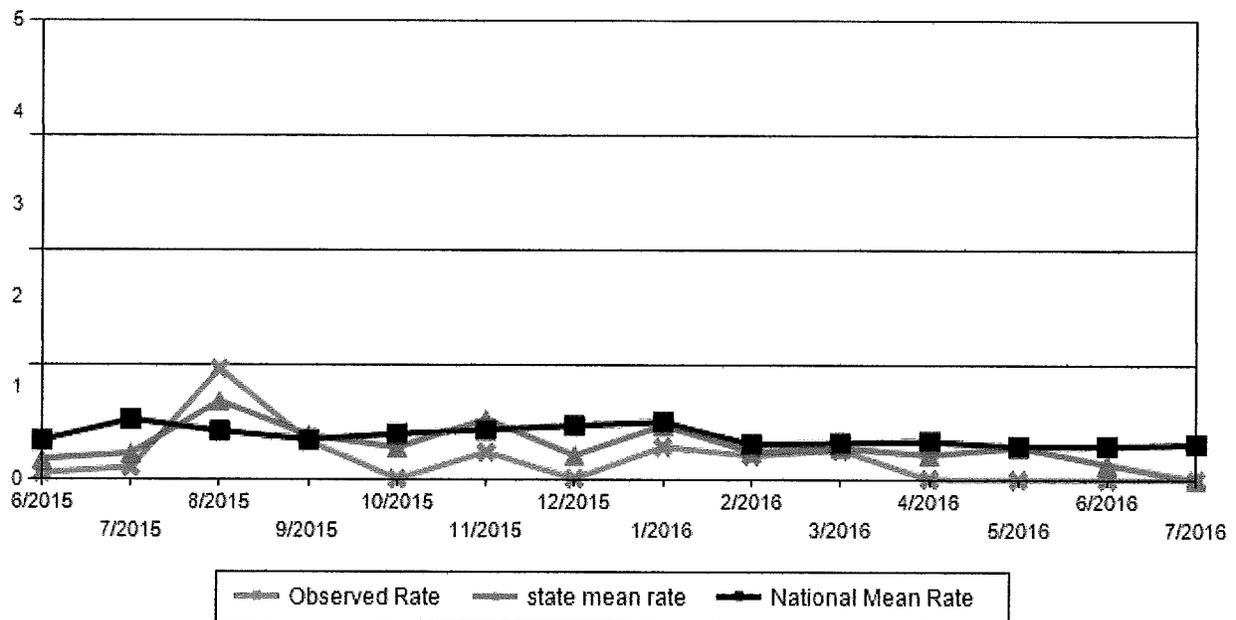
## COMPARATIVE STATISTICS

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

### NNAMHS Seclusion Data



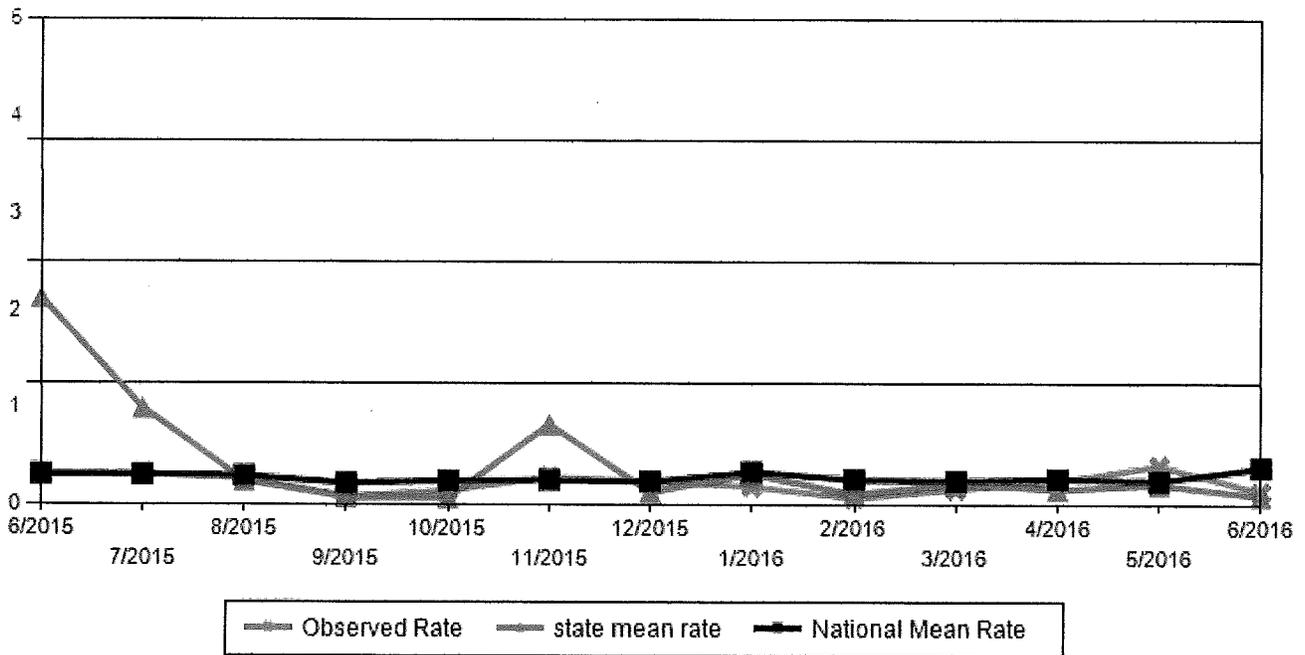
### NNAMHS Restraint Data



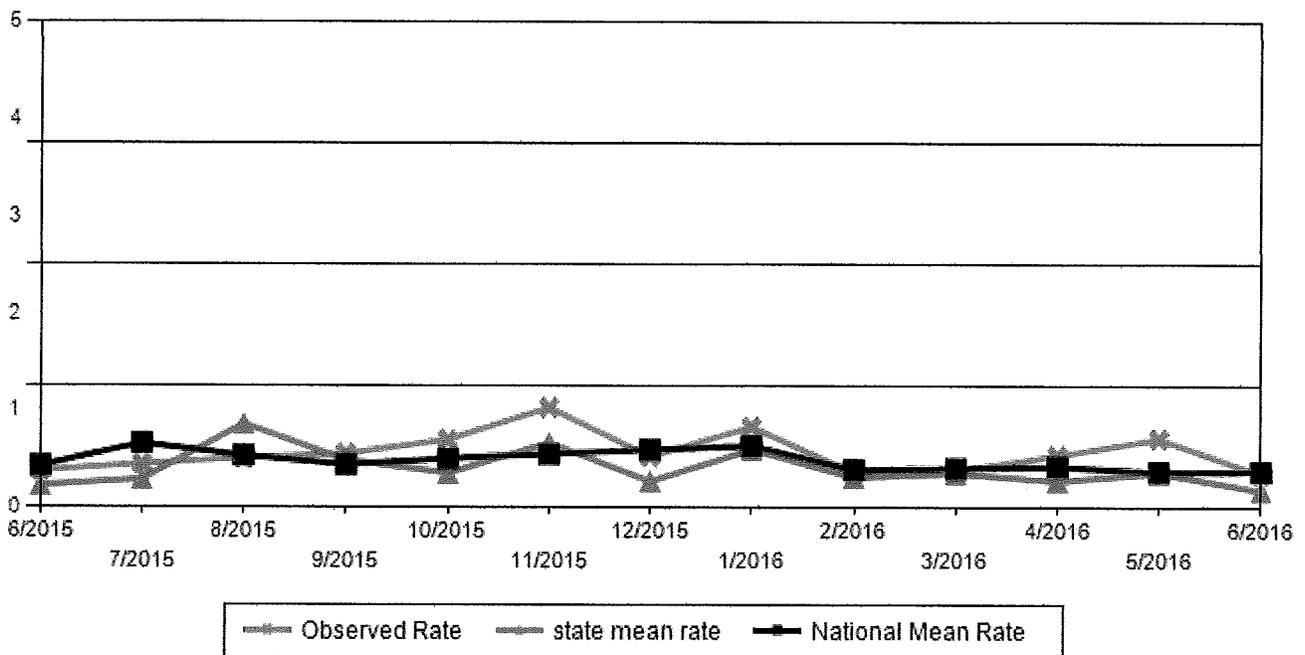
# Seclusion and Restraint Report

Friday, September 16, 2016

## SNAMHS Seclusion Data



## SNAMHS Restraint Data



## Seclusion and Restraint Report

Friday, September 16, 2016

### 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 do 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 Programming**
  - *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.

## Seclusion and Restraint Report

Friday, September 16, 2016

- **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.

## Seclusion and Restraint Report

Friday, September 16, 2016

### 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.

## Seclusion and Restraint Report

Friday, September 16, 2016

**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

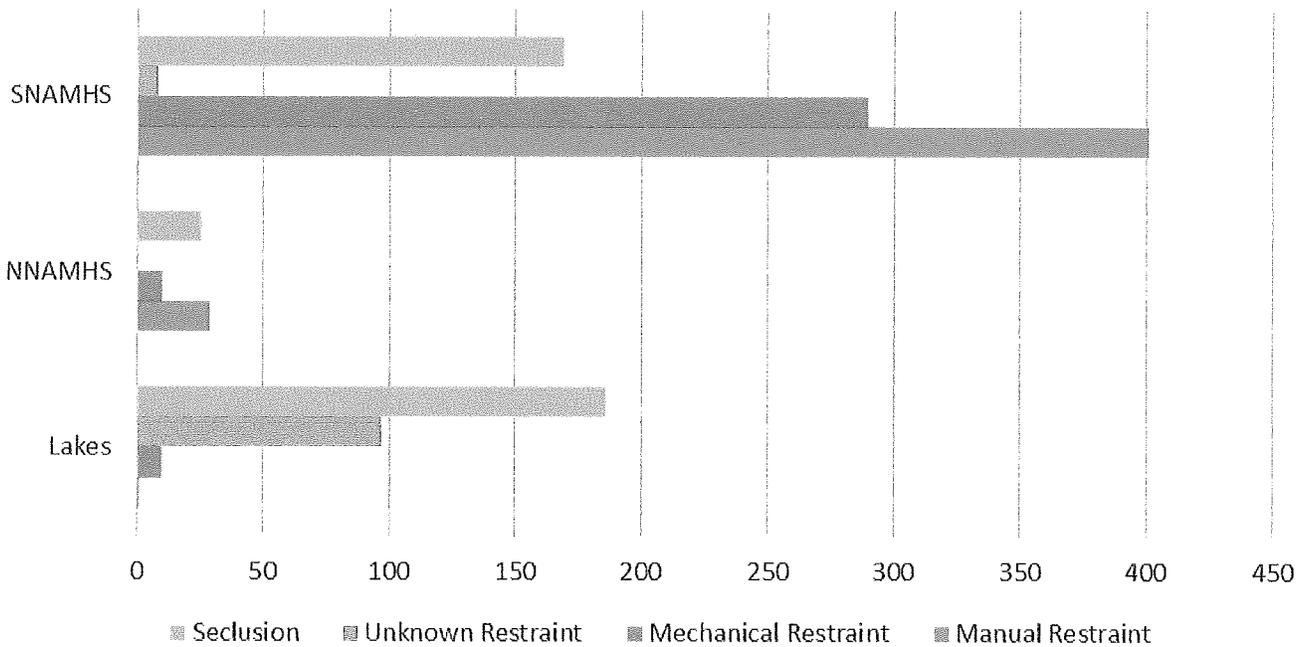
**Note:** These facilities are of varying size and function. Comparisons between facilities should be made with extreme caution.

#### 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
<b>Total</b>	<b>431</b>	<b>310</b>	<b>105</b>	<b>380</b>	<b>1226</b>

NRI from July 1, 2015 to June 30, 2016



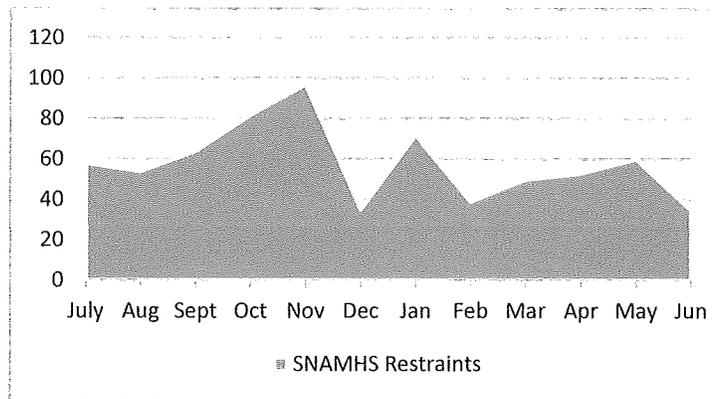
Average Daily Census from July 1, 2015 to June 30, 2016

SNAMHS	114
NNAMHS	27
Lake's Crossing	74

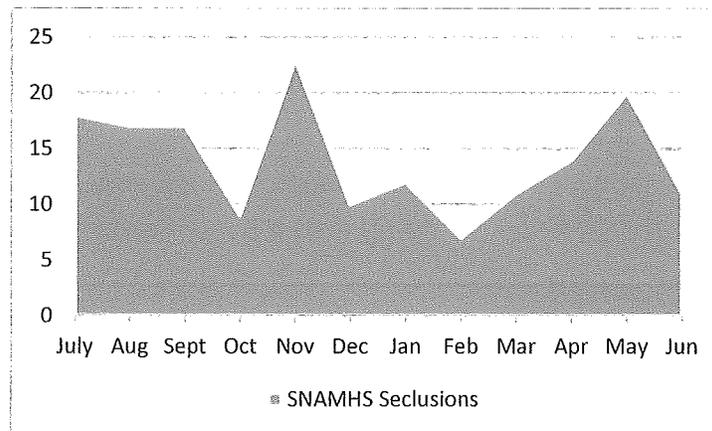
**Nevada Division of Public & Behavioral Health - Commission on Behavioral Health**  
**Seclusion and Restraint Report**  
 Friday, September 16, 2016

**Tables 3 – 4 – 5: SNAMHS Restraints & Seclusions**

<b>SNAMHS - Restraints</b>													
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	<b>699</b>
Individuals with Multiple Events	15	18	12	18	16	11	19	8	10	15	14	9	<b>165</b>
≤4 hours	57	52	64	78	92	32	68	36	47	51	55	33	<b>665</b>
4 to 8 hours	1	2	0	3	4	2	1	2	1	3	4	2	<b>25</b>
>8 hours	0	0	0	1	1	1	3	1	2	0	1	0	<b>10</b>



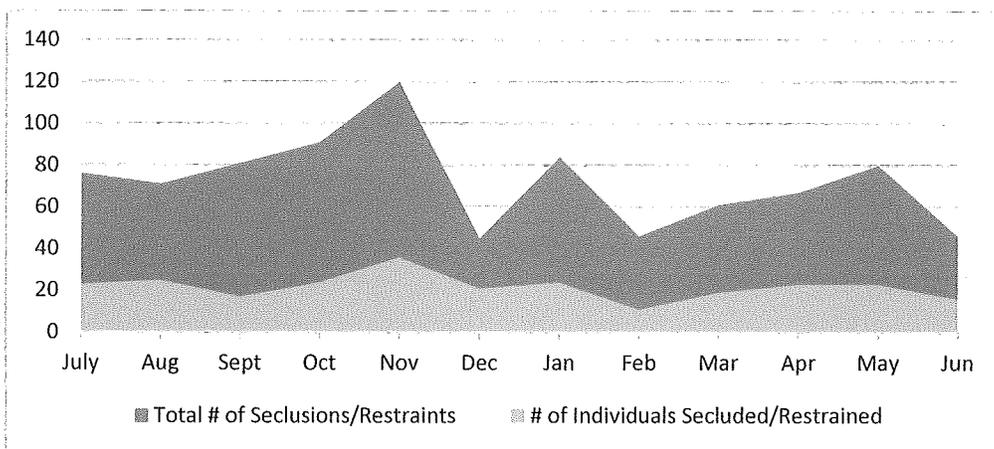
<b>SNAMHS - Seclusions</b>													
Month	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Seclusions	18	17	17	9	23	10	12	7	11	14	20	11	<b>169</b>
Individuals with Multiple Events	3	3	1	2	5	2	4	2	1	4	4	2	<b>33</b>
≤4 hours	16	17	17	9	23	8	10	7	11	13	19	10	<b>160</b>
4 to 8 hours	2	0	0	0	0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



## Seclusion and Restraint Report

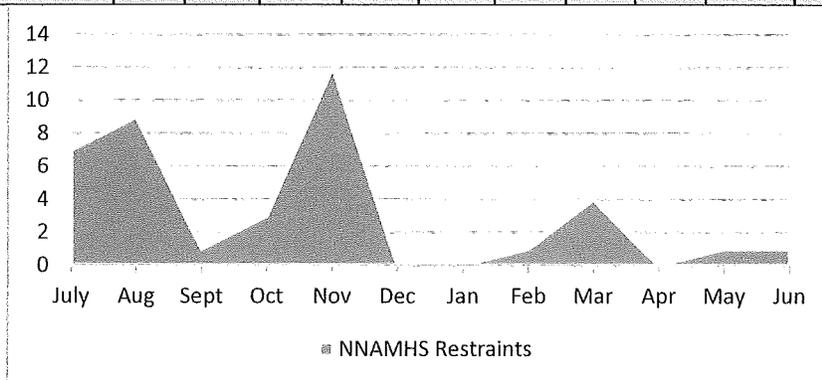
Friday, September 16, 2016

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	<b>262</b>
Total Number of Seclusion/Restraint Events	76	71	81	91	120	45	84	46	61	67	80	46	<b>868</b>
Events with Treatment Plan Review	51	52	38	16	1	0	0	0	0	0	0	0	<b>158</b>
Events with Progress Note Completed	74	68	81	91	120	45	83	46	61	67	80	46	<b>862</b>
Positive Behavioral Support Plan in Place at Time of Event	26	39	39	0	47	18	23	24	0	0	30	13	<b>259</b>
Events with Patient Injuries	6	8	9	7	10	4	6	3	2	5	8	5	<b>73</b>
Events with Staff Injuries	12	12	10	11	13	7	17	3	16	5	8	9	<b>123</b>



Tables 6 – 7 – 8: NNAMHS Restraints & Seclusions

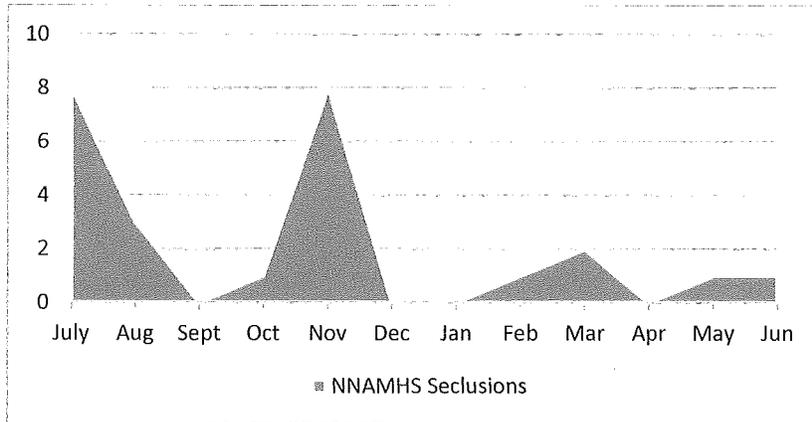
NNAMHS - Restraints													
Month	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Restraints	7	9	1	3	12	0	0	1	4	0	1	1	<b>39</b>
Individuals with Multiple Events	1	1	0	1	4	0	0	0	1	0	0	0	<b>8</b>
≤4 hours	7	9	1	3	12	0	0	1	3	0	1	1	<b>38</b>
>8 hours	0	0	0	0	0	0	0	0	1	0	0	0	<b>1</b>



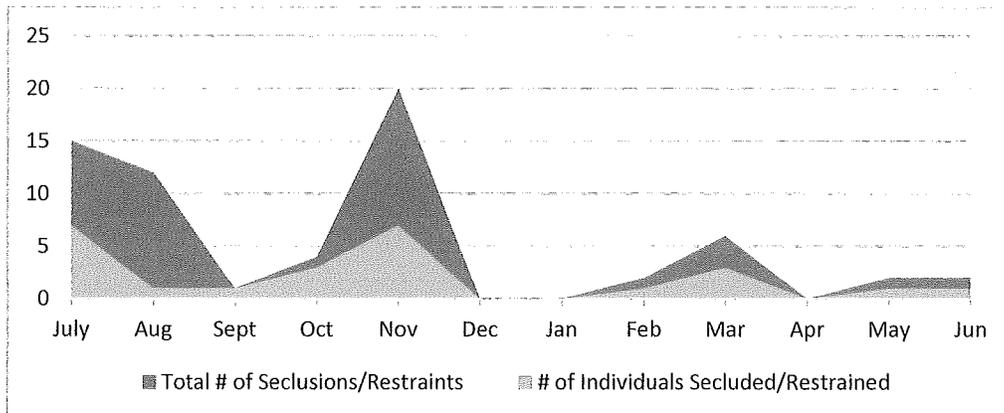
## Seclusion and Restraint Report

Friday, September 16, 2016

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	<b>25</b>
Individuals with Multiple Events	2	1	0	0	1	0	0	0	1	0	0	0	<b>5</b>
≤4 hours	8	3	0	1	7	0	0	1	2	0	1	1	<b>24</b>
4 to 8 hours	0	0	0	0	1	0	0	0	0	0	0	0	<b>1</b>



NNAMHS - Seclusions/Restrains													
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	<b>25</b>
Total Number of Seclusion/Restraint Events	15	12	1	4	20	0	0	2	6	0	2	2	<b>64</b>
Events with Treatment Plan Review	5	0	0	0	0	0	0	0	0	0	0	0	<b>5</b>
Events with Progress Note Completed	12	12	0	1	20	0	0	2	6	0	2	2	<b>57</b>
Events with Patient Injuries	0	0	0	0	0	0	0	0	0	0	0	0	<b>0</b>
Events with Staff Injuries	0	1	0	0	0	0	0	0	0	0	0	0	<b>1</b>

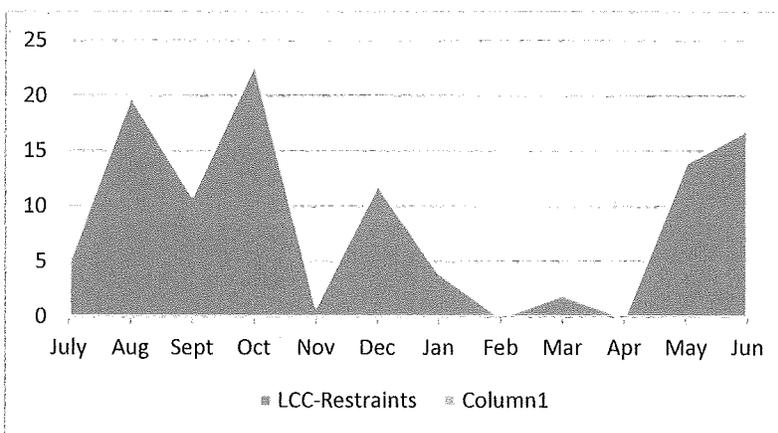


## Seclusion and Restraint Report

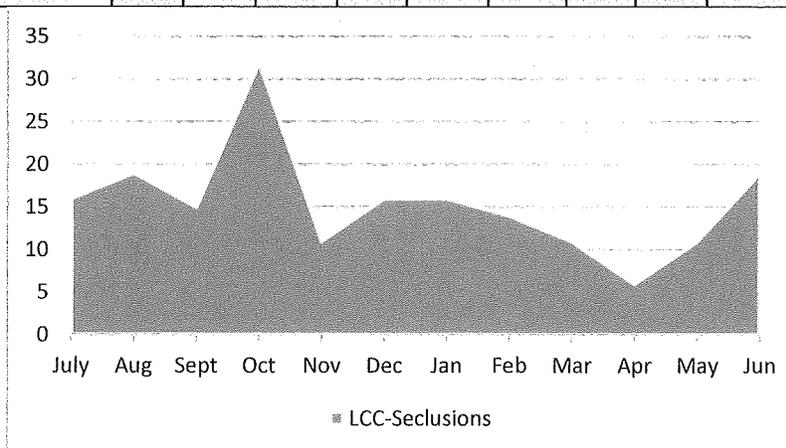
Friday, September 16, 2016

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	<b>109</b>
Individuals with Multiple Events	2	5	2	5	0	1	4	0	0	0	1	2	<b>22</b>
≤4 hours	5	20	11	20	1	12	4	0	1	0	13	17	<b>104</b>
4 to 8 hours	0	0	0	0	0	0	0	0	1	0	0	0	<b>1</b>
>8 hours	0	0	0	0	0	0	0	0	0	0	1	0	<b>1</b>



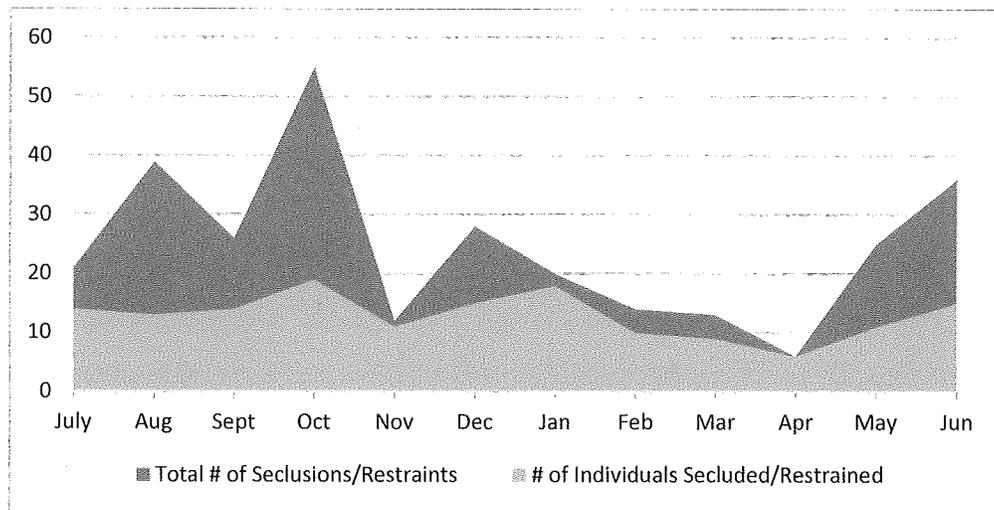
Lake's Crossing - Seclusions													
Month	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Seclusions	16	19	15	32	11	16	16	14	11	6	11	19	<b>186</b>
Individuals with Multiple Events	3	6	2	12	0	1	0	2	2	0	1	3	<b>32</b>
≤4 hours	2	1	2	5	4	5	3	2	0	0	1	2	<b>27</b>
4 to 8 hours	0	3	1	0	1	2	0	2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



## Seclusion and Restraint Report

Friday, September 16, 2016

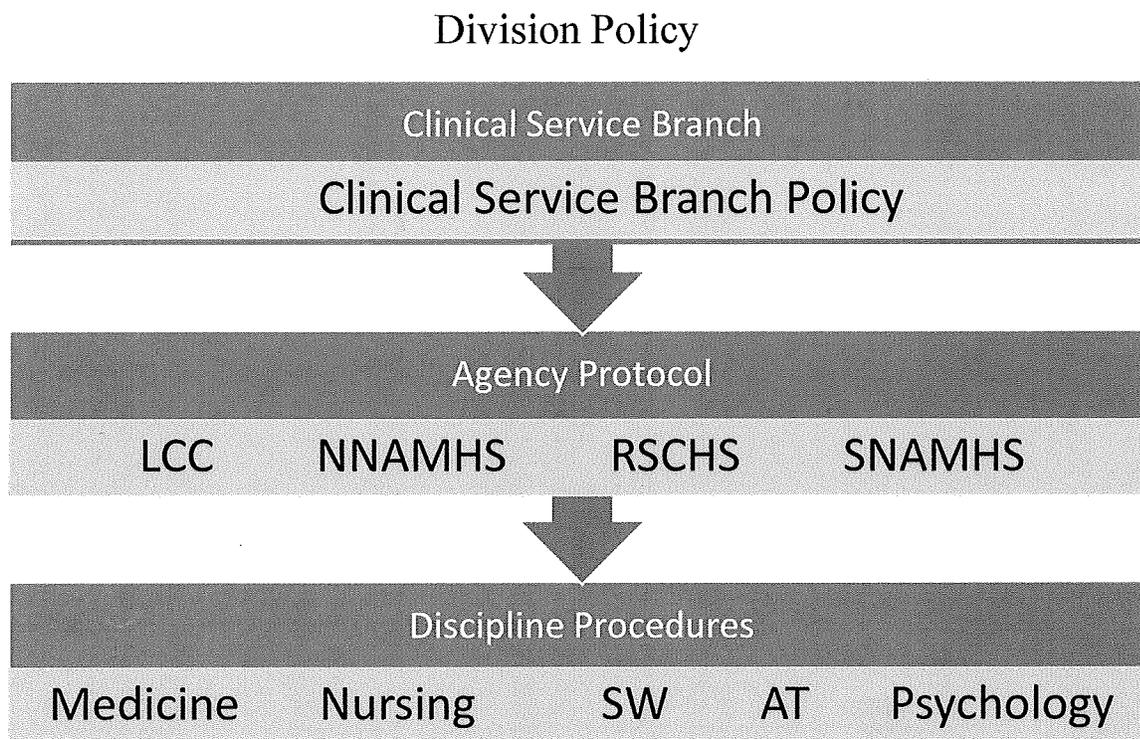
Lake's Crossing – Seclusions/Restrains													
Month	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Number of Individuals Secluded/Restrained	14	13	14	19	11	15	18	10	9	6	11	15	<b>155</b>
Total Number of Seclusion/Restraint Events	21	39	26	55	12	28	20	14	13	6	25	36	<b>295</b>
Events with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



# Division of Public and Behavioral Health

## Policy and Procedure Standardization Concept

With a goal towards standardizing, clarifying and improving the standard of services offered through the DPBH Clinical Services Branch, policy, procedure and discipline protocol will move to a unified structure.

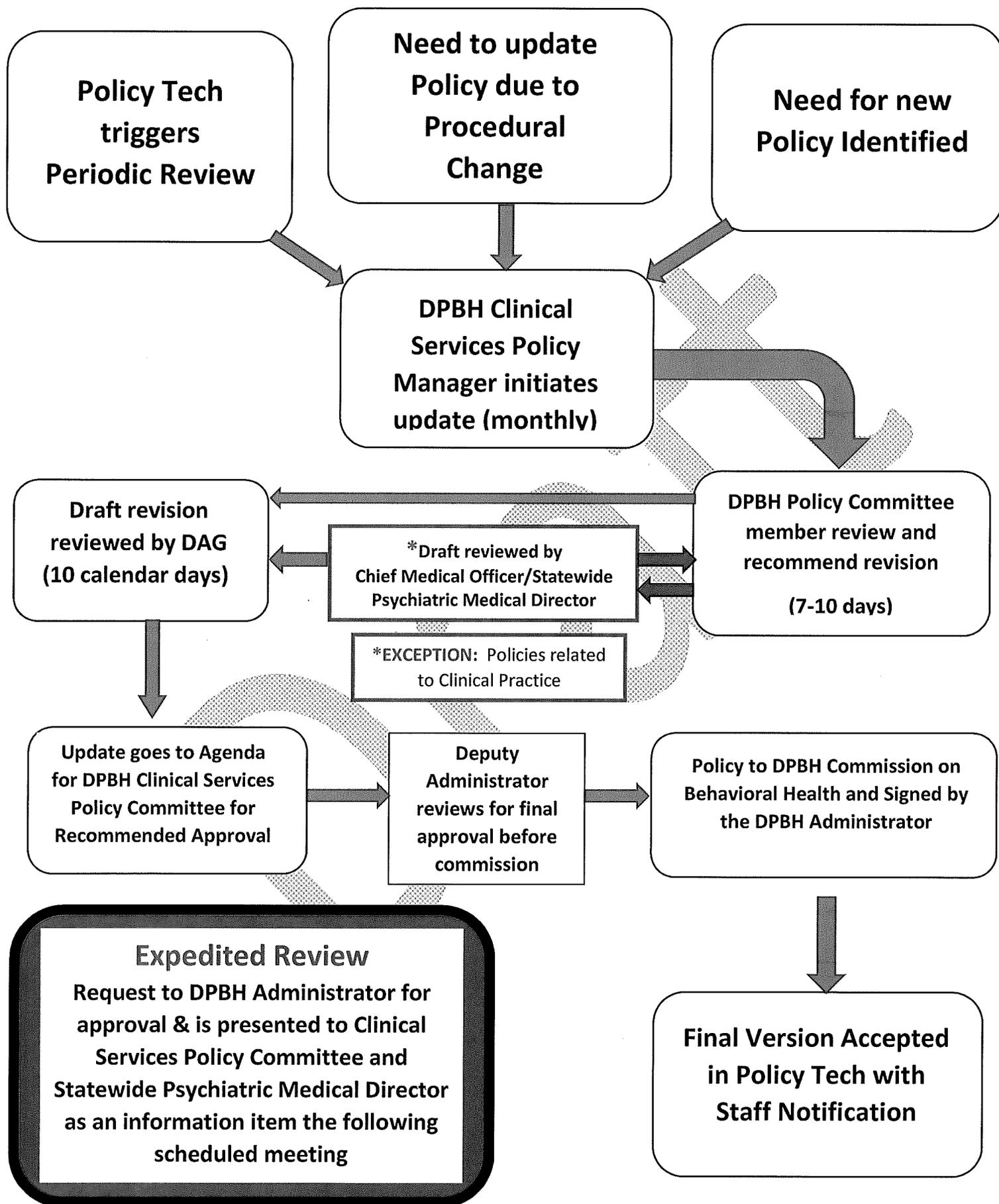


Division Clinical Services Branch Policy will be the standard policy for all agencies housed within the branch. Individual agency policy will become protocol and will support and add clarity at the agency level for implementation of Division policy.

Discipline procedures will outline discipline specific processes. Discipline procedure will not duplicate Clinical Services Branch Policy or agency level protocol. Discipline specific procedures will cross walk across agencies. Example: a procedure on vital signs will apply to all nurses regardless of the location of their duty assignment.

Agency medical record forms will be developed in a uniform fashion and will be consistent across duty locations. Forms should support a process that is outlined in a policy or protocol and must go through an approval process.

# DPBH CLINICAL SERVICES POLICY PROCESS





DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
CLINICAL SERVICES

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<b>Control #</b> SP-5.1	<b>Rev.</b>	<b>Title: PASRR PROGRAM</b>	<b>Effective Date:</b>
			<b>Next Review Date:</b>

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- 1.0. **POLICY:** It is the policy of the DPBH to provide oversight and authority to the Level II PASRR program pertaining to screening determinations, specialized services, and monitoring activities
- 2.0. **PURPOSE:** Pursuant to federal regulations addressed in 42 CFR 483 the state mental health authority (SMHA) and mental retardation authorities (SMRA) are responsible for oversight and administration of PASRR Level II functions. This policy pertains **only** to the DPBH portion of the PASRR program in its role as the SMHA. Described within this policy are common definitions, procedures and protocols which will guide all PASRR requirements and operations.
- 3.0. **SCOPE:** Division Wide
- 4.0. **REFERENCE:** 42 Code of Federal Regulations (CFR) 483.108 to 483.136
- 5.0. **PROCEDURE:**
- 5.1. Common PASRR Definitions:
- 5.1.1. **PASRR** – Pre-Admission Screening and Resident Review. Before admission into a nursing facility a person must be screened to determine the presence of mental illness, mental retardation or a related condition. If such a condition exists, a further screening may be required to determine whether or not an individual may be placed in a nursing facility or another alternative setting.
- 5.1.2. **Medicaid** – Division of Health Care Financing and Policy (DHCFP) – Nevada Medicaid. The State Medicaid Authority (SMA) is responsible for the overall oversight and administration of the PASRR program.
- 5.1.3. **Level I** - Pursuant to 42 Code of Federal Regulations (CFR) 483.128 (a), the identification of individuals with a Mental Illness (MI) or Mental Retardation (MR). The PASRR program must identify all individuals who are suspected of having MI or MR as defined in 42 CFR 483.102.
- 5.1.4. **Level II** – Pursuant to 42 CFR 483.128 (a), the function of evaluating and determining whether nursing facility (NF) services and specialized services are needed for individuals identified with MI or MR as defined in 42 CFR 483.102.
- 5.1.5. **PASRR II-B** – A PASRR II-B consumer is a person who has been screened as having mental illness, mental retardation or a related condition, and as a condition of being placed or allowing to remain in a nursing facility, requires PASRR Specialized Services. Additionally, if an individual in a nursing facility has a “significant status change” they are required to receive a PASRR screening.



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5.1.6. **DPBH** – As defined by terminology used by the federal Centers for Medicare and Medicaid Services (CMS), the Nevada Division of Public and Behavioral Health (DPBH) is the state mental health authority (SMHA) in Nevada. DPBH is responsible for operation of state funded outpatient community mental health programs, psychiatric inpatient programs, and mental health forensic services.

5.1.6.1. Within mental health are four agency service sites: Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS), Rural Services – Mental Health and Lake’s Crossing Center. The final agency within DPBH is the Substance Abuse Prevention and Treatment Agency (SAPTA).

5.6.1.2. By Nevada state statute DPBH is responsible for planning, administration, policy setting, monitoring and budgeting development of all state funded Public and Behavioral Health programs.

## 5.2. Specialized Services

5.2.1. Pursuant to 42 CFR 483.120 (a), for mental illness, specialized services means the services are specified by the state (mental health authority) which, combined with services provided by the nursing facility, results in the continuous and aggressive implementation of an individualized plan of care that:

5.2.1.1. is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals and, as appropriate, other professions;

5.2.1.2. prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitate supervision by trained mental health personnel; and 3) is directed toward diagnosing and reducing the resident’s behavioral symptoms that necessitated institutionalization, improving his or her level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

5.2.1.3. Specialized Services Include but are not limited to:

5.2.1.3.1. Psychotherapy (individual/group/family)

5.2.1.3.2. Psychotropic Medications

5.2.1.3.3. Psychiatrist Follow-Up Services

5.2.1.3.4. Psychiatric Evaluation

5.2.1.3.5. Psychological Testing

5.2.1.3.6. Transitioning services, to assist in moving to a less restrictive environment

5.2.1.3.7. Monitoring and Advocacy

5.2.1.3.8. Other: \_\_\_\_\_



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5.2.1.4. working with nursing facilities to provide or arrange for the provision of specialized services to all nursing facility residents with mental illness whose needs are such that continuous supervision, treatment and training by qualified mental health personnel is necessary.

5.2.2. Hewlett Packard Enterprise Services, The Medicaid Quality Improvement Organization-Like (QIO-like) vendor contracted by DHCFP-Medicaid. Hewlett Packard Enterprise Services provides an array of fiscal agent, health care management and provider services. Among its array of contractual obligations to DHCFP-Medicaid, Hewlett Packard Enterprise Services is responsible for making nursing facility PASRR Levels I and II and Specialized Service determinations for Level II- related services – this is permitted through a “Delegation of Authority” Agreement DPBH has with DHCFP-Medicaid and Hewlett Packard Enterprise Services.

5.3. PASRR Program Requirements:

5.3.1. Pursuant to its being permitted by 42 CFR 483.106 (d) (2) (e), as the State’s mental health authority DPBH delegates the responsibilities to Hewlett Packard Enterprise Services to perform PASRR Level II evaluations and determinations, including, when it determines to be clinically necessary due to the consumer’s mental illness, specialized service determinations. Hewlett Packard Enterprise Services is responsible for:

5.3.1.1. Submitting copies of PASRR Level II determinations and evaluations/summary of findings to DPBH within three (3) business day of completion;

5.3.1.2. Informing nursing facility applicants or residents of individual PASRR determinations;

5.3.1.3. Maintaining a tracking system for all PASRR Level I and II determinations and submitting to DPBH a monthly report of PASRR II activities;

5.3.1.4. Participating with DPBH and DHCFP-Medicaid in providing necessary PASRR-related training to nursing facilities, hospitals and other relevant providers, and when necessary, DPBH staff; and

5.3.1.5. Participating in the Medicaid appeals process.

5.3.2. DPBH will cooperate in efforts to establish a relationship between nursing facilities, Hewlett Packard Enterprise Services and Medicaid necessary to comply with federally mandated PASRR requirements, including training, joint planning, access to records and exchange of information concerning individuals with mental illness, developmental disabilities or related conditions.



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5.3.3. Upon receipt of PASRR Level II-B screening determinations from Hewlett Packard Enterprise Services, DPBH PASRR regional coordinators will create a hard copy file for each consumer determined to need mental health specialized services (PASRR II-B), which contains as a minimum:

- 5.3.3.1. PASRR II determination and evaluation;
- 5.3.3.2. NF notification and DPBH Specialized Services forms;
- 5.3.3.3. Documentation that identifies each specific mental health service(s) and specialized service(s) that are to be provided, the anticipated duration of each, and who is to provide each of these services;
- 5.3.3.4. Completed Quarterly PASRR Review forms; and
- 5.3.3.5. DPBH Central Office Communication forms (Attachments A and B).

Additionally, all Level II PASRR data will be collected and stored in both DPBH' data base and by DPBH agency hard copy files.

All PASRR Level II hard copy and electronic files are to be maintained in a secure location under the direction of the DPBH PASRR Manager and/or his/her delegate.

5.3.4. DPBH regional agency PASRR staff will assist nursing facilities with arranging, delivering and/or monitoring the provision of specialized services to all individuals who agree to receive and comply with such services, as required by the federal PASRR regulations. Each DPBH regional agency PASRR coordinator shall assume the following responsibilities for specialized services:

- 5.3.4.1. Within 30 days of being notified by the DPBH PASRR Program that a new PASRR II-B consumer is being added to their caseload, DPBH regional PASRR coordinators will provide an initial review of the consumer. Then, following the initial review, DPBH regional PASRR agency coordinators will conduct a quarterly consumer review every 90 days thereafter. This initial and quarterly review, monitoring and documentation are to assure that the PASRR II-B consumers are receiving Specialized Services. Additionally, the DPBH PASRR Program must be notified by DPBH' Regional PASRR agency coordinators if there is a change in status warranting the consumer no longer requires PASRR services, or the consumer is no longer at the nursing facility (death or discharge to another setting). This review, monitoring and documentation compliance will be done by way of formal quarterly visits/reviews using the "DPBH PASRR II-B Quarterly Nursing Facility Review Form (Attachment C)."



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- 5.3.4.2. Whenever possible, assist in developing the plan for specialized services- this is most often accomplished by being a member of the PASRR II-B consumer's nursing facility multi-disciplinary team, responsible for developing and monitoring the consumer's plan of care. The consumer's DPBH regional agency PASRR coordinator will notify individuals identified as needing specialized services or alternate placement options and help to facilitate such services or placement.
- 5.3.4.3. For PASRR II-B consumers placed in out-of-state nursing facilities, DPBH PASRR Regional Coordinators, in lieu of performing onsite nursing facility quarterly visits, will utilize the Out-of-State Documentation Request for Nevada PASRR II-B Residents Quarterly Review (Attachment E) form.
- 5.3.5. DPBH' PASRR II-B consumers, regardless of location of the state, who are placed or reside in an out-of-state (OOS) nursing facility, will be assigned to the caseload of Rural Clinics (RC). RC will only be responsible for reviewing and monitoring the initial and ongoing (quarterly) reviews of OOS PASRR II-B consumers. If no other resources are available and the Specialized Services the OOS PASRR II-B consumer requires must be provided and/or financed by DPBH. The DPBH agency in the geographic area of Nevada the consumer was placed from to the OOS nursing facility is responsible for this action.
- 5.3.6. If a consumer requires specialized services, but is not eligible for NF placement, DPBH PASRR agencies will participate fully with Medicaid staff and/or the nursing facility to arrange for appropriate services, including alternative placement elsewhere.
- 5.3.7. DPBH will complete and submit the "DPBH PASRR II-B Quarterly Report" to DHCFP-Medicaid.
- 5.3.8. DPBH will participate with Medicaid and Hewlett Packard Enterprise Services in an Appeals process for individuals adversely affected by PASRR Level II Determinations.



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- 6.0. To comply with 42 CFR 483.106 (d) (2) (e) (i) which requires the State mental health authority to retain ultimate control and responsibility of PASRR Level II obligations, DPBH' Statewide PASRR Program Manager will conduct a periodic DPBH PASRR Program Compliance Review to a) verify the appropriateness of Hewlett Packard Enterprise Services PASRR Level II screening determinations and evaluations/summary of findings, b) verify that the consumer is receiving appropriate and clinically necessary specialized services as recommended by the PASRR Level II determination and 3) ascertain and verify the work responsibilities of the DPBH Regional Coordinators are being appropriately performed

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ADMINISTRATOR



DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
CLINICAL SERVICES

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Attachment A: NURSING FACILITY (NF) PASRR II-B NOTIFICATION FORM (to be completed by Nursing Facilities)

Attachment B: PASRR LEVEL II-B Communication Form (to be completed by the DPBH Regional PASRR Coordinators)

Attachment C: DPBH PASRR II-B Quarterly Nursing Facility Review Form (to be completed by DPBH Regional PASRR Coordinators)

Attachment D: Nursing Facility PASRR II-B Specialized Services Resident Review Progress Note

Attachment E: Out-of-State Documentation Request for Nevada PASRR IIB Resident Quarterly Review

Attachment F: PASRR Specialized Services Flow

Attachment G: Sample Resident Care Plan: PASRR II-B Specialized Services (for persons with mental illness)

Attachment H: Sample Resident Care Plan: PASRR II-B Specialized Services (for persons with developmental/intellectual disabilities)

EFFECTIVE DATE: 4/19/02

REVISED/REVIEWED DATE: 1/1/03, 7/22/03, 1/1/05, 2/9/07, 1/1/10, 1/1/11 SUPERSEDES:

Policy #4.057 PASRR PROGRAM

APPROVED BY DPBH ADMINISTRATOR: 12/30/10

APPROVED BY DPBH COMMISSION: 4/19/02

**DPBH PASRR II-B QUARTERLY NURSING FACILITY REVIEW FORM**

**(To be completed by Regional PASRR Coordinators)**

**I. Demographic Information**

Resident's Name: \_\_\_\_\_

Nursing Facility: \_\_\_\_\_

PASRR II-B Determination Date: \_\_\_\_\_

Date of PASRR Regional Coordinator's Review: \_\_\_\_\_

**II. Specialized Services Recommended on Level II Determination (by Hewlett Packard Enterprise Services):**

**DPBH - Mental Illness (MI)**

**ADSD – Intellectual Disabilities (ID)**

- \_\_\_\_ Psychotherapy (individual/group/  
Family)
- \_\_\_\_ Psychiatrist Follow-Up Services
- \_\_\_\_ Monitoring and Advocacy
- \_\_\_\_ Psychotropic Medications
- \_\_\_\_ Psychiatric Evaluation
- \_\_\_\_ Psychological Evaluation
- \_\_\_\_ Transitioning services, to assist in  
moving to a less restrictive setting
- \_\_\_\_ Other: \_\_\_\_\_

- \_\_\_\_ Psychological Services
- \_\_\_\_ School Referrals and Services
- \_\_\_\_ Monitoring and Advocacy
- \_\_\_\_ Day Services
- \_\_\_\_ Transition Services, to assist in moving to a  
less restrictive environment
- \_\_\_\_ Other: \_\_\_\_\_

**III. Specialized Services Actually Being Provided:**

**DPBH - Mental Illness (MI)**

**ADSD – Intellectual Disabilities (ID)**

- \_\_\_\_ Psychotherapy (individual/group/  
Family)
- \_\_\_\_ Psychiatrist Follow-Up Services
- \_\_\_\_ Monitoring and Advocacy
- \_\_\_\_ Psychotropic Medications
- \_\_\_\_ Psychiatric Evaluation
- \_\_\_\_ Psychological Evaluation
- \_\_\_\_ Transitioning services, to assist in  
Moving to a less restrictive setting
- \_\_\_\_ Other: \_\_\_\_\_

- \_\_\_\_ Psychological Services
- \_\_\_\_ School Referrals and Services
- \_\_\_\_ Monitoring and Advocacy
- \_\_\_\_ Day Services
- \_\_\_\_ Transition Services, to assist in moving to a  
less restrictive environment
- \_\_\_\_ Other: \_\_\_\_\_

**DO NOT PURGE** - One copy of this review form must be kept in the client's active medical record/chart at all times, including, if the PASRR II-B Resident is discharged and readmitted, and be carried over to the new medical record/chart. The other copy (original) will be kept/maintained by the DPBH PASRR II Reviewer.

Resident Name: \_\_\_\_\_

Review Date: \_\_\_\_\_

**IV. Reviewer participated in the development and ongoing monitoring of Specialized Services the client receives from the NF:**

Development?         Yes     No  
Monitoring?         Yes     No

Please explain: (e.g., care plan team, IEP, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**V. Resident's Care/Treatment Plan and Progress Notes (both) appropriately Addresses and Documents the Resident is Receiving Needed PASRR Specialized Services? (Please be sure to specifically address each and every PASRR II-B specialized service (i.e., verify if it is being delivered, how often, including dates if possible, if the resident is benefiting from specialized service, etc.)**

\_\_\_\_\_  
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**VI. Does the PASRR Regional Coordinator recommend for the Resident any additional or different specialized services that may not have been previously recommended by Hewlett Packard Enterprise Services (HPES)?**

No                       Yes

If Yes, please document recommended or different specialized service:

**DPBH - Mental Illness (MI)**

- Psychotherapy (individual/group/  
Family)
- Psychiatrist Follow-Up Services
- Monitoring and Advocacy
- Psychotropic Medications
- Psychiatric Evaluation
- Psychological Evaluation
- Transitioning services, to assist in  
moving to a less restrictive setting
- Other: \_\_\_\_\_

**ADSD – Intellectual Disabilities**

- Psychological Services
- School Referrals and Services
- Monitoring and Advocacy
- Day Services
- Transition Services, to assist in moving to a  
less restrictive environment
- Other: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Resident Name: \_\_\_\_\_

Review Date: \_\_\_\_\_

**VII. Is the Resident appropriate for possible discharge within the next 90 days, based on availability of services?**

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

Yes or No, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**VIII. PASRR Regional Coordinator's Review Summary:**

1. Is the resident still appropriate at a PASRR Level II-B?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If no, instruct the Nursing Facility to request a new PASRR Level I screening from Hewlett Packard Enterprise Services (HPES). The nursing facility must indicate that a new screening is necessary and that a new PASRR screening determination may be appropriate, and must forward supportive clinical documentation showing "significant status change."

2. Does the Resident still require the Specialized Services as indicated in section II (on page 1 of 2)?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If no, the PASRR Regional Coordinator should recommend additional or different specialized services in VI above, or no specialized services at all.

3. Narrative Statement (e.g., what MHDS or the nursing facility may be working on or trying to arrange for the individual, whether specialized services, discharge from the nursing facility, on waiting list for community-based services, etc.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Regional PASRR Coordinator (Print)

\_\_\_\_\_  
Regional PASRR Coordinator (Signed)

\_\_\_\_\_  
Date

Resident Name: \_\_\_\_\_

Review Date: \_\_\_\_\_

## NURSING FACILITY PASRR II-B SPECIALIZED SERVICES RESIDENT QUARTERLY PROGRESS NOTE (Social Services)

*This Nursing Facility PASRR II-B Specialized Services Resident Quarterly Progress Note is to be completed in conjunction with the resident's quarterly care plan update and/or general social services quarterly progress notes, and kept in the social services (or where other PASRR information is kept) portion of the resident's chart/medical record. Please be sure this document is carried over to resident's new chart if readmission occurs). In part, federal regulations at 42 CFR 483.120 and 483.126 require persons' screened and identified as needing specialized services (PASRR II-B) by the mental health authority or its agent as a condition to be admitted to a nursing facility, to receive specialized services identified in the PASRR II-B screening determination – receipt and provision of these specialized services by nursing facilities must clearly be documented.*

**I. Resident:** \_\_\_\_\_ **PASRR II-B Determination Date:** \_\_\_\_\_

**Nursing Facility:** \_\_\_\_\_

**II. PASRR Specialized Services recommended on PASRR Level II-B Determination (by Hewlett Packard Enterprise Services):**

**DPBH - Mental Illness (MI)**

\_\_\_\_ Psychotherapy (individual/group/  
Family)  
\_\_\_\_ Psychiatrist Follow-Up Services  
\_\_\_\_ Monitoring and Advocacy  
\_\_\_\_ Psychotropic Medications  
\_\_\_\_ Psychiatric Evaluation  
\_\_\_\_ Psychological Evaluation  
\_\_\_\_ Transitioning services, to assist in  
moving to a less restrictive setting  
\_\_\_\_ Other: \_\_\_\_\_

**ADSD – Intellectual Disabilities**

\_\_\_\_ Psychological Services  
\_\_\_\_ School Referrals and Services  
\_\_\_\_ Monitoring and Advocacy  
\_\_\_\_ Day Services  
\_\_\_\_ Transition Services, to assist in moving to  
a less restrictive environment  
\_\_\_\_ Other: \_\_\_\_\_

**III. PASRR Specialized Services Actually Being Provided:**

**DPBH Mental Illness (MI)**

\_\_\_\_ Psychotherapy (individual/group/  
Family)  
\_\_\_\_ Psychiatrist Follow-Up Services  
\_\_\_\_ Monitoring and Advocacy  
\_\_\_\_ Psychotropic Medications  
\_\_\_\_ Psychiatric Evaluation  
\_\_\_\_ Psychological Evaluation  
\_\_\_\_ Transitioning services, to assist in  
moving to a less restrictive setting  
\_\_\_\_ Other: \_\_\_\_\_

**ADSD – Intellectual Disabilities**

\_\_\_\_ Psychological Services  
\_\_\_\_ School Referrals and Services  
\_\_\_\_ Monitoring and Advocacy  
\_\_\_\_ Day Services  
\_\_\_\_ Transition Services, to assist in moving to  
a less restrictive environment  
\_\_\_\_ Other: \_\_\_\_\_

**DO NOT PURGE** - One copy of this review sheet must be kept at all times in the client's active medical record/chart at all times, including, if resident is discharged and readmitted, carried over to the new medical record/chart.

Resident Name: \_\_\_\_\_

Review Date: \_\_\_\_\_



**Attachment E**

STATE OF NEVADA

**BRIAN SANDOVAL**  
*Governor*

**RICHARD WHITLEY, MS**  
*Director*



**CODY L. PHINNEY, MPH**  
*Administrator*

**TRACEY D. GREEN, MD**  
*Chief Medical Officer*

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**

**Date:**

**To:** {Name of Nursing Facility PASRR Contact Person}  
{Name of Out-of-State Nursing Facility}

**From:** {Name, Title and Location of Nevada Regional PASRR Coordinator}

**RE:** {Name of Nevada PASRR II-B Nursing Facility Resident}  
**Out-of-State Documentation Request for Nevada PASRR II-B Resident Quarterly Review**

As you may be aware, the above Nevada nursing facility resident has received a Nevada PASRR II-B screening determination, and is permitted to be admitted to, or remain in, your nursing facility, but only if he/she is receiving PASRR Level II-B Specialized Services.

Federal regulations at 42 Code of Federal Regulations (CFR) 483.116 and 483.120 require the state mental health (Division of Public and Behavioral Health) and state intellectual disabilities (Aging and Disabilities Services Division) authorities, to make determinations of the appropriate placement, and verify residents are receiving PASRR specialized services, as determined by Hewlett Packard Enterprise Services (HPES), the Nevada PASRR Program contractor.

As we are unable to conduct on-site reviews for our PASRR resident who is receiving care in your nursing facility, DPBH respectfully requests the following information for purposes of assisting us to conduct our quarterly reviews. **Please submit the following information no later than {list date}:**

- ✓ Last 180 days of MD orders
- ✓ Last 180 days of medication sheets and behavior monitoring sheets
- ✓ Last Social Services Quarterly Progress Note
- ✓ Nevada Nursing Facility PASRR II-B Specialized Services Resident Progress Note (Social Services) - Attachment D
- ✓ Most recent Resident Plan of Care
- ✓ Most recent MDS (approximately 10-pages).
- ✓ Any other information you deem relevant

Thank you very much for your cooperation and collaboration with providing this requested information in a timely manner. Out-of-state nursing facilities that do not provide this requested information timely are in violation of federal requirements pertaining to the PASRR Level II program. Additionally, non-compliance with this request could affect Nevada Medicaid payment to your nursing facility.

[Type here]

Should you have any questions regarding this request please do not hesitate to contact me. I can be reached at {Regional PASRR Coordinator's phone number}. Administrative PASRR Program questions may be directed to the Nevada Statewide PASRR Coordinator, Kevin P. Filippelli, MS, NCC, at (702) 486-4095 (office), (775) 400-0790 (cell) or [kfilippelli@health.nv.gov](mailto:kfilippelli@health.nv.gov).

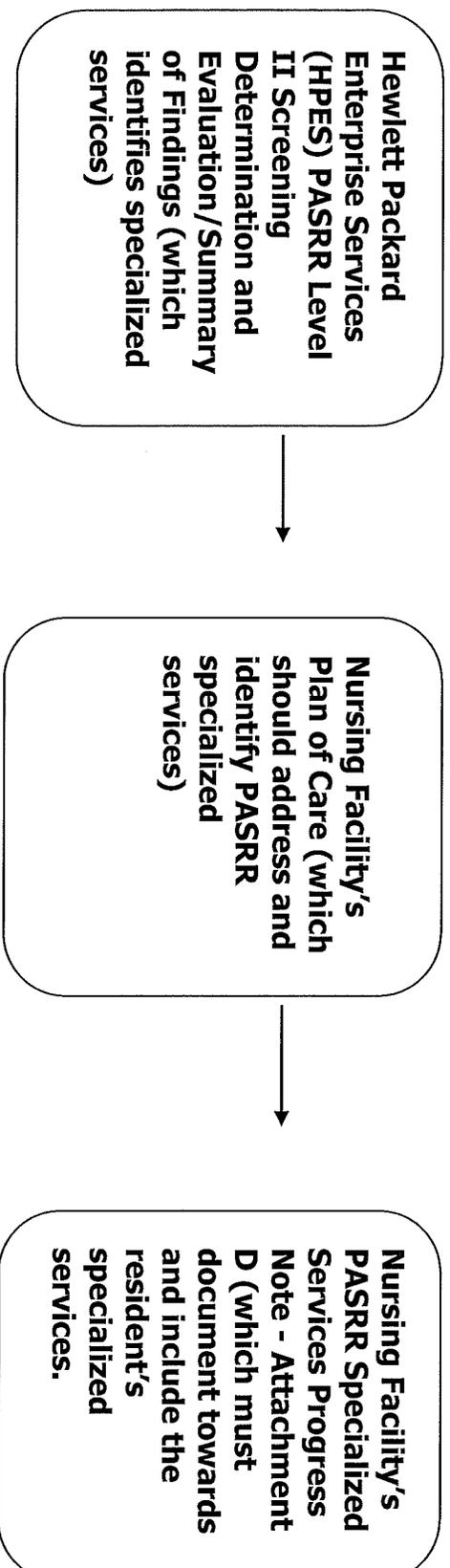
Thank you so much for your cooperation.

Sincerely,

Regional PASRR Coordinator

[Type here]

## PASRR SPECIALIZED SERVICES FLOW



[Type here]

## SAMPLE RESIDENT CARE PLAN FOR PASRR II-B SPECIALIZED SERVICES (Persons with Mental Illness)

Problem/Need	Goal/Objective	Approach/Intervention	Discipline
<p>Resident has depression and psychosis, and has been identified in the PASRR II-B Screening and Evaluation as requiring PASRR II-B Specialized Services</p>	<p>Resident will receive the following PASRR-B specialized services as identified in his/her PASRR II-B screening determination and evaluation:</p> <ol style="list-style-type: none"> <li>1) Psychotropic Medications</li> <li>2) Psychiatric Follow-up</li> <li>3) Monitoring and Advocacy</li> </ol>	<p>The following provision of specialized services will be delivered, and by whom:</p> <ol style="list-style-type: none"> <li>1) <u>Psychotropic Medications:</u> The resident will receive his physician prescribed medication of Seroquel (list dosage, frequency, etc.) and Zyprexa (list dosage, frequency, etc.).</li> <li>2) <u>Psychiatric Follow-up:</u> The resident will receive at least quarterly follow-up from a psychiatrist or physician with monitoring his medications or the resident will receive weekly psychotherapy (whatever the case is)</li> <li>3) <u>Monitoring and Advocacy</u> – The resident will receive quarterly monitoring and advocacy visits and reviews (Attachment C) from his/her DPBH State PASRR Regional Coordinator</li> </ol>	<p>Social Services</p>

[Type here]

## SAMPLE RESIDENT CARE PLAN FOR PASRR II-B SPECIALIZED SERVICES (Persons with Developmental/Intellectual Disabilities)

Problem/Need	Goal/Objective	Approach/Intervention	Discipline
<p>Resident has diagnosis of Moderate Mental Retardation (and/or a related condition, such as Cerebral Palsy, Traumatic Brain Injury, etc.) and has been identified in the PASRR II-B Screening Determination and Evaluation as requiring PASRR II-B Specialized Services</p>	<p>Resident will receive the following PASRR-B specialized services as identified in his/her PASRR II-B screening determination and evaluation:</p> <ol style="list-style-type: none"> <li>1) School Services (Special Ed)</li> <li>2) Day Services (for job development and training)</li> <li>3) Monitoring and Advocacy</li> </ol>	<p>The following provision of specialized services will be delivered, and by whom:</p> <ol style="list-style-type: none"> <li>1) <u>School Services</u>: The resident will receive special education services by _____ county school district, which will provide the resident's transportation (or the special education program will be brought to the resident at the NF).</li> <li>2) <u>Day Services</u> (for job development/training) – the resident will receive job training at _____, which will provide (or the NF will) transportation.</li> <li>3) <u>Monitoring and Advocacy</u> – The resident will receive quarterly monitoring and advocacy visits and reviews (Attachment C) from his/her DPBH State PASRR Regional Coordinator</li> </ol>	<p>Social Services</p>

[Type here]



Division of Public and Behavioral Health  
Clinical Services

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<b>Control #</b>	<b>Rev.</b>	<b>Title</b>	<b>Effective Date 2/16</b>
<b>Gov1.1</b>	<b>New</b>	<b>Clinical Services Hospital Governing</b>	<b>Review Date 2/18</b>
	<b>2/16</b>	<b>Body Policy</b>	

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## **1.0 POLICY**

The Division of Public and Behavioral Health (DBPH) in accordance with Nevada Revised Statutes NRS 449.0302 and NAC 449.286 has an established Governing Body that is legally responsible for the conduct of DBPH Inpatient Facilities. One Governing Body may be responsible for all DBPH inpatient facilities regardless of differing CMS Certification Numbers

## **2.0 PURPOSE**

To define procedures that guide the process of DBPH inpatient facility governance and to define the shared and unique responsibilities of Hospital Administration, Medical Staff Leadership and the Governing Body.

## **3.0 SCOPE**

Division wide, including all DBPH run inpatient facilities

## **4.0 DEFINITIONS**

4.1 Governing Body (NRS 440.0302 and NAC 449.286) - the person or group of persons, including a board of trustees, board of directors or other body, in whom the final authority and responsibility is vested for conduct of a hospital.

## **5.0 PROCEDURES**

5.1 The Governing Body will:

- 5.1.1 Include a member or members of the hospital's medical staff
- 5.1.2 Identify those responsible for the provision of care.
- 5.1.3 Hold meetings at least quarterly and more frequently when needed.
- 5.1.4 Adopt a workable set of bylaws which must be in writing and available to all members.
- 5.1.5 Establish mechanisms for formal approval of policies, bylaws, rules and regulations of the medical staff and its departments in the hospital.
- 5.1.6 Participate in the appointment of a qualified Chief Executive Officer (hospital administrator) using as its criteria the actual experience, nature and duration, or similar field, of the appointee.
- 5.1.7 A member of the Governing Body may participate in the hiring panel for the Chief Executive Officer (Hospital Administrator).
- 5.1.8 Determine, in accordance with state law, which categories of practitioners are eligible for appointment to the medical staff.



Division of Public and Behavioral Health  
Clinical Services

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<b>Control #</b>	<b>Rev.</b>	<b>Title</b>	<b>Effective Date 2/16</b>
<b>Gov1.1</b>	<b>New</b>	<b>Clinical Services Hospital Governing</b>	<b>Review Date 2/18</b>
	<b>2/16</b>	<b>Body Policy</b>	

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- 5.1.9 Appoint members of the medical staff after considering the recommendations of the existing medical staff.
- 5.1.10 Ensure that the medical staff has bylaws.
- 5.1.11 Approve medical staff bylaws and other medical staff rules and regulations.
- 5.1.12 Review written and verbal reports from the medical staff highlighting the quality of care which the medical staff provide to patients.
- 5.1.13 Ensure the criteria for selection of medical staff includes individual competence, training, experience and judgment.
- 5.1.14 The Governing Body will assure that every patient is under the care of:
  - 5.1.14.1 A doctor of medicine or osteopathy
  - 5.1.14.2 A clinical psychiatrist
  - 5.1.14.3 Advanced Practice Registered Nurse (APRN)
- 5.1.15 Patients are admitted to the hospital only on the recommendation of a licensed practitioner, permitted by the state to admit patients to a hospital.
- 5.1.16 A doctor of medicine, osteopathy or psychiatry is on duty or on call at all times.
- 5.1.17 A doctor of medicine, osteopathy, psychiatry and/or and APRN is responsible for the care of each patient with respect to the medical or psychiatric problem that a present on admission or develops during the hospitalization.
- 5.1.18 Meetings of the Governing Body shall be to:
  - 5.1.18.1 Evaluate the conduct of the hospital, including the care and treatment of patients.
  - 5.1.18.2 The Governing Body shall take necessary actions sufficient to correct noted problems.
  - 5.1.18.3 A record of all governing body proceedings which reflects all business conducted, including findings, conclusions and recommendations, shall be maintained for review and analysis.
  - 5.1.18.4 Take all appropriate and necessary action to monitor and restore compliance when deficiencies in the hospital's compliance with statutory and/or regulatory requirements



Division of Public and Behavioral Health  
Clinical Services

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<b>Control #</b>	<b>Rev.</b>	<b>Title</b>	<b>Effective Date</b>
<b>Gov1.1</b>	<b>New</b>	<b>Clinical Services Hospital Governing Body Policy</b>	<b>2/16</b>
	<b>2/16</b>		<b>Review Date 2/18</b>

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are identified, including but not limited to monitoring the hospital administrator's submission and implementation of all plans of correction.

5.1.18.5 Shall be responsible for the quality of patient care services, for the conduct of the agencies and for ensuring compliance with all Federal, State, and Local law.

5.2 Medical Staff will:

5.2.1 Ensure that the medical staff is accountable to the Governing Body for the quality of care provided to the patients.

5.2.2 Ensure that under no circumstances is the accordance of medical staff membership or professional privileges dependent solely upon certification, fellowship or membership in a specialty body or society.

5.2.3 Ensure that when telemedicine services are furnished to patients through an agreement with a distance-site hospital, the agreement is written and that it specifies that it is the responsibility of the Governing Body of the distance site hospital to meet the requirements in sections (A)(1) through (A)(8) of this section with regard to the distance site hospital's physicians and practitioners that are authorized to provide telemedicine services.

5.2.3.1 The Governing Body of the hospital whose patients are receiving telemedicine services may in accordance with CFR 482.33(A)(3) grant privileges based on its medical staff recommendations that rely on information provided by the distance site hospital.

5.2.4 Ensure that when telemedicine services are provided to patients through an agreement with a distance-site telemedicine entity, the written agreement specifies that the distance-site telemedicine entity is a contractor of services.

5.2.4.1 The contractor furnishes the contracted services in a manner that permits the hospital to comply with all applicable conditions of participation for the contracted services, including but not limited to the paragraphs of this section with regard to the distance-site's medical staff.

5.2.4.2 The distant site's medical staff providing telemedicine services may be granted privileges based on said hospital's medical staff recommendations;



Division of Public and Behavioral Health  
Clinical Services

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Control #	Rev.	Title	Effective Date
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5.2.4.3 Staff recommendations may rely on information provided by the distance-site telemedicine entity.

5.3 The Chief Executive Officer is/will:

5.3.1 Assume responsibility for management of the hospital and for providing liaisons among the governing body, medical staff, nursing staff and other departments, units or services of the hospital.

5.3.2 Keep the governing body fully informed of the conduct of the hospital through regular written reports.

5.3.3 Ensure that the hospital has an overall institutional plan which includes an annual operating budget that is prepared in accordance with generally accepted accounting principles (GAAP)

5.3.3.1 The annual budget must include anticipated income and expenses.

5.3.3.2 The hospital is not required to identify item-by-item components of each anticipated income or expense.

5.4 Contracted Services – The Governing Body is responsible for services whether or not they are provided by contractors. The Governing Body ensures that contractor services comply with all applicable conditions of participation and standards.

5.4.1 The Governing Body must ensure that the services performed under a contract are provided in a safe and effective manner via the Medical Director.

**6.0 ATTACHMENTS**

**7.0 IMPLEMENTATION OF POLICY**

Each Division agency within the scope of this policy shall implement this policy and may develop specific written procedures as necessary to do so effectively.

ADMINISTRATOR



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**  
**CLINICAL SERVICES**

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<b>Control #</b>	<b>Rev.</b>	<b>Title</b>	<b>Effective Date</b>	<b>Next Review Date</b>
<b>A6.1</b>		<b>Psychological First Aid Counselor Response</b>		

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**1.0 POLICY**

The Division of Public and Behavioral Health (DPBH), Clinical Services branch is responsible for maintaining the capacity for the Psychological First Aid Counselor (PFA) response within the state of Nevada.

**2.0 PURPOSE**

This policy serves to ensure that the DPBH is prepared to assist a statewide disaster response through the deployment of Psychological First Aid Counselors in collaboration with other disaster response efforts at state and local levels and within the National Incident Command Management System (NIMS).

**3.0 SCOPE**

State and Local Official request for PFA support.

**4.0 DEFINITIONS: N/A**

**5.0 PROCEDURE**

- 5.1 The Statewide Disaster Preparedness and Response Coordinator has the responsibility for overall statewide DPBH disaster preparedness and response operations. This position is the liaison between the Division and other state agencies with roles and responsibilities in disaster situations. This position is also responsible for assuring that all disaster response program activities are compatible with the National Incident Management System (NIMS).
- 5.2 The DPBH will identify four regional Preparedness and Response Coordinators (one in the north, one in rural, and one in the south) who report to the Statewide Disaster Preparedness and Response Coordinator.
- 5.3 The DPBH Regional Preparedness and Response Coordinators will be responsible to cooperate and collaborate with the regional authority to incorporate agency level Psychological First Aid Counselor response for behavioral health needs.



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**  
**CLINICAL SERVICES**

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<b>Control #</b>	<b>Rev.</b>	<b>Title</b>	<b>Effective Date</b>	<b>Next Review Date</b>
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<b>A6.1</b>		<b>Psychological First Aid Counselor Response</b>		
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- 5.4 During a presidential or governor declared disaster, the Statewide Disaster and Response Coordinator will be responsible for reporting to the State’s Emergency Operations Center (SEOC) in Carson City when requested by the Department of Emergency Management (DEM).
  - 5.4.1 The Northern and Rural preparedness and Response Coordinators will provide back up or be deployed by the Statewide Coordinator. This includes primary responsibility to operate and direct the Emergency Support Function (ESP) 8-1.
  - 5.4.2 The Southern Regional Preparedness and Response Coordinator will serve as a backup for SEOC functions, as well as participate, if needed, in the Clark County Emergency Operations.
- 5.5 The Regional Coordinators are responsible for coordinating with Division Agency staff to identify and maintain contact information for crisis counselors through the use of NXT Communicator.
- 5.6 The Regional Coordinators will distribute and monitor Psychological First Aid Counselor “Go Bags” for use in deployment.
- 5.7 Psychological First Aid Counselors will be easily identifiable by their Division identification badge, a secondary form of government issued identification and their light blue Community Support Vest, which will be provided by the Division within the “Go Bags” response kits.
- 5.8 The specific duties and overall responsibilities of the Division are outline in the DPBH ALL Hazards Disaster Response and Preparedness Plan, and the Behavioral Health Annex.



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<b>A6.1</b>		<b>Psychological First Aid Counselor Response</b>		

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**6.0 ATTACHMENTS: N/A**

**7.0 IMPLEMENTATION OF POLICY**

Each Division agency within the scope of this policy shall implement this policy and may develop specific written protocol as necessary to do so effectively.

ADMINISTRATOR

EFFECTIVE DATE:

DATE APPROVED BY DPBH ADMINISTRATOR:

DATE APPROVED BY THE COMMISSION ON BEHAVIORAL HEALTH:



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<b>Control #</b>	<b>Rev.</b>	<b>Title</b>	<b>Effective Date: 03/2016</b>
<b>A 5.3 (4.039)</b>	<b>03/2016</b>	<b>QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT</b>	<b>Next Review Date: 03/2018</b>

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**1.0 POLICY:**

The Division of Public and Behavioral Health (DPBH) Clinical Services Branch shall maintain a statewide, comprehensive and integrated quality assurance and performance improvement (QAPI) program. Responsibility for oversight and coordination of QAPI initiatives and processes at the Division, Agency and Program levels lies with the DPBH Clinical Services QAPI Department under the leadership of the Statewide QAPI Manager. The QAPI Department is driven by the following values: (a) a non-static, dynamic concept of quality; (b) efficiency in resource allocation; (c) consumer driven and directed services; (d) staff empowerment in organizational improvement activities; (e) valuing DPBH staff and their contributions; (f) diversity and cultural competency; (g) positive reinforcement; and (h) adherence to the DPBH Strategic Plan.

**2.0 PURPOSE:**

QAPI uses data-driven, proactive approach to improving the quality of care and services in DPBH inpatient and outpatient behavioral health care facilities and services. The activities of QAPI involve members at all levels of the organization to identify opportunities for improvement, address gaps in systems or processes, develop and implement an improvement or corrective plan, and continuously monitor the effectiveness of interventions.

The mission of the DBPH Clinical Services QAPI Department is “to create an organizational focus on continuous performance improvement, patient safety and staff development in all functional areas to assist adults with mental illness improve their quality of life.”



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**  
**CLINICAL SERVICES**

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<b>Control #</b>	<b>Rev.</b>	<b>Title</b>	<b>Effective Date: 03/2016</b>
<b>A 5.3 (4.039)</b>	<b>03/2016</b>	<b>QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT</b>	<b>Next Review Date: 03/2018</b>

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The quality assurance (QA) components of QAPI focus on assisting the Division in meeting or exceeding regulatory standards as set forth by State CMS (HCQC), The Joint Commission (TJC), and the Centers for Medicare and Medicaid Services (CMS). The performance improvement (PI) components of QAPI move beyond the expectations of external regulatory entities to promote Division-wide continuous improvement in the efficiency, effectiveness and availability of resources aimed at meeting the needs of and protecting, promoting and improving the lives of consumers who seek our services.

PI is a continuous, positive, process-oriented endeavor that provides educational and technical support to leadership and staff at Division, Agency and Program levels.

**3.0 SCOPE:**

All DPBH entities within the Clinical Services branch including (1) Southern Nevada Adult Mental Health Services-SNAMHS, (2) Northern Nevada Adult Mental Health Services-NNAMHS, (3) Rural Community Health Services-RCHS, (4) Lakes Crossing Center-LCC.

**4.0 DEFINITIONS**

**Agency** – A local entity within the DPBH Clinical Services Branch providing services to a defined geographic area or a defined population. Examples would include SNAMHS, NNAMHS, RCHS, and LCC.

**Clinical Services** – A Branch within the DPBH with the primary purpose of providing statewide inpatient, outpatient and community-based public and behavioral health services to Nevadans.

**CMS** – The Centers for Medicare & Medicaid Services. CMS is part of the Federal Department of Health and Human Services (HHS) and administers Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and the Health Insurance Marketplace.



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**DPBH** – The Nevada Division of Public and Behavioral Health, part of the Nevada Department of Health and Human Services, protects, promotes and improves the physical and behavioral health of the people in Nevada.

**HCQC** – The Bureau of Health Care Quality and Compliance (HCQC) licenses medical and other health facilities, laboratories, dieticians, and music therapists in Nevada.

**LCC** – Lake's Crossing Center (LCC) is Nevada's first forensic psychiatric facility. The program provides inpatient and outpatient services statewide to individuals involved with the criminal justice system who have concurrent mental health issues.

**NNAMHS** – Northern Nevada Adult Mental Health Services. The Agency within the Clinical Services Branch of DPBH providing inpatient and outpatient services to individuals and families in northern Nevada.

**PI** – Performance Improvement. The part of QAPI that focuses on continuously analyzing performance and developing systematic efforts to improve it.

**PIP** – Performance Improvement Plan. A concentrated effort on a particular problem in one area of a facility/agency or facility/agency wide.

**Program** – A service delivery entity within a local agency focused on a specific population or specific outcomes.

**QA** – Quality Assurance. The process of meeting quality standards and assuring that care reaches an acceptable level.

**QAPI** – Quality Assurance Performance Improvement. A comprehensive approach to ensuring high quality care and services. Also, the name for the Department within the Clinical Services Branch responsible for oversight of QAPI initiatives.



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**RCHS** – Rural Community Health Services. The Agency within the Clinical services Branch offering outpatient behavioral health services to both children and adults in 13 clinics and one integrated care center in the northern rural areas of the state.

**SNAMHS** – Southern Nevada Adult Mental Health Services. The Agency within the Clinical Services Branch of DPBH providing inpatient and outpatient services for adults living in Clark County and adults, children and adolescents in four southern rural communities – Pahrump, Mesquite, Caliente and Laughlin.

**TJC** – The Joint Commission. An independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization’s commitment to meeting certain performance standards.

**5.0 PROCEDURES:**

**5.1:** QAPI team members will provide technical assistance, support and training to leadership and staff regarding QAPI processes, including the standards used by HCQC, TJC and CMS for site reviews, which may include, but is not limited to: (a) consumer surveys; (b) staff surveys; (c) administrative/fiscal review; (d) environment of care review; (e) contract service provider review; (f) clinical record review; (g) individual centered evaluation; (h) cultural competency.

**5.2:** QAPI activities are the responsibility of all staff at all levels of the Division. Coordination of these activities is the responsibility of the DPBH Clinical Services QAPI Department. Coordination and implementation of the QAPI process at the Agency level (including contract providers) is the responsibility of the Agency Director. QAPI team member(s) located at the agencies shall assist and provide technical support to Agency Directors in order to implement and coordinate the QAPI process. It is the responsibility of QAPI personnel to resist the tendency to assume full



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responsibility for QAPI activities at the Agency and/or Program level and instead provide guidance, technical assistance, consultation and oversight.

**5.3:** Division Administration and Agency Directors will participate in the analysis of QAPI reports and approval of remediation plans. QAPI Activity Reports and Program Evaluation Data Reports shall be considered QAPI reports.

**5.4:** The Division shall have a defined process for reviewing, analyzing and noting actions required of QAPI reports. This process shall include Division staff, the Agency Director, other management staff and QAPI personnel. Each Agency shall have a defined process for reviewing, analyzing and noting actions required of QAPI reports. This process shall include the Agency Director, other management staff and QAPI personnel.

**5.5:** All QAPI activities will be aligned with accreditation, certification and licensing requirements to the extent possible.

**5.6:** Each Agency shall develop and maintain a comprehensive and integrated QAPI process throughout all programs (clinical and administrative) at the Agency (including the role of contract providers). Each Department and/or Program within each Agency will submit a Performance Improvement Plan (PIP) on an annual basis. Each PIP should be: (a) multi-tiered, (b) involve staff at all levels, (d) approved by the Agency QAPI Coordinator and the Agency Director.

**5.7:** QAPI will collaborate with staff training coordinators at the Division and Agency levels to enhance competencies related to performance improvement activities.

**5.8:** QAPI may be involved with, but is not limited to, the following initiatives at the Division and Agency levels: (a) licensure, certification and accreditation of DPBH hospitals; (b) developing and implementing the DPBH Annual Medicaid State Plan; (c) DPBH Strategic Planning; (d) Reviewing Serious Incident Reports; (e) Administering the Statewide PASRR Program in collaboration with the Division of



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Health Care Financing and Policy; (f) Patient Safety; (g) Patient Satisfaction; (h) Patient Advocacy, Compliments, Complaints and Grievances; (i) Policy and Procedure Development and Management; (j) Disaster Management and Emergency Preparedness; (k) Corrective Action Plans and Measures of Success; (l) Root Cause Analyses; (m) Staff Development and Training.

**6.0 ATTACHMENTS**

**7.0 Implementation of Policy**

Each Division agency within the scope of this policy shall implement this policy and may develop specific written procedures as necessary to do so effectively.

ADMINISTRATOR

EFFECTIVE DATE:

DATE APPROVED BY DPBH ADMINISTRATOR:

DATE APPROVED BY THE COMMISSION ON BEHAVIORAL HEALTH:



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**1.0. POLICY:** It is the policy of the Division of Public and Behavioral Health to ensure that all Division policies are relevant, effective, and current.

**2.0. PURPOSE:** To establish a system for the development, review, approval and communication of Division policies

**3.0. SCOPE:** Division wide

**4.0. REFERENCE:** NRS 433.314(1) (2)

**5.0. DEFINITIONS:**

- 5.1.** Policy: DPBH Clinical Service Branch guideline or principles upon which a program or course of action is based.
- 5.2.** Agency Protocol: Individual agency guidance will become protocol and will support and add clarity at the agency level for implementation of Division policy.
- 5.3.** Procedure: Outline of established steps or specific method of completing desired outcomes or action. Discipline procedures will outline discipline specific processes. Discipline procedure will not duplicate Clinical Services Branch Policy or agency level protocol. Discipline specific procedures will cross walk across DPBH Clinical Service Branch agencies.
- 5.4.** Policy Tech: Online policy and procedure management system used by the Division of Public and Behavioral Health to store track and manage agency policy and procedure.
  - 5.4.1.** Document Owner: The department lead assigned to create, monitor, maintain, and update agency policy. The document owner has the authority to delegate and assign writers, proxy authors, reviewers and readers.
  - 5.4.2.** Writer: Assigned by the document owner to write or collaborate in writing a document.
  - 5.4.3.** Reviewer: An individual assigned by the document owner to review a document for content accuracy.



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- 5.4.4. Approver: The approver has final authority and responsibility for approving a policy for adoption by the agency.
- 5.4.5. Reader: A user assigned to read the policy. Readers have a responsibility to read policies as assigned and mark the policy as read to acknowledge that they have read and understand the contents of the policy. Policies may have short quizzes that must be completed prior to submitting “mark as read”
- 5.4.6. Reports: Policy Tech has the capacity to produce reports by reader (employee) or document. Reports by **reader** allow a supervisor or other authority to view a list of all the documents “marked as read” by an employee. Reports by document allow management to view a list of all of the readers (employees) who have responsibility to read and acknowledge by “mark as read” that they read and understand a policy or procedure.
- 5.4.7. Document Control Administrator (DCA): Individuals assigned with the responsibility to manager user accounts (set user names, passwords and assign roles), upload and manage policies and procedures and create “reader groups.”

**6.0. PROCEDURES:**

- 6.1. A new policy can be initiated by a Division agency, or by the Clinical Services Statewide Policy and Procedure Manager.
  - 6.1.1. To avoid duplication of efforts, notify the Clinical Services Statewide Policy and Procedure Manager of the intention to develop the policy, and the proposed title or subject of the policy.
  - 6.1.2. The Clinical Services Statewide Policy and Procedure Manager will forward for next agenda to the DPBH Clinical Services Policy Committee, ensure that the policy meets all regulatory and NRS requirements, and prepare it for submission to the Deputy Attorney General and the Commission on Behavioral Health for final review and approval.
  - 6.1.3. When the policy is related to direct client or clinical care, the policy will be submitted for review by the Statewide Medical Director for Adult Mental Health Services
  - 6.1.4. The Clinical Services Statewide Policy and Procedure Manager will provide the initiating agency with:



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- 6.1.4.1.** Electronic copies of the format to be used (Attachment A);
    - 6.1.4.2.** Policy Review Form (Attachment B); and
    - 6.1.4.3.** Considerations for Policy Development and Review (Attachment C).
- 6.2.** Development of the content of the policy will be enhanced by an inclusive process that provides an opportunity for review and comment from the range of staff within the agencies that are affected by the policy.
- 6.3.** The draft of the policy is submitted to the Clinical Services Statewide Policy and Procedure Manager for further review, approval, and distribution process.
  - 6.3.1.** The document is to be marked “DRAFT,” provided electronically in the specified format (Attachment A.). The policy originator’s contact information is to be included. Do not include any dates at the conclusion of the policy; the appropriate date(s) will be added by the Clinical Services Statewide Policy and Procedure Manager.
  - 6.3.2.** The Clinical Services Statewide Policy and Procedure Manager will assign a policy number and submit the policy electronically to the DPBH Policy Committee for their opportunity for review and comment. Members of the DPBH Policy Committee will share the draft policy for review with members of their constituency and will be the single voice to bring that input back to the committee.
  - 6.3.3.** Revision recommendation for the new policy must be received by the Clinical Services Statewide Policy and Procedure Manager using “track changes” by close of business the first Wednesday of each month for prior to review at next scheduled DPBH Policy Committee meeting.
  - 6.3.4.** Upon edit, review and approval of the policy, the Clinical Services Statewide Policy and Procedure Manager will submit the draft policy to the assigned Deputy Attorney General for review and input.
  - 6.3.5.** When the policy is related to clinical care it will also be submitted to the Chief Medical Officer and Statewide Psychiatric Medical Director. In the absence of a



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response from the Chief Medical Officer in seven (7) calendar days, the policy will be deemed appropriate to move forward to the Deputy Attorney General for final review.

- 6.3.6.** Upon final review by the Deputy Attorney General, the Clinical Services Branch Deputy Director will have final review.
- 6.3.7.** In the absence of revisions that affect intent or process the policy will then be prepared for submission at the next DPBH Commission on Behavioral Health for final approval.
- 6.3.8.** When there are changes that affect intent or process, the policy will be routed for re-review by the DPBH Policy Committee.
- 6.3.9.** Upon completion of all reviews, the policy will be submitted to the DPBH Commission on Behavioral Health.
- 6.3.10.** To meet open meeting law requirements, policies must be submitted to DPBH Administration no later than three weeks prior to the Commission meeting. If received after that, they will be held for the next Commission meeting.
- 6.4.** Upon approval by the Commission, the Clinical Services Statewide Policy and Procedure Manager will process the policy including ensuring that the policy is in the appropriate format, adding the approval date, and facilitating placement of the policy in Policy Tech.
  - 6.4.1.** To ensure communication about the new policy, the Clinical Services Statewide Policy and Procedure Manager will assign the policy to all appropriate reader's groups in Policy Tech.
  - 6.4.2.** It is the responsibility of each Agency Director and the DPBH Policy Committee Members to ensure that agency reader's groups are kept current.
- 6.5.** The policy identification convention is described below.
  - 6.5.1.** Policies are divided into six (6) categories:
    - 6.5.1.1.** Consumer Rights and Responsibilities (CRR)



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6.5.1.2. Services and Programs (SP)

6.5.1.3. Information Management, Records, and Technology (IMRT)

6.5.1.4. Human Resources (HR)

6.5.1.5. Administrative (A)

6.5.1.6. Fiscal (F)

6.5.2. The policies will be identified with the letter or letters of the appropriate category, a number to indicate the topic, and a number following a period to indicate the specific policy; the title of the policy will follow. Example: This policy, A –1.1 Policy Development and Review Process is labeled: Administrative (A), the topic (1) is policies, and after the period is the number (1) of the specific policy, which is followed by the title of the policy.

*Cody Phinney*

ADMINISTRATOR

**7.0. ATTACHMENTS:**

7.1. Policy Format

7.2. Policy Review Form

7.3. Considerations for Policy Development/Review



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EFFECTIVE DATE: 11/20/06

REVIEWED / REVISED DATE: 11/13/07, 08/06/10

SUPERSEDES: #4.066 Policy Development and Review Process

APPROVED BY MHDS ADMINISTRATOR: 08/06/10

APPROVED BY MHDS COMMISSION: 11/17/06, 09/17/10

APPROVED BY THE DPBH COMMISSION ON BEHAVIORAL HEALTH:



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<b>A 5.2</b>	<b>3/16</b>	<b>Review of Client Death For Adult Mental Health Agencies</b>	<b>Next Review Date:</b> <b>03/18</b>

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**1.0 POLICY:**

It is the policy of the Division to review certain cases in which people receiving services expire. Clients who expire while receiving services in hospital inpatient units will be reviewed according to Division Policy #4.054 Sentinel Events.

**2.0 PURPOSE:**

The purpose of this review is to assess the care provided and make recommendations for improvements to care systems thereby reducing risk for others receiving services. Recommendations stemming from these reviews will be used to promote quality care at all agencies.

**3.0 SCOPE:**

Performance Improvement: Review of Client Death for Adult Mental Health Agencies

**4.0 DEFINITIONS: N/A**

**5.0 PROCEDURE:**

5.1 Applicability of Root Cause Analysis Procedures:

- 5.1.1 In order to most efficiently use the resources of the State of Nevada, review activities are adjusted according to the circumstances of the death and the extent of services the person was receiving.
- 5.1.2 Any incident in which the person who died was currently receiving round the clock services from a Division Adult Mental Health agency or a suicide within 72 hours of discharge from such a setting is subject to Policy #4.054 Sentinel Events.
- 5.1.3 Outpatient clients who commit suicide or die in circumstances that are unclear will be analyzed using a root cause analysis type process.
- 5.1.4 Outpatients who die accidentally, by natural causes, from disease process or accidents unrelated to their mental illness will be reviewed by a designated staff person and referred to the more extensive root cause



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process only if deemed necessary by the Agency Director, State Medical Director, or Division Administration.

5.2 Immediate action upon receipt of notification of death:

5.2.1 Immediately, and in no event later than one (1) hour after receipt of notification of a death, the Agency Director or designee will secure and/or direct to be secured the client's complete, original clinical records to the custody of the Director of Health Information Services or applicable staff designated by the agency Director.

5.2.2 A Serious Incident Report (SIR) will be completed, per Division Policy #4.003 Reporting of Serious Incidents. The following information will be included in the SIR:

5.2.2.1 What is the reported time, date and reported/apparent cause of death?

5.2.2.2 Note if the coroner was contacted, if the information is available.

5.2.2.3 Where was the client found, if the information is available?

5.2.2.4 Who found the client, if the information is available?

5.2.2.5 Was there a history of suicide or assaultive symptoms? Give analysis of care specific to suicide or assaultive symptomatology for the last six months.

5.2.2.6 If the client missed appointments during the past six months, was appropriate follow-up done?

5.2.2.7 Give a summary of the client's contact with the Agency with special emphasis to services provided within the last six months, if the information is available.

5.2.2.8 Were any medical conditions present? If so, describe contacts with the medical provider during the last six months of care relative to the condition.

5.2.2.9 Describe interaction between Division programs and all non-Division community based programs for the past six months.



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5.2.2.10 Was grief counseling offered to the family? If not, give reasons.

5.2.3 The Agency Director, the Statewide Quality Assurance Performance Improvement Manager or the Agency Medical Director or their designees may refer the case for root cause analysis.

5.2.4 Upon notification of death, the Director of Health Information Services or appropriate staff will request a copy of the death certificate, Coroner's report, and toxicology report. Upon receipt these reports will become a part of the permanent medical record

5.2.5 The Agency Director may request that an agency debriefing team hold a debriefing meeting with the treating clinical staff team. The purpose of this meeting is to provide emotional support to staff, not to investigate the death. The coordinator of the debriefing will report to the Agency Director the time and date of the debriefing and the number of people participating.

5.2.6 Root Cause Analysis (RCA) Team – Structure:

5.2.6.1 The Root Cause Analysis Team is flexible based on the expertise required by the circumstances of each case. This also allows the agency to develop depth in the skills required to conduct such analysis.

5.2.7 Agency Medical Directors shall appoint a facilitator to the Root Cause Analysis Team. The facilitator must be someone who has received training on the root cause analysis process. The facilitator's responsibilities include but are not limited to the following:

5.2.7.1 Facilitate the root cause analysis process.

5.2.7.2 Ensure the collection of all necessary materials (i.e., medical records, police reports, policies, equipment).

5.2.7.3 Provide involved staff with information on the root cause analysis process and generally prepare team for the process.



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- 5.2.7.4 Ensure that a report on each review is sent to the Agency Director and Medical Director.
- 5.2.8 The Director of Health Information Services or appropriate staff of the Division agency, from which the client was receiving services, will serve as technical consultant in reviewing the clinical record for completion and adherence to agency standards regarding records.
- 5.2.9 The Director of Performance Improvement for each Division agency (or their designee), from which the client was receiving services, shall be a consultant to the team for specific policy, procedure, external standards and PI monitoring features.
- 5.2.10 A Pharmacist will be appointed by the Agency Director to consult with the Root Cause Analysis Team. Agencies that do not have a staff pharmacist may request assistance from an agency that does by making such a request to the Statewide Pharmacy Director.
- 5.2.11 The remainder of the committee will consist of at least three members of the staff representative of the positions involved in the treatment of the client including a physician.
- 5.3 Root Cause Analysis Team – Procedure:
- 5.3.1 All deaths on open clients ruled suicides are to be referred for Root Cause Analysis. Deaths due to other circumstances may be referred to the committee at the discretion of the the Agency Director, the Statewide Quality Assurance and Performance Improvement Manager and the Agency or Statewide Medical Director.
- 5.3.2 The team is to be convened as soon as practicable after the death but in no case later than six weeks after the death.
- 5.3.3 The review will be conducted as a root cause analysis. The purpose of the review is to establish any system improvements that will reduce risk of future similar outcomes. The review should include the following steps:
- 5.3.3.1 Event investigation;



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- 5.3.3.2 Event reconstruction and analysis;
- 5.3.3.3 Review of the chart review;
- 5.3.3.4 Recommendations stemming from chart review;
- 5.3.3.5 Identification of root causes and contributing factors;
- 5.3.3.6 Development of action plan; and
- 5.3.3.7 Report of findings.

5.4 Root Cause Analysis Team – Report:

5.4.1 The report is to be sent to the Agency Director and the Agency and Statewide Medical Director. The report must include the following:

- 5.4.1.1 Factual narrative of the event;
- 5.4.1.2 Description of the investigation and analysis process;
- 5.4.1.3 Factors contributing to the event;
- 5.4.1.4 Findings; and
- 5.4.1.5 Recommended action plan

5.4.2 The report should de-identify individuals using only coded labels (i.e. nurse1, tech2, CSW1 etc.)

5.4.3 The report is to be delivered to the Agency Director and the Statewide Medical Director no more than three (3) days after the Root Cause Analysis is completed.

5.5 Root Cause Analysis Team – Follow Up and Closure:

5.5.1 The Agency Director is responsible for ensuring the initiation and tracking of the action plan.

5.5.2 The Agency Director is responsible for submitting a follow-up SIR within one week of receiving the report to the Statewide Medical Director and the Division Administrator.

5.5.3 The Statewide Medical Director will review the report and comment within two weeks and shall forward any additional recommendations to the Agency Director, Division Administrator or designee and appropriate DAG.



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- 5.5.4 If The Statewide Medical Director makes additional recommendations, the Agency Director will respond within two weeks of the Statewide Medical Director's request.
- 5.5.5 Upon implementation of all action plans, the Agency Director may submit a request to Division Administrator for review and closure.
- 5.5.6 The Root Cause Analysis process shall not exceed 25 days, with the exception of cases involving unusual and extenuating circumstances that warrant additional time.
- 5.5.7 The Deputy Administrator will recommend closure of the incidents.
- 5.5.8 Agency Director will ensure that all action plans are completed and the results of such plans are reported to Agency and Division Leadership and the Executive Committee of the Medical Staff, when applicable.
- 5.6 All incidents of client suicides and unusual client deaths will be referred by the Division Deputy Administrator to the Commission for Mental Health for review.
- 5.7 The review, report and action provided pursuant to this policy is a performance improvement function of the Division agencies, undertaken to help assure appropriate quality services to Division clients. As such, the performance improvement privilege attached to the actions of the committee, Clinical Supervisors, Agency Directors, and Division Administrators, all documents, notes, conversations or discussions by the committee reviewed or made in the course of its exercise of its function are privileged and not subject to disclosure.
- 5.8 Each Division agency shall develop specific written procedures to implement the provision of this policy or shall incorporate this policy into the agency's policy manual.
- 5.9 Root Cause Analysis Team – Follow Up and Closure:
  - 5.9.1 The Agency Director is responsible for ensuring the initiation and tracking of the action plan.
  - 5.9.2 The Statewide Medical Director will review the report and comment within two weeks and shall forward any additional recommendations to



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the agency Director, Division Administrator or designee and appropriate DAG.

- 5.9.3 If the Statewide Medical Director makes additional recommendations, the Agency Director will respond within two weeks of the Statewide Medical Director's request.
- 5.9.4 Upon implementation of all action plans, the Agency Director may submit a request to Division Deputy Administrator for review and closure.
- 5.9.5 The Root Cause Analysis process shall not exceed 45 days, with the exception of cases involving unusual and extenuating circumstances that warrant additional time.
- 5.9.6 The Deputy Administrator will recommend/approve closure of the incidents.
- 5.9.7 The Agency Director will ensure that all action plans are completed and the results of such plans are reported to Agency and Division Leadership and the Executive Committee of the Medical Staff, when applicable.
- 5.10 All incidents of client suicides and unusual client deaths will be referred by the Division Deputy Administrator to the Commission for Mental Health and Developmental Services for review.
- 5.11 The review, report and action provided pursuant to this policy is a performance improvement function of the Division agencies, undertaken to help assure appropriate quality services to Division clients. As such, the performance improvement privilege attached to the actions of the committee, Clinical Supervisors, Agency Directors, and Division Administrators, all documents, notes, conversations or discussions by the committee reviewed or made in the course of its exercise of its function are privileged and not subject to disclosure.



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<b>A 5.2</b>	<b>3/16</b>	<b>Review of Client Death For Adult Mental Health Agencies</b>	<b>Next Review Date:</b> <b>03/18</b>

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**6.0 ATTACHMENTS:**

6.1 Root Cause Analysis Process Map

**7.0 Implementation of Policy**

Each Division agency within the scope of this policy shall implement this policy and may develop specific written procedures as necessary to do so effectively.

ADMINISTRATOR

EFFECTIVE DATE: 12/31/97

DATE REVISED: 11/27/02, 1/28/03, 7/07/03, 11/18/03, 5/28/07

DATE APPROVED BY DPBH ADMINISTRATOR:

DATE APPROVED BY THE COMMISSION ON BEHAVIORAL HEALTH:



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**1.0 POLICY**

It is policy of DPBH to provide psychotropic medication only with the consumer's consent, in an emergency, or in accordance with the procedure outlined here in order to protect the rights and safety of our consumers.

**2.0 PURPOSE**

The purpose of this policy is to protect the rights and safety of consumers' of mental health services by ensuring that all due process procedures are followed in the event that medication is provided on an involuntary basis.

**3.0 SCOPE**

This policy applies to civil inpatient settings within DPBH.

**4.0 DEFINITIONS**

- 4.1 **Consent to Treatment** – Informed consent requires that the consumer has been adequately informed as to the nature of his/her condition and the nature and purposes of the proposed treatment including its reasonable risks and benefits, alternative treatment options available and the potential consequences if treatment is refused. Informed consent is evidenced by the treating medical staff documentation in the electronic medical records and the consumer's signature on an approved medication consent form. In the event that the consumer refuses to sign documents but states that consent to treatment, two witnesses must indicate they have witnessed this statement.
- 4.2 **Emergency Treatment** – Emergency treatment allows for the administration of psychotropic medication for consumers who are refusing psychotropic medication and are acting out in a manner that poses an imminent danger to themselves or others, or who are suffering from an acute illness, disease or condition, if within a reasonable degree of medical certainty, delay in the initiation of emergency
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medical care or treatment would endanger the health of the consumer and for who a Denial of Right to Refuse Medication has been reported pursuant to NRS 433.535.4 4. The Administration of psychotropic drugs under these circumstances shall not extend beyond a period of forty-eight (48) consecutive without the consumer's consent or the meeting of the committee and administrative review as detailed in this policy.

- 4.3 **Medication Hearing Coordinator** – The Medication Hearing Coordinator is a staff member designated by the agency director to coordinate the scheduling of the review by the Medication Review Committee and any review by the medical director or designee.

## 5.0 PROCEDURE

- 5.1 Recommendation of medication and consent consultation:
- 5.1.1 The treating psychiatrist must determine that the consumer suffers from a mental illness and is gravely disabled, or poses a likelihood of serious harm to himself or others, requiring the administration psychotropic or other medication.
  - 5.1.2 The treating psychiatrist must explain to the consumer the purpose, risks and benefits of the medication to be prescribed, including possible side effects of the medication and alternative treatments, and the potential consequences if treatment is refused. The consumer then has the opportunity to provide written informed consent to treatment.
  - 5.1.3 This process shall be reflected in the consumer's medical record.
- 5.2 Determination of the need for involuntary medication:
- 5.2.1 If the consumer refuses to accept psychotropic medication, and the treating physician, in his/her professional judgment, determines that involuntary administration of medication is both appropriate and the least restrictive method of treatment, or if the physician determines to a reasonable degree of medical certainty that the consumer lacks capacity to
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understand and appreciate the nature of his/her condition and the nature of proposed treatment, the physician shall complete Form 1, "Recommendation for Administration of Medication."

- 5.2.2 A copy of the completed Form 1 shall be given to the consumer's social worker who will meet with the consumer to explain Form 1 and this policy.
- 5.2.3 The social worker will notify the consumer of the right to receive assistance from an advisor for the hearing.
- 5.2.4 In the event the consumer still indicates an unwillingness to take the medication and declines to sign consent, the social worker shall then assist him/her in filling out Form 2 "Notice to Consumer of Intention to Medicate and Request for Review."
- 5.2.5 If the consumer refuses to meet with the advisor, the social worker will assist in completing the form.
- 5.2.6 The social worker shall give the completed Form 2 to the Medication Hearing Coordinator who shall schedule the hearing, notify the advisor, and at least twenty-four (24) hours prior to the hearing, and provide the consumer with written notice of their rights related to the process.
- 5.3 Consumer Rights Related to the Hearing:
  - 5.3.1 The consumer will be notified no less than twenty-four (24) hours in advance of the hearing.
  - 5.3.2 The consumer may not be medicated during this twenty-four (24) hour period absent of an emergency.
  - 5.3.3 The consumer has a right to be informed of the diagnosis, the factual basis for the diagnosis, and why the treatment team believes medication is necessary.
  - 5.3.4 The consumer has the right to attend the hearing if they so desire.



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- 5.3.5 The consumer may cross examine any staff witnesses the committee interviews.
  - 5.3.6 The consumer has the right to assistance from an advisor. The advisor must be someone who is not involved with the consumer's case and who understands the psychiatric issues.
  - 5.3.7 The consumer has a right to a copy of the minutes of the hearing.
  - 5.3.8 The consumer may appeal the Committee's decision to the Medical Director.
  - 5.4 Advisor for the hearing:
    - 5.4.1 The advisor will be an individual who meets the following criteria:
      - 5.4.1.1 The advisor is not involved with the consumer's current episode of care;
      - 5.4.1.2 The advisor understands the psychiatric issues; and
      - 5.4.1.3 The advisor has received training (as arranged by DPBH or its agencies) on the purpose and process of the hearing and the role of the advisor.
    - 5.4.2 The advisor shall meet with the consumer in sufficient time prior to the hearing to prepare for the hearing.
    - 5.4.3 The role the advisor is to assist the consumer to communicate his/her position to the committee. The advisor shall not express his/her own opinion as to the appropriateness of the proposed treatment.
    - 5.4.4 The advisor shall complete the appropriate portion of Form 3.
    - 5.4.5 Each DPBH agency within the scope of this policy will establish a procedure for having advisors available.
  - 5.5 The Hearing Process:
    - 5.5.1 The Medication Hearing Committee is a group composed of at least three mental health professionals, one of whom must be a psychiatrist and none of whom may be currently involved in the consumer's diagnosis or
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treatment or serve as the Medical Director or designee who reviews the decision of the committee.

- 5.5.2 Factors the committee must consider:
  - 5.5.2.1 Consumer's stated objections, if any , to the medications;
  - 5.5.2.2 Any and all documents or evidence offered by the consumer's behalf
  - 5.5.2.3 Whether the consumer will harm himself or others without the medication;
  - 5.5.2.4 Whether the consumer cannot improve without the medication, or whether the consumer would improve but at a significantly slower rate;
  - 5.5.2.5 Whether there are less restrictive means that would accomplish the same or similar results;
  - 5.5.2.6 The consumer's prior experience with the proposed medications; and
  - 5.5.2.7 Other factors deemed relevant by the committee and noted in its decision.
  - 5.5.2.8 The committee may interview any persons it feels may be of assistance in conducting its review and/or receive any additional documents offered on behalf of staff or the consumer.
- 5.5.3 The decision of the committee involves the following:
  - 5.5.3.1 To approve use of the medication, the majority, which must include the psychiatrist, must find that the consumer suffers from a mental illness as defined in NRS 433A.155 and that the consumer is a danger to self or others or is gravely disabled.
  - 5.5.3.2 The vote of the committee will be noted in the consumer's chart.
  - 5.5.3.3 The committee will complete Form 3, "Committee Review and Findings." A copy of Form 3 will be given to the social worker



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who will review the form with the consumer and assist him/her in filling out Form 4, "Notice of medication Review Committee and Request for Review." In the event the consumer refuses to consent to medication and refuses to fill out Form 4, the social worker will complete the form and indicate that the consumer has refused to sign the request. The social worker will explain that the consumer has a right to appeal the decision of the committee to the Medical Director.

5.5.4 Record of Hearing will be maintained either in writing or by recording.

5.5.5 Consumer's presence at hearing:

5.5.5.1 Unless the consumer indicates verbally or through conduct that they do not intend to participate in the hearing, the proceedings will not commence until the consumer has arrived. The consumer has the right to be present for the entirety of the proceedings.

5.6 Review by Medical Director/Designee:

5.6.1 In the event that within twenty-four (24) hours of being served the committee decision of the necessity for administration of the medication, the consumer indicates on Form 3 that he/she wants a review of the committee findings, or the consumer still refuses to consent to treatment or sign Form 4, a copy of Forms 1 through 4 shall immediately be transmitted to the medical director or designee.

5.6.2 The medical director or designee, who must be a psychiatrist, has twenty-four (24) hours from the consumer's request for review to make a determination in accordance with this process.

5.6.3 The medical director or designee shall conduct a review of the process of denial of the consumer's right to decline the medication as soon as possible.



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- 5.6.4 The same factors considered by the committee shall be reviewed by the medical director or designee, in addition to:
- 5.6.4.1 Whether the proper procedures were followed by the committee;
  - 5.6.4.2 Whether the proposed medication is medically appropriate based on the consumer's diagnosis, and medical history;
  - 5.6.4.3 Whether medication is the least restrictive mean of treatment; and
  - 5.6.4.4 Any other factors deemed relevant by the medical director or designee.
  - 5.6.4.5 The medical director or designee shall review the chart and any other documents that were present to the committee during the review.
  - 5.6.4.6 If it is deemed necessary, the medical director or designee may interview any persons he/she feels may assist in conducting the review, and may conduct an independent examination of the consumer.
  - 5.6.4.7 The medical director or designee may approve the medication as prescribed, limit the dosage of the prescribed medication or disapprove the medication altogether.
  - 5.6.4.8 The medical director or designee shall enter his decision on Form 5, a copy shall be given to the social worker as well as the treating psychiatrist. The social worker shall transmit a copy of Form 5 to the consumer within one working day of receiving Form 5 from the medical director or designee.
  - 5.6.4.9 The social worker is responsible for notifying the consumer of the medical director's decision and explaining the right to request judicial review. This process is to be documented on Form 6.



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5.6.4.10 If the consumer requests judicial review, the social worker will fax the Denial of Rights (DOR) to the Attorney General's office immediately.

5.7 Administration of Medication

5.7.1 If the medical director or designee confirms that the medication is appropriate, and the consumer does not request judicial review and continues to refuse to consent to treatment, the consumer may be medicated without his/her permission. No medication will be given until the entire procedure is carried out, including the administrative review by the medical director or designee and judicial review where applicable.

5.7.2 Before administering the medication, the treating psychiatrist shall initiate a Denial of Right to Refuse Medication form to which all forms referred to in this policy shall be attached, and which will be reviewed by the Mental Health and Developmental Services commission pursuant to NRS 433.534.

5.7.3 The administration of the medication does not have to await commission review.

5.8 Continuation of Medication

5.8.1 Medication can continue for 14 days as a result of the first hearing. In the event that the consumer continues to refuse to consent to treatment, a second hearing is necessary to continue treatment beyond 14 days. The committee can re-authorize treatment based on review of the written record. The medication can only continue with either consent from the consumer, or periodic review.

5.8.2 If the consumer is medicated following this process, his/her treating physician must submit bi-weekly reports to the medical director or designee for the duration of the treatment documenting the need to



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continue the involuntary administration of medication, as long as the need to involuntarily administer the medication persists.

5.8.3 If the need to continue involuntary administration of medication persists after 30 days of the original involuntary administration of medication, this review process shall take place anew. This process will be repeated every 30 days while the consumer continues to refuse the voluntary administration of medication.

5.9 Documentation

5.9.1 All the APM 92-4R Involuntary Administration of Medication Forms (A-F) will be added to consumer's medical record.

**6.0 ATTACHMENTS: N/A**

**7.0 Implementation of Policy**

Each Division agency within the scope of this policy shall implement this policy and may develop specific written procedures as necessary to do so effectively.

ADMINISTRATOR

EFFECTIVE DATE:

DATE APPROVED BY DPBH ADMINISTRATOR:

DATE APPROVED BY THE COMMISSION ON BEHAVIORA



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**1.0 POLICY:**

It is the policy of DPBH to provide psychotropic medication only with the client's consent, in an emergency, or in accordance with a court order to protect the rights and safety of our consumers.

**2.0 PURPOSE**

The purpose of this policy is to protect the rights and safety of clients of mental health services by ensuring that all due process procedures are followed in the event that medication is provided on an involuntary basis.

**3.0 SCOPE**

This policy applies to forensic inpatient settings within DPBH.

**4.0 DEFINITIONS**

- 4.1 Forensic Client – A client who is committed by the court for evaluation and/or restoration to competency, treatment subsequent to a finding of Not Guilty by Reason of Insanity (NGRI) or commitment subsequent to a finding of Incompetent Without Probability of achieving competence and dangerous per Nevada Revised Statute (NRS) 178.461.
- 4.2 Forensic Facility – Means a secure facility of the Division of Public and Behavioral Health of the Department of Health and Human Services that provides services to individuals involved with the Criminal Justices System that are diagnosed with or may have a mental disorder
- 4.3 Consent to treatment Informed consent requires that the consumer has been adequately informed as to the nature of his/her condition and of the nature and purpose of the proposed treatment including its reasonable risks and benefits, alternative treatment options available and the potential consequences if treatment is refused. Informed consent is evidenced by the treating medical staff documentation in the electronic medical records and the consumer's signature on an approved medication consent form. In the event that the consumer refuses to



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sign documents but states they consent to treatment, two witnesses must indicate they have witnessed this statement.

- 4.4 Emergency treatment – Emergency treatment allows for the administration of psychotropic medication for forensic clients who are refusing psychotropic medication and are behaving in a manner that poses an imminent danger to themselves or others, or who are suffering from an acute illness, disease or condition, if within a reasonable degree of medical certainty, delay in the initiation of emergency medical care or treatment would endanger the health of the consumer. The administration of psychotropic drugs under these circumstances shall not extend beyond emergency situation without the client’s consent or administrative review as detailed in this policy.
- 4.5 Advisor - An advisor to patients during the DOR process may be the client’s counsel of record, a social worker not on the client’s treatment team or a peer counselor trained to provide appropriate information and services to the patient/defendant.

**5.0 PROCEDURE INVOLUNTARY MEDICATION FOR DANGEROUSNESS**

**5.1 Procedure for Emergent Medication**

- 5.1.1 Recommendations of medication and consent consultation: The treating psychiatrist must determine that the patient suffers from a mental illness and is gravely disabled, and poses a likelihood of serious harm to himself or others requiring the administration of medication.
- 5.1.2 The treating psychiatrist must explain to the consumer the purpose, risks and benefits of the medication to be prescribed, including possible side effects of the medication and alternative treatments, and the potential consequences if treatment is refused. The consumer then has the opportunity to provide written informed consent to treatment.
- 5.1.3 This process shall be reflected in the consumer’s medical record.

**5.2 Determination of the need for involuntary medication**

- 5.2.1 If the consumer refuses to accept psychotropic medication, and the treating physician, in his/her professional judgment determines that involuntary administration of medication is appropriate, the physician



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shall complete Form 1, "Recommendation for Administration of Medication."

- 5.2.2 A copy of the completed Form 1 shall be given to the social worker who will meet with the consumer to explain Form 1 and this policy.
- 5.2.3 The social worker will notify the client of the right to receive assistance from an advisor for the hearing.
- 5.2.4 In the event the client still indicates an unwillingness to take the medication and declines to sign consent, the social worker shall then assist him/her in filling out Form 2, "Notice to Consumer of Intention to Medicate and Request for Review."
- 5.2.5 If the client refuses to meet with the advisor, the social worker will assist in completing the form.

**6.0 THE HEARING PROCESS FOR DENIAL OF RIGHTS FOR DANGEROUSNESS**

- 6.1.1 The Medication Hearing Committee (committee) is a group composed of at least three mental health professionals, one of whom must be a psychiatrist and none of whom may be currently involved in the client's diagnosis or treatment or serve as the Medical Director or designee who reviews the decision of the committee.
- 6.1.2 Factors the committee must consider:
  - 6.1.2.1 Client's stated objections, if any, to the medications;
  - 6.1.2.2 Any and all documents or evidence offered by the client;
  - 6.1.2.3 Any witness testimony offered by the consumer or on the client's behalf;
  - 6.1.2.4 Whether the client will harm himself or others without the medication;
  - 6.1.2.5 Whether the client cannot improve without the medication, or whether the client would improve but at a significantly slower rate.
  - 6.1.2.6 Whether there are less restrictive means that would accomplish the same or similar results;
  - 6.1.2.7 The client's prior experience with the proposed medications; and,
  - 6.1.2.8 Other factors deemed relevant by the committee and noted in its



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decision.

- 6.1.2.9 The committee may interview any person it feels may be of assistance in conducting its review and/or receive any additional documents offered on behalf of staff or the client.
- 6.2.1 The decision of the committee involves the following:
  - 6.2.1.1 To approve use of the medication, the majority, which must include the psychiatrist, must find that the consumer suffers from a mental illness as defined in NRS 433A.155 and that the consumer is a danger to self or others, is gravely disabled.
  - 6.2.2.2 The vote of the committee will be noted in the consumer's chart.
  - 6.2.2.3 The committee will complete Form 3, "Committee Review and findings." A copy of Form 3 will be given to the social worker who will review the form with the consumer and assist him/her in filling out Form 4, "Notice of Medication Review Committee and Request for Review."
  - 6.2.2.4 In the event the client refuses to consent to medication and refuses to fill out Form 4, the social worker will complete the form and indicate that the consumer has refused to sign the request. The social worker will explain that the consumer has a right to appeal the decision of the committee to the Medical Director.
- 6.2.2 Record of Hearing
  - 6.2.2.1 A record of the hearing will be maintained either in writing or by recording.
- 6.2.3 Consumer's presence at hearing:
  - 6.2.3.1 Unless the consumer indicates verbally or through conduct that they do not intend to participate in the hearing, the proceedings will not commence until the consumer has arrived. The consumer has the right to be present for the entirety of the proceedings.



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**7.0 Review by Medical Director/Designee:**

7.1.1 In the event that within twenty-four (24) hours of being served the committee decision of the necessity for administration of the medication, the consumer indicates on Form 4 that he/she wants a review of the committee findings, or the client still refuses to consent to treatment or sign Form 4, a copy of Forms 1 through 4 shall immediately be transmitted to the medical director or designee

7.1.1.1 The medical director or designee, who must be a psychiatrist, has twenty-four (24) hours from the client's request for review to make a determination in accordance with this process. If the Medical Director review does not occur within 24 hours the reason for the inability to review shall be documented.

7.1.1.2 The medical director or designee shall conduct a review of the process of denial of the client's right to decline the medication as soon as possible but no later than twenty-four (24) hours after the request..

**7.1.2 Administration of Medication:**

7.1.2.1 If the Medical director or designee confirms that the medication is appropriate and the client continues to refuse to consent to treatment , the client may be medicated without his/her permission. (The administrative review per *Washington v. Harper* is sufficient for administration of medication subsequent to a determination of dangerousness.)

**7.1.3 Continuation of Medication**

7.1.3.1 Medication can continue for 14 days as a result of the initial administrative review and approval by the Medical Director. In the event that the client continues to refuse to consent to treatment, a second review by the Review Committee is necessary to continue treatment beyond 14 days. A second Review Committee should review after 180 days if the client is still hospitalized.

7.1.3.2 If the client is medicated following this process, his/her treating physician must submit bi-weekly reports to the medical director or designee for the duration of the treatment documenting the need to continue the involuntary administration of medication as long as the need to involuntarily administer medication for dangerousness persists.



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8.0 INVOLUNTARY MEDICATION FOR RESTORATION OF COMPETENCY TO STAND TRIAL

8.1 Medication to competency is initiated by a petition from the district attorney in the client's county of origin wherein the petition is filed in the court of criminal venue or if one is available, the specialty Competency Court in the County of origin by the district attorney for an Evidentiary Hearing for Involuntary Medication.

8.1.2. The treating psychiatrist shall assist the court, at the prosecutor's request, with the appropriate medical assessment regarding whether the client is likely to be restored with medication, the appropriate medications to accomplish the restoration, whether there will be any significant side effects that would impact the client's ability to participate in court, whether side effects would adversely impact the client in any other way and any other relevant information as delineated in the protocols outlined in the pertinent case law.

8.1.3 If the treating team perceives that the client is unlikely to be restored to competency without the benefit of medication, the treatment team leaders may notify the appropriate District Attorney and provide a report to the court stating the evaluator's conclusion in that regard.

8.1.4 Should the prosecutor determine that the client's charges are sufficient to warrant filing a petition for an Evidentiary Hearing for Involuntary Medication, the prosecutor will request the appropriate report as outlined above from the physician and ask the court to docket a hearing.

8.1.5 The treating psychiatrist shall be available via subpoena to testify at the hearing in regard to the appropriateness of the medication and treatment plan for restoring the client to competency to proceed to adjudication.

8.1.6 If the court determines that a court order for medication to restore the client to competency is appropriate, the treating physician will initiate involuntary



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medication per that order as soon as it is practicable after the order is received.

8.1.7 Orders for Involuntary Medication to Restore to Competency remain in effect until the adjudicative process for the relevant charges has been completed and the case disposition resolved. No further court hearings are necessary and the order continues to be in place when the client returns to the county of origin.

**IX. Documentation**

Form 1 Recommendation for the Administration of Medication

Form 2 Notice to Client of Intent to Medicate and Request Review

Form 3 Committee Review and Findings

Form 4 Notice of Recommendation for Medication Review Committee and Request for Review.

Form 5 Decision of Medical Director

Form 6 Decision of Medical Director (2)

**X. Implementation of Policy**

Each Division agency within the scope of this policy shall implement this policy and may develop specific written procedures as necessary to do so effectively.

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**ATTACHMENTS:**

Form 1: Recommendation for Administration of Medication

Form 2: Notice to Client of Intent to Medicate and Request for Review

Form 3: Committee Review and Findings

Form 4 Notice of Recommendation for Medication Review Committee and Request for Review.

Form 5 Decision of Medical Director

Form 6 Decision of Medical Director (2)

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**DATE APPROVED BY DPBH ADMINISTRATOR:**

**DATE APPROVED BY THE COMMISSION ON BEHAVIORAL HEALTH:**



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		Root Cause Analysis (RCA)	Next Review Date
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### 1.0 POLICY:

It is the policy of the Division of Public and Behavioral Health, Clinical Services Branch to review all sentinel events, designated near misses or at the discretion of the Medical Director, Patient Safety Officer or Statewide QAPI (Quality Assurance and Performance Improvement) Director.

### 2.0 PURPOSE:

To overview the Root Cause Analysis methodology used to analyze actual or potential adverse events using a systems approach. A root cause analysis focuses primarily on systems and processes, not individual performance. The objective of an RCA must not be to assign individual blame but to determine a process or processes and the causes or potential causes of variation that can lead to error, and identify process changes that would make variation less likely to recur. The goal of the root cause analysis is to produce an *action plan* that identifies the strategies the organization intends to implement to reduce the risk of similar events occurring in the future.

### 3.0 DEFINITIONS:

- 3.1 *Root Cause* is the most fundamental reason (or one of several fundamental reasons) a failure or situation in which performance does not meet expectation, has occurred.
- 3.2 *Cause* refers to the relationship or potential relationship between certain factors that enable an event to occur. Cause does not imply the assignment of blame.
- 3.3 *Sentinel Event* is an unexpected occurrence involving the death of a person or serious physical or psychological injury, or the risk thereof when he/she is on state property or in residential services with 24 hour awake staff. Serious injury specifically includes but is not limited to loss of limb or function. Events are considered "sentinel" because they signal a need for an immediate investigation and response.
- 3.4 *Patient Safety Officer* as used in this policy references NRS 439.815 and means a person who is designated as such by a medical facility pursuant to NRS 439.870.
- 3.5 *Root Cause Analysis* is a formal process for identifying causal factors that contribute to an event associated with adverse outcomes or near miss/close call situations.
- 3.6 *Reportable Event* is an event that occurs on state property or in residential services with 24 hour awake staff and results in:



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3.6.1		Death or unanticipated death within 48 hours of discharge.	
3.6.2		Suicide within 72 hours of discharge from an inpatient setting	
3.6.3		Loss of limb or permanent loss of function.	
3.6.4		Sexual assault.	
3.6.5		Paralysis, coma or other major permanent loss of function associated with a medication error or other treatment intervention.	
3.6.6		Consumer death or major permanent loss of function which occurs during an elopement, i.e., unauthorized departure.	
3.6.7		Any elopement of a person from a staffed around-the-clock care setting leading to death, permanent harm, or severe temporary harm to the patient.	
3.6.8		Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor or vendor while onsite at the hospital.	
3.6.9		Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care.	
3.6.10		<i>Sexual abuse/assault</i> (including rape) as a sentinel event is defined as nonconsensual sexual contact involving a patient and another patient, staff member or other perpetrator while being treated or on the premises of the hospital, including oral, vaginal, or anal penetration or fondling of a patient's sex organ(s) by another individual's hand, sex organ or object. One or more of the following must be present to determine that it is a sentinel event:	
3.6.1		Any staff-witnessed sexual contact, as described above that occurred on the premises;	
3.6.2		Admission by the perpetrator that sexual contact, as described above, occurred on the premises	
3.6.3		Sufficient clinical evidence obtained by the hospital to support allegations of nonconsensual sexual contact	
3.6.11		<i>Severe Temporary Harm</i> is critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.	



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3.6.12 *Adverse outcomes* are outcomes that are directly related to the natural course of an illness or underlying condition are exempt from the reporting requirement.

#### 4.0 PROCEDURE

- 4.1 Agency Medical Director or Designee shall appoint a Root Cause Analysis Facilitator.
  - 4.1.1 The facilitator must be a Supervising Manager and have had training in the root cause analysis process
  - 4.1.2 The facilitator will ensure collection of all necessary materials, i.e. medical records, police reports, policies, equipment
  - 4.1.3 Assign team members, to include the attending physician, social worker, mental health technician, nurse.
  - 4.1.4 Assign a member of Performance Improvement to be a consultant to the team for specific policy, procedure, external standards and PI monitoring features and the Health Information Director or appropriate designee to serve as technical consult in reviewing the clinical record for completion and adherence to agency standards regarding records.
  - 4.1.5 Assign other representatives as needed i.e. Occupational Therapy, Activity Therapy, Psychology, Dietary, Maintenance, Pharmacy and any other pertinent disciplines.
  - 4.1.6 Assign team members to conduct any necessary interviews, data collection (monitor boards, allegation packets, equipment, policies, etc.)
    - 4.1.6.1 The first meeting is to be convened within 48 hours.
    - 4.1.6.2 The facilitator will contact staff supervisors and staffing department with meeting schedules to ensure coverage on the units.
    - 4.1.6.3 The facilitator will provide involved staff with information on the root cause analysis process and prepare the team for process.
- 4.2 Use the Joint Commission RCA framework form.
  - 4.2.1 Each element of the RCA Framework Template must be addressed. “Not Applicable (NA)” may not be used.
- 4.3 The RCA must focus on identifying the systems and processes that may have led to the event.



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- 4.3.1 Gather information to find out what happened.
- 4.3.2 Analyze why the event happened.
- 4.3.3 Develop what steps you need to take to prevent it from happening again.
- 4.3.4 Prepare RCA Action Plan.
- 4.3.5 Submit to the Agency Medical Director for review and approval.
- 4.3.6 Submit to the Agency Administrator for review and approval.
- 4.3.7 Upon final approval Agency Administrator submit to QAPI for submission to
- 4.3.8 appropriate agencies (The Joint Commission and/ or Nevada Sentinel Event Registry, or OSHA).

**5.0 REFERENCES:**

- 5.1 Root Cause Analysis in Health Care: Tools and Techniques 5<sup>th</sup> Edition Joint Commission Resources
- 5.2 Sentinel Events CAMBHC Update 2, January 2016
- 5.3 Sentinel Events CAMH Update 2, January 2016
- 5.3 Root Cause Analysis Basics Candace J. Hamner, RN MA and Kurt a. Patton, MS, RPh 2008
- 5.4 DPBH policy A 5.2 Review of Client Death for Adult Mental Health Agencies
- 5.5 DPBH policy CRR 014 Risk Management and Reporting Serious Incidents
- 5.6 DPBH policy CRR 1.13 Sentinel Event

**6.0 ATTACHMENTS:**

- 6.1 Reporting Requirements Sheet Attachment A
- 6.2 Joint Commission- Root Cause Analysis Questions Guidelines Template
- 6.3 Key Witness Interview Documentation Form

**7.0 Implementation of Policy**

Each Division agency within the scope of this policy shall implement this policy and may develop specific written protocols as necessary to do so effectively.

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EFFECTIVE DATE:

DATE APPROVED BY DPBH ADMINISTRATOR:

DATE APPROVED BY THE COMMISSION ON BEHAVIORAL HEALTH:



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1.0. **Purpose:**

The purpose of this policy is to describe the Division of Public and Behavioral Health Sentinel Event review and intervention process. This process is designed to focus attention on understanding the causes that underlie unexpected occurrences involving death or serious physical or psychological injury, or the risk of same, and to make the necessary organizational changes to: 1) have positive impact in improving patient care, treatment and services and preventing unintended harm, 2) to focus attention on understanding the factors that contributed to the event, latent conditions and active failures and 3) reduce the probability of similar events occurring in the future.

2.0. **Policy:**

It is the policy of the Division of Public and Behavioral Health that all Division Mental Health Agencies will have a Sentinel Event protocol to manage, investigate and appropriately report Sentinel Events, as defined in this policy.

All Sentinel Events will be reported to the Division of Public and Behavioral Health Administrator/designee, the State Medical Director, and Statewide Quality Assurance and Performance Improvement Manager by Agency Directors or their designee as defined in NRS 439.830.

The Division of Public and Behavioral Health is committed to improving the quality of care, throughout its service system. The occurrence of a Sentinel Event identifies an opportunity for improvement. A performance improvement/peer review process will be used in each occurrence of a Sentinel Event to assess the root cause of the event and identify opportunities for improvement.

3.0. **Definitions:**

3.1. Sentinel Event is an unexpected occurrence involving the death of a person or serious physical or psychological injury, or the risk thereof when he/she is on state property or in residential services with 24 hour awake staff. Serious injury specifically includes but is not limited to loss of limb or function. Events are considered "sentinel" because the signal a need for an immediate investigation and response.



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- 3.2. Patient Safety Officer as used in this policy references NRS. 439.815 means a person who is designated as such by a medical facility pursuant to NRS 439.870.
- 3.3. Root Cause Analysis is a formal process for identifying causal factors that contribute to an event associated with adverse outcomes or near miss/close call situations.
- 3.4. Reportable event is an event that occurs on state property or in residential services with 24 hour awake staff and results in:
  - 3.4.1. Death or unanticipated death within 48 hours of discharge.
  - 3.4.2. Suicide within 72 hours of discharge from an inpatient setting
  - 3.4.3. Loss of limb or permanent loss of function.
  - 3.4.4. Sexual assault.
  - 3.4.5. Paralysis, coma or other major permanent loss of function associated with a medication error or other treatment intervention.
  - 3.4.6. Consumer death or major permanent loss of function occurs during an elopement, i.e., unauthorized departure.
  - 3.4.7. Any elopement of a person from a staffed around-the-clock care setting leading to death, permanent harm, or severe temporary harm to the patient.
  - 3.4.8. Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor or vendor while onsite at the hospital.
  - 3.4.9. Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care.
- 3.3 Sexual abuse/assault (including rape) as a sentinel event is defined as nonconsensual sexual contact involving a patient and another patient, staff member or other perpetrator while being treated or on the premises of the hospital, including oral, vaginal, or anal penetration or fondling of a patient's sex organ(s) by another individual's hand, sex organ or object. One or more of the following must be present to determine that it is a sentinel event:
  - 3.3.1 Any staff witnessed sexual contact, as described above, occurred on the Premises.
  - 3.3.2 Admission by the perpetrator that sexual contact, as described above,



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3.3.3 occurred on the premises  
Sufficient clinical evidence obtained by the hospital to support  
allegations of nonconsensual sexual contact

3.4 Severe Temporary Harm is critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.

3.5 Adverse outcomes are outcomes that are directly related to the natural course of an illness or underlying condition are exempt from the reporting requirement.

4.0. **Procedures:**

4.1. When agency staff becomes aware of a Sentinel Event, as defined in this policy, they must notify their supervisor within one (1) hour of the event.

4.2. When agency staff become aware of incidents that could have resulted in any of the outcomes described in Section 3.3 and 3.3, they must notify their supervisor within one (1) hour of the event.

4.3. The Supervisor must notify the Agency Director/designee within one (1) hour of notification of the event.

4.4. The Agency Director/designee will notify the Administrator/designee of the Division of Public and Behavioral Health, and the Statewide Medical Director, and the Quality Assurance and Performance Improvement Manager of the event within one (1) hour of notification of the event.

4.5. Agency staff must complete a serious incident report before the end of shift.

4.5.1. The report must include the immediate care rendered to the individual; contributing factors involved; the nature of any injury.

4.5.2. If equipment or a medical device was involved, the name, model number, and serial number for the device.

4.5.3. This report will be given to the Agency Performance Improvement Coordinator within one (1) business day following the event.



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- 4.5.4. The Incident Report shall be sent to Division, the Statewide Medical Director, and within one (1) working day.
- 4.6. Sentinel Events shall be investigated by a team appointed by the Agency Director. The team shall use the Division of Public and Behavioral Health Services review process or the Joint Commission Root Cause Analysis Model, depending on the accreditation of the agency. For Sentinel events meeting criteria for DPBH policy A.5.2 Performance Improvement: Review of Client Death for Mental Health Agencies; the structure, procedure and report will follow the Death Analysis /Root Cause Team analysis required process.
- 4.7. The Medical Director/designee shall appoint a Root Cause Analysis team within 24 hours which should include:
  - 4.7.1. Facilitator/lead (supervisory level staff);
  - 4.7.2. Staff who were involved with the care of the patient; and
  - 4.7.3. Staff not involved in the care of the patient to include; nursing, mental health technician, social worker, psychiatrist, and other disciplines as appropriate.
- 4.8. The Medical Director/designee shall inform the patient or surrogate decision-maker about unanticipated outcomes of care, treatment and services that relate to the Sentinel Event when the patient is not already aware of the occurrence or when further discussion is needed.
- 4.9. Agency Director/designee responsibilities within the first 24 hours of the event:
  - 4.9.1. Ensure that staff is providing follow-up care/services to ensure the best possible outcomes for injured parties and staff members.
  - 4.9.2. Ensure that all parties to the event (i.e., family members, staff members, providers, etc.) receive appropriate information.
  - 4.9.3. Keep members of the facility leadership informed.
  - 4.9.4. Follow regulatory reporting requirements, e.g., the Occupational Safety and Health Administration (OSHA) in the case of any employee death.
  - 4.9.5. Consult with the Deputy Attorney General and other resources as needed.
  - 4.9.6. Ensure that all pertinent documentation and data is collected and safely secured with the Patient Safety Officer or designee.



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- 4.9.7 Instruct the Director of Health Information Services or Clinic Director for Rural Services to secure the medical record and all other evidence.
- 4.9.8 Maintain confidentiality surrounding the event and the patient.

4.10 Sentinel Event Team Responsibilities:

- 4.10.1 Within one (1) week of the event the sentinel event team will:
  - 4.10.1.1 Meet as necessary, and interview those staff involved with and/or familiar with the event.
  - 4.10.1.2 Obtain written statements.
  - 4.10.1.3 Conduct a root cause analysis of the event that includes an analysis of all related processes and systems.
    - 4.10.1.3.1 If the failure of a piece of equipment is involved in the incident, the Sentinel Event Team, through the Agency Patient Safety Officer, will submit the appropriate reports to the Food and Drug Administration, Bureau of Health Care Quality and Compliance within 10 (ten) days of the incident. The team will preserve the equipment in its last-used state and have a qualified vendor review the equipment.
    - 4.10.1.4 The Sentinel Event report will be sent to the Agency Medical Director and Agency Director for review within three (3) working days of the committee's findings.
- 4.10.2 The Agency Director will forward the root cause analysis to the Division of Public and Behavioral Health, Statewide Medical Director.
- 4.10.3 The Agency Director will present an overview of the root cause analysis to the Agency Leadership Committee for discussion and action. The overview will include at a minimum:
  - 4.10.3.1 The Root Cause Analysis action plan that identifies strategies to reduce the risk of similar events occurring in the future. The plan must include:
    - 4.10.3.1.1 Corrective actions to eliminate or control system hazards or vulnerabilities directly related to causal and contributory factors.
    - 4.10.3.1.2 Responsibility for implementation
    - 4.10.3.1.3 Timelines for completion
    - 4.10.3.1.4 Strategies for evaluating effectiveness
    - 4.10.3.1.5 Strategies to sustain change



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- 4.10.3.2 The Agency Medical Director and/or Agency Director will approve or recommend changes to the action plan.
- 4.10.3.3 The Agency Director will assign the appropriate staff to initiate and complete each item on the action plan.
- 4.10.3.4 The Agency Quality Assurance and Performance Improvement manager will monitor completion of all areas identified for improvement and submit a final report to the Agency Director and Leadership team.
- 4.10.3.5 The Agency Director will submit evidence of the completed plan to the Administrator of the Division of Public and Behavioral Health, the State Medical Director.
- 4.10.4 The Sentinel Event report including all correspondence will be filed and secured in the Performance Improvement Office.
- 4.11 Mandatory Reporting of Sentinel Events
  - 4.11.1 Except as otherwise provided:
    - 4.11.1.1 A person who is employed by a medical facility shall, within 24 hours after becoming aware of a sentinel event that occurred at the medical facility, notify the facility Patient Safety Officer or designee of the sentinel event; and
    - 4.11.1.2 The Patient Safety Officer or designee shall, within seven (7) days after receiving notification report the date, the time and a brief description of the sentinel event to:
      - 4.11.1.2.1 The Division of Public and Behavioral Health; The representative designated pursuant to NRS 439.855, if that person is different from the Patient Safety Officer; and
      - 4.11.1.2.2 The Joint Commission (as applicable) using the Quality Monitoring Sentinel Event Organization Self Report.
      - 4.11.1.2.3 The DPBH Sentinel Event Registry (NRS 439.805)
  - 4.11.2 If the Patient Safety Officer of a medical facility personally discovers or becomes aware, in the absence of notification by another employee, of a sentinel event that occurred at the medical facility, the Patient



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Safety Officer shall, within 14 days after discovering or becoming aware of the sentinel event, report the date, time and brief description of the sentinel event to:

- 4.11.2.1 The Division of Public and Behavioral Health ; and
- 4.11.2.2 The representative designated pursuant to NRS 439.855, if that person is different from the Patient Safety Officer.
- 4.11.2.3 The DPBH Sentinel Event Registry (NRS 439.805)

- 4.11.3 The Administrator of the Division of Public and Behavioral health shall prescribe the manner in which reports of sentinel events must be made pursuant to this section.

**5.0 REFERENCES:**

- 5.1 Nevada Revised Statute (NRS 439.800-890) Mandatory Reporting of Sentinel Events.
- 5.2 The Joint Commission, CAMH Accreditation Reporting Requirements Chapter current edition
- 5.3 The Joint Commission, CAMH Sentinel Events Chapter Update 2
- 5.4 The Joint Commission, CAMBHC Sentinel Events Chapter Update 2
- 5.5 State of Nevada Division of Public and Behavioral Health Records of Retention.

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Administrator

Effective Date: 11/17/03  
Revised Date: 06/22/05; 10/31/07  
Approved by Commission on MHDS: 11/17/03