1.0 POLICY:

It shall be the policy to have uniform prevention, reporting, investigation, review and response to each episode of civil inpatient elopement.

2.0 PURPOSE:

The purpose of this policy is to reduce the incidence of elopement by providing a uniform basis for the prevention, reporting, investigation, and review of all episodes of elopement.

3.0 SCOPE:

Division wide

4.0 DEFINITIONS:

Elopement: a consumer is eloped when they leave a 24 hour facility, or custody of 24 hour staff, without authorization of Medical Staff, treatment team or agency administrator. The term elopement is used in some settings, and for purposes of this policy is considered to be synonymous with eloped.

5.0 PROCEDURE:

5.1 HOSPITALS:

5.1.1 Prevention of Elopement Episodes:

5.1.1.1 Each hospital will develop a procedure for the assessment of each consumer for elopement risk. The following must be addressed:

- 5.1.1.1.1 Initial assessment
- 5.1.1.1.2 Documentation of risk level
- 5.1.1.1.3 Communication of risk level
- 5.1.1.1.4 Frequency of reassessment
- 5.1.1.1.5 Triggers for reassessment
- 5.1.1.1.6 Prevention plans to be used depending on risk level

5.1.1.2 Each hospital will develop a procedure identifying elopement prevention training for staff. The following must be addressed:
5.1.2 Reporting of Elopement Episodes:
5.1.2.1 All division agencies will develop procedures for the reporting of elopement incidents, which will include:
   5.1.2.1.1 Reporting of elopement incidents using the SIR format and reporting time frames as given in Division Policy CRR-1.4;
   5.1.2.1.2 Notifying the local law enforcement agency immediately;
   5.1.2.1.3 Notifying legal guardians and family of record; and
   5.1.2.1.4 Notifying any person in the community toward whom the consumer had been known to make a threat verbal or otherwise.

5.1.3 Investigation of elopement Episodes:
5.1.3.1 All staff immediately involved in the elopement incident will provide statements regarding the elopement prior to the end of their work shift.
5.1.3.2 Environmental risk assessment will be completed immediately and in no case more than one (1) day following an elopement episode.
5.1.3.3 All staff involved in an elopement episode will undergo debriefing within one (1) working day which will be documented.

5.1.4 Reporting of Elopement Episodes:
5.1.4.1 All elopement will be reported to Division using an SIR and reporting time frames as given in Division Policy CRR-1.4 within (1) one business day of discovery.
5.1.4.2 Elopements will be reported to law enforcement as missing persons.
5.1.4.3 Elopments resulting in death or severe harm will be reported to the Sentinel Event Registry

6.0 REFERENCES:
6.1 Division Policy #4.003 Reporting of Serious Incidents
6.2 Division Policy #4.048 DPBH Investigations Manual
6.3 CRR 1.13 Sentinel Event Policy

7.0 ATTACHMENTS:
N/A
8.0 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:
SUPERSEDES: NEW
DATE APPROVED BY DPBH ADMINISTRATOR:
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH:
1.0 POLICY:

It is the policy of the Division of Public and Behavioral Health (DPBH) that all patients/clients be treated and managed in the least restrictive manner consistent with their clinical status and needs and that seclusion or restraint be used only in an emergency situation to insure safety of the patient/client and others and when less restrictive interventions have been determined to be ineffective to protect the patient/client or others from harm.

The decision to use seclusion or restraint is not driven by diagnosis. It is driven by a client assessment that indicates that a less intrusive measure poses a greater risk of harm to self or others than the risk of using a seclusion or restraint.

The patient/client has the right to be free from seclusion or restraints of any form that are imposed as a means of coercion, discipline, convenience, or retaliation by staff.

Seclusion or restraint events shall be terminated when the behaviors that necessitated the seclusion or restraint order are no longer in evidence and documented.

2.0 PURPOSE:

The goal of DPBH is to eliminate the need for people we serve to be secluded or restrained. This policy is designed to maximize the safety of people served and staff and to ensure the rights of people are protected. This policy is designed to maximize the safety of people served and staff and to ensure the rights of people are protected.

3.0 SCOPE:

Division of Public and Behavioral Health agencies.

4.0 DEFINITIONS:

4.1 Restraint: means the direct application of physical force to a patient, with or without the patient’s/client’s consent to restrict his/her freedom of movement.

4.1.1 Physical restraint: Pursuant to NRS 433.5476 and NRS 449.774, physical restraint means the use of physical contact to limit a person’s movement or hold a person immobile. (A physical restraint implies resistance from the client, whereas physical guidance/contact may be used to stabilize, support or guide a client while ambulating, transferring, etc.)

4.1.2 Mechanical restraint: Pursuant to NRS 433.547 and NRS 449.772, mechanical restraint means the use of devices to limit a person’s movement or hold a person
imobile. This means the use of devices, including, without limitation, mittens,
straps and restraint chairs to limit a person’s movement or hold a person immobile.
All devices utilized as mechanical restraints must be ordered and re-ordered by a
physician in accordance with regulation.
Note: Mechanical restraint may include the use of the Spithood.

4.1.3 Chemical restraint: Pursuant to NRS 433.5456 and NRS 449.767, 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 an ongoing basis as prescribed by
medical staff to treat the symptoms of mental, physical, emotional or behavioral
disorders or for assisting a person in gaining self-control over his or her impulses.

4.1.3.1 The term does not include the administration of drugs on an ongoing basis
as prescribed by medical staff to treat the symptoms of mental, physical, emotional or behavioral
disorders or for assisting a person in gaining self-control over his or her impulses. CMS CoP 42 CFR 482.13 defines
chemical restraint as a drug or medication when it is used as a restriction
to manage the patient/client’s behavior or restrict the patient/client’s freedom of movement, and is not a standard treatment or dosage for the
patient/client’s condition. Drugs that are used as part of a patient/client’s
standard medical or psychiatric treatment, and are administered within the
standard dosage for the patient/client’s condition is not considered a
chemical restraint.

When a patient/client is given medication without previously signing written
medication consent, a Denial of Rights for Written Consent to Medical
Treatment will be initiated.

4.1.3.2 Chemical Restraint (The Joint Commission), a drug or medication when it is
used as a restriction to manage the patient/client’s behavior or restrict the
patient/client’s freedom of movement and is not a standard treatment or dosage for the
patient/client’s condition.

4.1.3.3 NRS 433.5503 states that a chemical restraint may be utilized on a person
with a disability who is an client.

4.1.3.4 The client has been diagnosed as mentally ill, as defined in NRS 433.515, and is receiving
mental health services from a facility;

4.1.3.4.1 The chemical restraint is administered to the client while he or she is under the care of the
facility;

4.1.3.4.2 An emergency exists that necessitates the use of chemical restraint;

4.1.3.4.3 A medical order authorizing the use of chemical restraint is obtained from the client’s attending
physician or psychiatrist;

4.1.3.4.4 The physician or psychiatrist who signed the order required pursuant to paragraph (d) immediately
above examines the client not later than one (1) working day immediately after the administration of the
chemical restraint end.
4.4.4.2 The chemical restraint is administered by a person licensed to
4.4.4.3 administer medication.

4.1.4 For purposes of this policy, a medication will be considered a chemical restraint when:

4.1.4.1 The medication is not part of a treatment plan and has not been consented to as evidenced by previously signed written medication consent or otherwise previously expressed consent and documented in the patient's medical records; or

4.1.4.2 In emergency situation, the medication is used as a restriction to manage the patient/client's behavior or restrict the patient/client freedom of movement and is not a standard treatment or dosage for the patient/client's condition.

4.1.4.3 When a client served is given medication without consent, a Denial of Rights (DOR) for Written Consent to Medical Treatment will be initiated.

4.1.5 At DPBH, chemical restraints are only given during emergency situation when the patient/client's behavior poses a danger to him/herself or others and where other interventions were unsuccessful in maintaining the patient/client's safety.

4.1.5.1 All uses of drugs as a restraint can only be implemented following a written order. An order for the use of medication as a restraint must specify that the medication is to be used as a restraint. The prescribing practitioner must identify the duration of time for which the patient must be monitored once the medication has been given.

4.1.5.2 Monitoring and observation must include post medication administration assessment by a registered nurse and shall include the same monitoring requirements as mechanical or mutual restraint.

DPBH does not use chemical restraint.

4.2 Seclusion: Seclusion is the involuntary confinement of a client in a locked room (or unlocked with employee used to prevent exit) or a specific area from which the client is physically prevented from leaving. Seclusion does not include confinement on a locked unit or ward, where the client is with others. Seclusion is not just confining a client to an area, but separating him or her from others. Seclusion may only be used for the management of violent behaviors towards others.

4.2.1 Emergency: Pursuant to NRS 433.5466 and NRS 449.770, emergency means a situation in which immediate intervention is necessary to protect the physical safety of a client served or others from an immediate threat of physical injury or to protect against an immediate threat of severe property damage. It may be a situation in which a client's behavior is violent or aggressive.

4.2.2 Time Out: Time out means allowing a client to voluntarily be alone in an unlocked room for quiet time and to promote a calming effect so they may return to the therapeutic milieu. Time out is not seclusion. Clients may not be forced or coerced to go to voluntary time out. Clients in time out have the choice to leave the room or area. Staff shall not use physical force or verbal or physical intimidation to persuade a client to go to or remain in a time out area.

4.2.3 Physical Guidance/Contact: Utilizing physical touch and prompting to assist in
CRR 1.6 Seclusion and Restraint

completing a task or response if there is no, or minimal, resistance (appropriately labeled physical guidance, not restraint, and therefore not requiring the completion of paperwork related to restraint use.)

4.2.4 Mechanical Supports: Mechanical devices utilized for the purpose of protecting a person from injury because of lack of coordination or frequent loss of consciousness, and/or for the purpose of body alignment/positioning as noted in a plan of treatment (appropriately labeled mechanical support, not restraint, and therefore not requiring the completion of paperwork related to restraint use.)

4.2.5 Mental Health Technician (MHT): Mental Health Technician means an individual employed by the Division of Public and Behavioral Health who, for compensation, carries out procedures and techniques as outlined in NRS.

4.2.6 Forensic Client: Client who is committed by a criminal court.

4.2.7 Forensic Specialist: Certain employees of Division of Public and Behavioral Health of Department of Health and Human Services. Forensic technicians and correctional officers employed by the Division of Public and Behavioral Health of the Department of Health and Human Services at facilities for offenders with mental disorders have the powers of peace officers when performing duties prescribed by the Administrator of the Division. NRS.289.240.

4.2.8 Safety search: a search performed to ensure the personal safety of the client or other patients that requires a physical contact; a hands on safety examination of the patient’s clothed body.

4.3 Philosophy of Care:

4.3.1 The Division of Public and Behavioral Health recognizes that seclusion and restraint are safety interventions of last resort and are not therapeutic treatment interventions. Seclusion and/or restraint will never be used for the purpose of discipline, coercion, active treatment, staff convenience, or as a replacement for adequate levels of staff.

4.3.2 The use of seclusion and/or restraint creates significant risk for people with psychiatric disorders. These risks include physical injury, including death, the re-traumatization of people who have a history of trauma, loss of dignity, and other psychological harm. In light of these potentially serious consequences, seclusion or restraint will be used only when there exists an imminent risk of danger to the client or others and no other safe and effective intervention is possible.

4.3.3 When seclusion and/or restraints are applied, they must be implemented with the necessary safety precautions and following procedures as identified by the particular setting.

4.3.4 The goal of each setting is a violence free milieu that eliminates the need for seclusion or restraint. This goal can best be achieved by establishing and adhering to values that promote a culture of caring, recovery and inclusion.

4.3.5 The following approaches shall be implemented to reduce the need for seclusion and/or restraint:

4.3.6 Early identification and assessment of clients who may be at risk of receiving these interventions. Once assessed, staff will discuss with each client and their treatment team strategies to reduce agitation or aggression that might lead to the use of seclusion or restraint. This discussion will include identifying the treatment or preventative interventions that would be most helpful and least traumatic for the client.

4.3.7 Use of the treatment plan and its components as a specific intervention tool. Treatment plans shall address client strengths, gender issues, history of trauma, age, and culture
CRR 1.6 Seclusion and Restraint

issues as well as staff and the client’s identified alternatives to use in times of conflict, symptom escalation, and behavioral escalation.

4.3.8 Trained and competent staff that effectively employ treatment plans and/or including individualized alternative strategies to prevent and defuse escalating situations.

4.3.9 Agency policies and procedures that clearly state that seclusion and/or restraint will be used only as emergency safety measures in situations of imminent danger to staff, the client served or others.

4.3.10 Continuous performance improvement monitoring activities throughout the organization.

4.4 Staff Training:

4.4.1 Restraint/Seclusion Training for Mental Health/Forensic inpatient/ICF direct support personnel and designated clinical staff shall complete Division approved Crisis intervention training, to gain competency in seclusion and restraint techniques.

4.4.2 Individual direct support staff, to include MHT, Forensic Technicians, and other Division staff as designated by each agency must complete an agency approved crisis intervention training within agency established timeframes, which emphasize prevention strategies.

4.4.3 Training shall include:

4.4.3.1 Division and Agency philosophy regarding restraint/seclusion;
4.4.3.2 Prevention strategies that will focus on assisting clients to maintain control and learn safer ways to deal with difficult feelings;
4.4.3.3 Emphasis on client safety during restraint/seclusion; and
4.4.3.4 Development of skills and abilities to assess risk and trauma.

4.4.4 Per NRS 433.5499, the mechanical restraint is applied by a member of the staff of the facility who is trained and qualified to apply mechanical restraint. Employees may not participate in physical or mechanical restraints of clients served without approved agency training.

4.4.5 Retraining, recertification, and demonstration of competency must occur within timeframes established in Policy HR-2.5 CPART.

4.4.6 Staff who implement restraint must have current certification in a Division approved program which emphasizes prevention strategies.

4.4.6.3 Training shall include:

4.4.6.3.1 Best practices and philosophy of the use of seclusion and restraint;
4.4.6.3.2 Prevention strategies that focus on assisting clients to maintain
4.4.6.3.3 Emphasis on safety during restraint/seclusion;
4.4.6.3.4 Development of skills and abilities to assess risk and trauma; and
4.4.6.3.5 Training in the specific restraint(s) and de-escalation techniques.

4.5 Continuous Improvement Monitoring:

4.5.1 The Agency Director and leadership staff of each agency shall maintain a performance improvement program designed to continuously review, monitor and analyze the use of restraint and/or seclusion working toward the goal of eliminating the need for these interventions.

4.5.2 For inpatient/forensic facilities, the Agency Director and Medical Director are responsible for ensuring that ongoing monitoring is maintained for clients placed in seclusion or restraints, and documented accordingly.
5.0 RESTRATN/SECLUSION FOR NON – FORENSIC PSYCHIATRIC HOSPITALS.

5.1 Standards for Seclusion and Restraint: In the event that the use of seclusion or restraint becomes necessary, the following standards will apply to each episode:

5.1.1 The dignity, privacy, and safety of clients will be preserved;

5.1.2 Seclusion or restraint will be initiated only in identified emergency situations;

5.1.3 Physicians who order these interventions shall be specially trained and qualified to assess and monitor the client’s safety and the significant medical and behavioral risk inherent in the interventions;

5.1.4 Only competent, trained staff that have been credentialed or certified to perform these interventions will participate in implementation;

5.1.5 The least restrictive restraint and/or seclusion method that is safe and effective will be administered;

5.1.6 Clients placed in seclusion or restraint will be appropriately communicated with verbally and monitored at a minimum of required intervals;

5.1.7 All seclusion or restraint orders will be limited to a specific period of time; however, interventions will be ended as soon as it becomes safe to do so, even if the time-limited order has not expired; and

5.1.8 Clients who have been secluded or restrained, staff that have participated in these interventions, and appropriate other persons will participate in debriefings in order to review the episode and to plan for earlier, alternative interventions.

5.1.9 Notification: Upon admission, the service recipient and, with the service recipient’s consent, their family/legal guardian shall be informed of the policies and procedures regarding the use of seclusion and restraint. With the service recipient’s consent, as documented in the medical record, designated family members/legal guardians shall be informed of their opportunity to be notified of each occurrence of seclusion or restraint within the timeframe agreed to by the family and to participate in the client’s debriefing as appropriate. If there is no family member/legal guardian available, upon consent of the service recipient, the office of Nevada Disability Advocacy & Law Center (NIDALC) may be used.

5.2 Safety Procedures: Each agency shall have safety procedures for initiating and providing care for service recipients in seclusion and/or restraint. The safety procedures shall include, at a minimum:

5.2.1 Removal of all potentially dangerous items from the client, the room, and staff prior to placement in seclusion and/or restraint.

5.2.2 Sufficient staff necessary to accomplish seclusion and/or restraint procedure in the safest manner possible.

5.2.3 Positioning of a client that avoids placing physical or mechanical restraint or excessive pressure on the chest or back of the client or inhibits or impedes the client’s ability to breathe. In general, the client’s face will always be maintained in view of staff to assure immediate identification of physical distress such as pain or breathing difficulties.

5.2.4 Restraint of clients in a manner to minimize potential medical complications.

5.2.5 Staff plans to mitigate the potential negative impact of seclusion/restraints likely to occur in service recipient with a personal history of trauma.

5.2.6 Service recipient shall be continually monitored by staff, face to face. Such monitoring will be documented no less than every 15 minutes.

5.2.7 The client in seclusion and/or restraint will have vital signs taken and documented at a minimum of every 30 minutes for the first hour and then hourly.

5.2.8 Any concerns will be referred to the physician by the registered nurse.
5.2.9 Staff will offer fluids, toileting and comfort measures every fifteen (15) minutes. Meals and snacks will be offered at regular times. Staff will assist the client with hand washing after toileting and before meals. Any exception to the above procedures must be clinically justified and noted in the medical record.

5.2.10 Range of motion and movement of limbs will be provided for at least ten (10) minutes at least every two (2) hours. Relief from mechanical restraint will occur as long as it is deemed to be safe. If client has not regained sufficient control to be considered safe, this must be documented in the progress note. During relief periods, the staff shall insure proper positioning of the client and provide movement of limbs as necessary.

5.2.11 The seclusion and/or restraint will be terminated when the behaviors that necessitated the seclusion and/or restraint order are no longer in evidence and the behavioral release criteria are attained.

5.2.12 If the client is falling asleep or falls asleep, an immediate assessment of the client and the release criteria will be made. Clients who are sleeping in seclusion and/or restraint must be evaluated and removed from seclusion and/or restraint if they meet release criteria. A sleeping client continues to require face to face monitoring while in seclusion or restraint.

5.2.13 In any emergency requiring unit evacuation (including drills), the client shall be removed from seclusion and/or restraint, and staff will stay with the client on a minimum of 1:1 basis.

5.2.14 Precautions shall be taken to assure the protection of the client in restraints from being mistreated or harmed by other persons.

5.3 Nursing Functions: Each agency shall have appropriate Nursing staff procedures for initiating and/or providing care for clients in seclusion and/or restraint.

5.3.1 A registered nurse must be notified immediately if a client exhibits threatening or harmful behavior. The emergency use of seclusion and/or restraints requires an RN assessment.

5.3.2 The RN assessment will include alternatives used prior to the use of seclusion and/or restraint. These may include, but are not limited to:

5.3.2.1 Client’s verbalization of feelings;
5.3.2.2 Verbal reassurance/redirection given to client;
5.3.2.3 1:1 interaction for the client with staff;
5.3.2.4 Reduction in stimuli;
5.3.2.5 Environmental changes for the client;
5.3.2.6 Limit setting;
5.3.2.7 Time Out offered to the client;
5.3.2.8 Medication offered to the client;
5.3.2.9 Antecedent behaviors or events which triggered the escalation;
5.3.2.10 Determining the point of conflict and deciding why the person cannot “win” or get his/her way.

5.4 Upon determination by a registered nurse that seclusion or restraint is necessary, a physician order is obtained. The RN notifies the physician of the client’s behavior, and the RN’s assessment of same.

5.4.1 Order to seclude and/or restrain:

5.4.1.1 Orders will be written on the Seclusion and Restraint Order. Form more than fifteen (15) minutes after employment of these measures. Verbal orders to a staff Registered Nurse are acceptable. The RN shall record the details on the Seclusion
and Restraint Order Form and place the form in sequence in the order section of the client’s medical record.

5.4.1.2 No application of seclusion or restraint shall occur without a Department of Public and Behavioral Health physician’s order, stating the reason for use.

5.4.1.3 The order will include the method of seclusion and/or restraint to be utilized and the clinical reason for seclusion and/or restraint (e.g., danger to self or others).

5.4.1.4 Neither restraint nor seclusion orders shall be written as PRN orders.

5.4.1.5 The original order shall be for a maximum of four (4) hours.

5.4.1.6 The original order may be extended for four (4) hours. However, the client may not be in restraints longer than eight (8) hours.

5.4.1.7 If continued seclusion or restraint is needed, the RN must contact the physician and review the reassessment prior to the extension of the original order.

5.4.1.8 If restraints or seclusion are discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating seclusion or reapplying the restraints.

5.4.1.9 The Nursing Supervisor, or charge nurse on duty, must be notified immediately of all applications and removals of restraints and/or seclusions. The Nursing Supervisor must come to that unit to assist/observe and provide senior clinical assistance (such as during a cardiac arrest).

5.4.1.10 The RN must document the clinical rationale for the use of seclusion and/or restraint. This documentation shall include, but not be limited to:

5.4.1.10.1 An assessment of the client’s behavior including any relevant behavioral history. History of violent assaultive behavior is a significant consideration and therefore shall be included in the assessment, with examples.

5.4.1.10.2 Clinical justification necessitating the use of seclusion and/or restraint. The justification shall clearly specify the nature of the CURRENT dangerous behavior. (The use of seclusion and/or restraint may not be based solely on past history, criminal behavior, convictions, or commitment status.)

5.4.1.10.3 The treatment techniques attempted prior to using seclusion and/or restraint (e.g., administration of medication, counseling, quiet time).

5.4.1.10.4 Criteria for termination of seclusion and/or restraint shall be explained to the client. This shall include the behavior that will determine their readiness for release from seclusion and/or restraint.

5.4.1.10.5 A description of interventions implemented to assist the client in meeting the release criteria.

5.4.1.10.6 A summary of the client’s current physical assessment, including vital signs.
CRR 1.6 Seclusion and Restraint

5.4.1.11 Continuation of seclusion/restraint is determined by need:

5.4.1.11.1 The client must be continuously assessed monitored and re-evaluated as to the need for seclusion and/or restraint. This review and assessment will occur and be documented within one (1) hour following the initiation of seclusion and/or restraint and follow every two (2) hours, as well as any time there is a change in the client’s physical status and at shift change by the RN coming on duty. Each agency policy and procedures shall include the necessary factors to assess.

5.5 Release conditions for seclusion or restraint: Release criteria includes that the person must be able to demonstrate calm behavior(s) and/or be able to state that they are calm. Other actions as documented by the physician and nursing staff are considered interventions to assist the client in accomplishing the emergency behavioral plan.

5.6 Client in seclusion or restraint at shift change: If a client remains in seclusion or restraint when a nursing shift ends, the RN going off duty and the RN coming on duty must assess the client together. This will be documented in a progress note.

5.7 Progress notes and observation report entries: All progress notes and observation report entries on each client shall be in chronological order in the medical record.

5.8 Physician Functions: Each agency shall have appropriate Medical Staff procedures for initiating and/or providing care for clients in seclusion and/or restraint, including the Physician’s assessment of the client, the clinical reason for seclusion and/or restraint order and documentation of all criteria involved.

5.9 Client and Staff Debriefing:

5.9.1 An initial staff debriefing shall occur immediately after the seclusion or restraint and prior to any shift change. This shall be done by a licensed mental health professional and, where applicable, Individual Assistance staff. The purpose of this debriefing will be to elicit feedback information from the client about the intervention. Findings from the staff debriefing and proposed administrative changes or strategies to prevent reoccurrence shall also be documented in the electronic medical record on the seclusion and restraint tab. This information shall be available to the treatment team prior to its next meeting with the client.

5.9.2 If the client refuses to participate in the debriefing, a licensed mental health professional shall meet separately with the client following release from seclusion or restraint to review the reason or purpose of the restraint. This must be done prior to any shift change, and no later than eight (8) hours post restraint/seclusion.

5.10 Immediate notification and submission of incident report required to the on-call executive for the following:
CRR 1.6 Seclusion and Restraint

5.10.1 For incidents of seclusion or restraint that exceed twelve (12) hours, or an
client that experiences more than two separate episodes of restraint and/or
seclusion within a 24 hour period, Agency Administration and clinical
leadership shall be notified within 1 hour. For episodes in excess of twelve
(12) hours, daily administrative review and clinical rationale to continue
seclusion and/or restraint shall be provided by a non-treating psychiatrist
or designee of the Medical Director.

5.10.2 Within 48 hours, a formal interdisciplinary Treatment Plan Review will be
held for all clients placed in seclusion or restraints. This shall be
documented in the medical record.

5.10.3 The Agency Director or designee will review all seclusion orders, restraint
orders, and documentation.

5.10.4 The Agency Director/designee will forward copies of the orders to the
DPBH Administrator for review. Seclusion or restraint events that exceed
12 hours, or more than two separate episodes of restraint and/or seclusion
within a 24 hour period will be forwarded by close of business on the next
working day. Originals of all documents are maintained in the medical
record.

5.10.5 Leadership staff of each state psychiatric hospital will include the review of
seclusion and/or restraint data in the facility performance improvement
program.

5.10.6 The data will be systematically aggregated and analyzed on an ongoing
basis by Leadership staff at each agency.

5.10.7 Ongoing efforts to reduce the utilization of seclusion and restraint shall be
employed by each agency.

5.10.8 The agency director of each state psychiatric hospital is responsible for
assuring that ongoing documentation and monitoring is maintained of
clients placed in seclusion and/or restraint.

5.10.9 The DPBH Administrator or designee will review and report seclusion and
restraint orders to the Commission on Behavioral Health.

5.10.10 The Commission on Behavioral Health will forward the seclusion and
restraint orders to the Nevada Division of Public and Behavioral Health.

5.11 Death report required: The agency director will report to the DPBH Administrator,
the Center or Medicare/ Medicaid Services (CMS), and the State of Nevada, Division
of Health Bureau of Health Care Quality and Compliance any death that occurs while
an client is restrained or in seclusion, or a death that occurs within one (1) week of a
seclusion or restraint in which it is reasonable to assume that an client’s death is a
result of restraint and/or seclusion.

5.11.1 Reasonable to assume” in this context includes, but is not limited to, death
related to restrictions of movement for prolonged periods of time, or death
related to chest compression, restriction of breathing, or asphyxiation. {42
CFR §482.13(g)}

5.11.2 Staff must document in the client’s medical record the date and time that
the death was reported to CMS. {42 CFR §482.13(g)}

5.12 RESTRAINT/SECLUSION PROCEDURES FOR FORENSIC PSYCHIATRIC HOSPITALS:
Restraints will be utilized under the same guidelines as non-forensic hospitals except for the
utilization of safety searches when clinical indicated.
CRR 1.6 Seclusion and Restraint

5.12.1 Prevention of restraint/seclusion: Agency policy and procedures shall delineate prevention steps to be used prior to initiation of seclusion and/or restraint.

5.12.2 De-Escalation: The first attempts to avoid seclusion/restraint will focus on de-escalating the client.

5.12.3 Timeout: Timeout is a voluntary intervention to assist in regaining control of their behavior by reducing environmental stimuli and allowing the client private time to re-think his behavior. Clients participate in timeout voluntarily; force or intimidation will not be used to initiate timeout.

5.12.4 Seclusion: Seclusion will be implemented by the nurse with a doctor’s order as a measure of last resort to protect the safety of clients being served, those providing services and the facility. When the nurse, in consultation with the Forensic Specialist Shift Supervisor or his designee, determines the client has gained a sufficient degree of control the client will be released from seclusion with a contract of expected behavior.

5.13 Physical/Mechanical Restraints:

5.13.1 In an emergency situation, a client may be briefly physically restrained to protect them and others until such a time as the nurse arrives to assess the clinical necessity and appropriateness of further intervention. Administration of restraints will be carried out according to agency policy and procedures.

5.13.2 The use of force in the application of restraints shall not exceed the force that is reasonable and necessary to contain the behavior of the client.

5.14 Procedures to be followed during implementation:

5.14.1 The dignity, privacy, and safety of clients will be preserved;

5.14.2 Seclusion or restraint will be initiated only in identified emergency situations; physicians who order these interventions shall be specially trained and qualified to assess and monitor the client's safety and the significant medical and behavioral risks inherent in the interventions; privileged psychiatrist must meet this criteria.

5.14.3 Only competent, trained staff that have been credentialed or certified to perform these interventions will participate in implementation.

5.14.4 The least restrictive restraint and/or seclusion method that is safe and effective will be administered;

5.14.4.1 Clients placed in seclusion or restraint will be appropriately communicated with verbally and monitored at a minimum of required intervals;

5.14.2.2 All seclusion or restraint orders will be limited to a specific period of time; however, interventions will be ended as soon as it becomes safe to do so, even if the time-limited order has not expired.

5.15 Documentation: Forensic staff, Nursing, and Physicians shall document seclusion and/or restraint according to agency policy and procedures. Administrative documentation will be accomplished according to policy and procedures by the Agency Director, the Treatment Team Leader, the Clinical Coordinator, and the Medical Director.

5.16 Debriefing/Notifications:
Notification: Forensic hospitals will assist the client to notify family members or their attorney if clinical indicated and justification of the decision will be noted in the electronic medical record.

5.16.1 Debriefing serves the purpose of allowing staff and clients to plan to avoid future events and trauma.
CRR 1.6 Seclusion and Restraint

5.16.2 Debriefing will occur as soon as appropriate and possible, but no longer than one business day following the incident.
5.16.3 If the client declines to participate in the debriefing, this will be documented in the medical record.
5.16.4 Debriefing with the treatment team leader, or designee, will occur no more than one business day following the event.
5.16.5 DPBH forensic hospitals shall develop and implement procedures to implement the provisions of this policy and to meet the requirements of state law with respect to seclusion and restraint of clients.

6.0 PROCEDURE:

6.1 Restraint:

6.1.1 If restraint is used:

6.1.1.1 Restraint shall be implemented in a manner designed to protect the client’s safety, dignity and emotional well-being.
6.1.1.2 Restraint procedures must provide only the minimum amount of restriction necessary as a protective measure and shall only be applied until the client no longer poses a danger to self or others.
6.1.1.3 As determined by the client’s treatment team, post-procedure debriefing and discussion shall occur that focuses on how future situations may be prevented or de-escalated by employing alternative preventive problem-solving measures.

6.1.2 Usage, Tracking and Reporting:

6.1.2.1 Physical and Mechanical Restraints may be used, per NRS 433.5486-433.5499 (inclusive), for the following reasons:
6.1.2.2 As a last resort, for protection of the person or others in an emergency;
6.1.2.3 The least restrictive restraint, such as a physical escort or basket-hold, shall be used prior to consideration of implementation of a more restrictive restraint procedure.
6.1.2.4 The restraint shall be employed for only the period of time necessary for the person to become calm
6.1.2.5 Physical restraint may also be used to escort or carry a person to safety
6.1.2.6 Mechanical restraint may also be used to enable treatment of the medical needs of a person

6.1.3 Physical guidance may be used to assist in completing a task or response where there is no or minimal resistance. The use of physical guidance is not considered a restraint procedure and does not require the completion of Denial of Rights paperwork.
6.1.3.1 Mechanical supports used for the following purposes are not considered restraint:
   and do not require the completion of Denial of Rights paperwork:
6.1.3.2 Protect a person from injury because of lack of coordination or frequent loss of consciousness, and
6.1.3.3 For the purpose of body alignment/positioning as noted in a plan of treatment.
CRR 1.6 Seclusion and Restraint

6.1.3.4 Safety searches are to be used to prevent harm to the patient or others with implied consent by nonresistance.

6.2 Post-Restraint functions:

6.2.1 Staff shall complete an assessment once a person is released from all restraints if an injury is suspected, staff will request medical consultation and assessment.

6.2.2 Staff shall provide documentation of this assessment in the electronic medical record.

6.2.3 The use of chemical restraint (i.e., medication used for the sole and exclusive purpose of controlling acute and episodic aggressive behavior) is not permitted.

6.2.4 The use of medication (including prn or "as needed" medication) is permitted when prescribed by a physician for the therapeutic treatment of targeted symptoms associated with a documented psychiatric diagnosis and consented to by the client/guardian is not considered a chemical restraint.

6.2.5 Any use of chemical restraint on a client served as outlined in NRS 533.5503 will be reported as a denial or rights pursuant to NRS 433.534.

6.3 Notification: Forensic hospitals will assist the client to notify family members or their attorney if clinical indicated and justification of the decision will be noted in the electronic medical record.

7.0 ATTACHMENTS:

N/A

8.0 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: 4/30/98
REVIEVED / REVISED DATE: 12/21/98, 2/4/99, 2/17/00, 1/15/02, 3/11/03, 8/01/04, 6/23/05, 11/7/07, 7/27/10, 8/23/11
SUPERSEDES: 2.005 SECLUSION/RESTRAINTS OF INDIVIDUALS
APPROVED BY MHDS ADMINISTRATOR: 7/27/10, 8/25/11
APPROVED BY MHDS COMMISSION: 1/30/98, 9/16/11

DATE APPROVED BY DBBH ADMINISTRATOR:

DATE APPROVED BY THE COMMISSION ON BEHAVIORAL HEALTH:
1.0 POLICY:

The Division of Public and Behavioral Health and Developmental Services (DPBH) requires that each Division agency will have a procedure to receive and process complaints, grievances, suggestions, compliments, and other input from consumers, family, and stakeholders. A response shall be provided at the Division agency and/or Division Central Office level.

2.0 PURPOSE:

The Division of DPBH ensures the rights of consumers’ of Division services to submit complaints, grievances, suggestions, compliments, and other input, including concerns regarding the confidentiality of their private health information (PHI) or allegations of discrimination. Consumers’ concerns and opinions shall be respected and considered as an opportunity to enhance services.

3.0 SCOPE:

Division Wide

4.0 DEFINITIONS:

N/A

5.0 PROCEDURE:

5.1 Each agency shall have a complaint procedure for consumers, family, and stakeholders. The process shall include promptly addressing complaints and other comments of consumers, their family, or stakeholders.

5.2 The process shall include a method to address complaints regarding protected health information (PHI), following requirements of the Health Information Portability and Accountability Act (HIPAA).
5.3 The process shall include a method to address allegations of discrimination based on race, color, national origin, religion, gender, age, or disability.

5.4 The process shall include a method to evaluate suggestions and appropriately distribute the suggestions and compliments.

5.5 Consumers’ use of the complaint process shall not interfere with their ability to file complaints with regulatory agencies, nor shall it result in agency or Division retaliation in any manner.

5.6 Consumers’ use of the complaint process shall not result in a threat of or actual, current or future, denial, reduction, or cancellation of services.

5.7 The agency director shall identify the contact person(s) to receive and process these communications. This person’s contact information shall be provided to all DPBH consumers upon admission to services, and ongoing within notices provided in an accessible manner.

5.8 Each Division agency shall maintain records of complaints and other comments.

6.0 ATTACHMENTS:

N/A

7.0 REFERENCES:

7.1 Federal Health Insurance Portability and Accountability Act (HIPAA).
https://www.hhs.gov/hipaa

7.2 U.S. Department of Health and Human Services, Office for Civil Rights
https://www.hhs.gov/ocr
8.0 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.

EFFECTIVE DATE: 04/15/03

REVIEWED / REVISED DATE: 07/09/07, 08/06/10

SUPERSEDES: Policy #6.008 Client Complaint Procedures

APPROVED BY DPBH ADMINISTRATOR: 08/06/10

APPROVED BY DPBH COMMISSION: 09/17/10
1.0 POLICY:

It is the policy of the Department of Public and Behavioral Health (DPBH) to ensure proper communications during emergent events, while protecting and promoting the safety and confidentiality of those involved.

2.0 PURPOSE:

This policy establishes guidelines for proper communications during emergent events to the Director of DPBH with the use of telecommunications, electronic communications, and personal electronic devices. Each agency will incorporate this policy into their agency protocol. This protocol is not intended to replace existing policies related to significant/serious incident reports but rather to establish a quick reporting mechanism to key staff at the time the event is unfolding.

3.0 SCOPE:

Division Wide

4.0 DEFINITIONS:

4.1 Critical Incident – is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health safety or well-being of a DPBH client, employee, or the public.

4.1.1 Reportable critical incidents – abuse, death/suicide, lost/missing person, run-away/elopement, serious injury, threat of hostage situation, public health emergency, health facility emergency, fire/national disaster.

5.0 PROCEDURE:

5.1 Response to one of the above critical incidents requires action by staff in the immediate area, as well as an organization-wide response. The following steps will be taken:

5.1.1 The appropriate agency code will be called, over the intercom system,
when an incident occurs. Agency approved codes will be used for this notification.

5.1.2 Notification of the incident will be made immediately to the operator and/or Forensic Control Room staff by phone or in person.

5.1.3 Notification of security with pertinent information of the incident will be made by phone or in person.

5.1.4 Immediate search of the unit, agency, and/or surroundings area(s) in which the incident took place.

5.1.5 Immediate search of the hospital, facility, and/or grounds will be made by security/appropriate personnel.

5.1.6 Notification of 911, providing pertinent information about the incident and necessary response.

5.1.7 Voice-to-voice notification will be made to the House Supervisor, Nursing Director, Administrator on call and/or Hospital Administrator, the Capitol Police Division and immediate supervisor according to agency protocol.

5.1.8 Notification of Deputy Administrator and Administrator of Division of Public and Behavioral Health, according to DPBH protocol preferably by voice, text or email.

5.1.9 Notification of Partner Agency Managers within the geographic area. Once the incident has been cleared, notification will be made to all all agencies included in initial notification.

5.1.9.1 Notification should occur through multiple redundant communication mechanisms such as Nxt Communicator, Email, Text messaging, and Voice to voice to ensure rapid and inclusive awareness of the situation.

5.1.9.2 Mechanisms to communicate with non-state partner agencies should be preplanned as possible.

6.0 REFERENCES

6.1 DPBH Policy CRR 1.4 Reporting of Serious Incidents

6.2 DPBH Policy A6.1 Psychological First Aid Counselor Response

6.3 DPBH Policy A6.3 Clinical Services Disaster Requirement Plan
6.4  DPBH Comprehensive Emergency Management Plan
6.5  DPBH CRR 1.5 Management of Elopement Inpatient Services

7.0  ATTACHMENTS:  N/A

8.0  IMPLEMENTATION OF POLICY:
Each Division agency 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 COMMISION ON BEHAVIORAL HEALTH:
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY-WIDE

SUBJECT: Emergency Notification
NUMBER:

EFFECTIVE DATE:

REVIEW DATE:

APPROVED BY: /s/ Agency Manager

SUPERSEDES: N/A

I. PROTOCOL: It is the intent of the Division of Public and Behavioral Health (DPBH) to ensure proper communications during emergent events, while protecting and promoting the safety and confidentiality of those involved.

II. PURPOSE: The purpose of this protocol is to establish guidelines for proper communications during emergent events to the Director of DPBH with the use of telecommunications, electronic communications, and personal electronic devices. Each agency will incorporate this policy into their agency protocol. This protocol is not intended to replace existing policies related to significant/serious incident reports but rather to establish a quick reporting mechanism to key staff at the time the event is unfolding.

III. DEFINITIONS:

A. Critical Incident – is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health safety or well-being of a DPBH client, employee, or the public.

   1. Reportable critical incidents – abuse, death/suicide, lost/missing person, run-away/elopement, serious injury, threat of hostage situation, public health emergency, health facility emergency, fire/national disaster.

IV. PROCEDURE: Response to one of the above critical incidents requires action by staff in the immediate area, as well as an organization-wide response. The following steps will be taken:

A. The appropriate agency code will be called, over the intercom system, when an incident occurs. Agency approved codes will be used for this notification.
B. Notification of the incident will be made immediately to the operator and/or Forensic Control Room staff by phone or in person.

C. Notification of security with pertinent information of the incident will be made by phone or in person.

D. Immediate search of the unit, agency, and/or surroundings area(s) in which the incident took place.

E. Immediate search of the hospital, facility, and/or grounds will be made by security/appropriate personnel.

F. Notification of 911, providing pertinent information about the incident and necessary response.

G. Voice-to-voice notification will be made to the House Supervisor, Nursing Director, Administrator on call and/or Hospital Administrator, and immediate supervisor according to agency protocol.

H. Notification of Deputy Administrator and Administrator of Division of Public and Behavioral Health, according to DPBH protocol preferably by voice, text or email.

I. Notification of Campus-wide Agency Managers, including: Division of Child and Family Services, Desert Regional Center, Children’s Cabinet, Easter Seals, Opportunity Village, College of Southern Nevada, the LV CC Library, Capitol Police, Trinity United Methodist Church. Once the incident has been cleared, notification will be made to all parties listed above.

V. REFERENCES:

A. DPBH Policy CRR 1.4 Reporting of Serious Incidents (pending approval by Commission May 12)

B. DPBH Policy A6.1 Psychological First Aid Counselor Response

C. DPBH Policy A6.3 Clinical Services Disaster Requirement Plan

D. DPBH Comprehensive Emergency Management Plan

E. DPBH CRR1.5 Management of Elopement Inpatient Services (pending approval by Commission May 12)
1.0 POLICY: It is the policy of the Nevada Division of Mental Health & Developmental Services (MHDS) to not discriminate in provision of services, or hiring and employment practices, on the basis of race, age, color, creed, sex, sexual orientation, religion, disability (including AIDS and related Conditions), or national origin. MHDS has an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. These policies state, in part, that no person will, solely by reason of his or her race, age, color, creed, sex, sexual orientation, religion, disability (including AIDS and related Conditions), or national origin be excluded from participation in, be denied the benefits of, or subjected to discrimination under any program or activity receiving federal financial participation.

2.0 PURPOSE: To ensure equitable provision of services regardless of protected class statuses, and to provide federally required means for persons to file a complaint and receive a response at the Division level.

3.0 PROCEDURES:

3.1 Any person who believes he or she has been subjected to discrimination on the basis of race, age, color, creed, sex, sexual orientation, religion, disability (including AIDS and related Conditions), or national origin may file a grievance under this procedure. It is unlawful for MHDS to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

3.2 Grievances must be submitted to Central Office Personnel Officer, Civil Rights Coordinator (at Mental Health and Developmental Services, 4126 Technology Way., Suite 201, Carson City, NV 89706, 775/684-5943) within thirty days of the date the person filing the grievance becomes aware of the alleged discriminatory action.

3.3 A complaint must be in writing and contain the name and address of the person filing it ("the grievant"). The complaint must state the action alleged to be discriminatory and the relief sought.

3.4 The Civil Rights Coordinator (or designee) will conduct an investigation of the complaint to determine its validity. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Civil Rights Coordinator will maintain the files and records for MHDS relating to such grievances.
The Civil Rights Coordinator will issue a written decision on the grievance no later than 30 days after filing.

The grievant may appeal the decision for the Civil Rights Coordinator by filling an appeal in writing to the Division of MHDS Administrator within 15 days of receipt of the Civil Rights Coordinator's decision.

The Division of MHDS Administrator will issue a written decision in response to the appeal no later than 30 days after its filing.

The availability of this grievance procedure does not preclude a person from filing a complaint or discrimination on the basis of race, age, color, creed, sex, sexual orientation, religion, disability (including AIDS and related Conditions), or national origin with the Office for Civil Rights (OCR), 50 United Nations Plaza, Room 322, San Francisco, CA 94102; (415) 437-8310 (voice) or (415) 437 8311 (TDD). Note: If the complaint is made by an employee, the OCR has said it will be referred to the relevant office of EEOC. The Division’s primary document describing employee discrimination complaints is its policy 5.027, Non-Discrimination in Employment.

If the grievance is based on a disability, the Division of MHDS will make appropriate arrangements to assure that persons with disabilities can participate arrangements to assure that persons with disabilities can participate in or make use of this grievance process the same as persons who do not have disabilities. Such arrangements may include, but not be limited to, the provision of interpreters for the deaf, providing taped cassettes for the blind, or assuring a barrier-free location for the proceedings. The Division of MHDS Civil Rights Coordinator will be responsible for providing such arrangements.

Administrator

Effective Date: 3/1/00

Date Revised: 11/06/07

Date Approved by MHDS Commission: