1.0 POLICY:

The Division of Public and Behavioral Health is responsible for mitigation against, preparation for, response to, and recovery from emergencies and disasters in order to provide assistance that saves lives and protects health, safety and property.

1.1 Public Health Preparedness and Behavioral Health are part of the Statewide Comprehensive Emergency Management Plan which describes the methods by which the State of Nevada will mobilize resources and conduct disaster response and recovery activities.

1.2 The Division of Public and Behavioral Health is also part of the overall Continuity of Operations Plan for state agencies.

1.3 Each facility and agency under the Clinical Services Branch of DPBH is required to have an All Hazards Emergency Operations Plan that is reviewed and updated annually.

2.0 PURPOSE:

This policy serves to ensure that the DPBH, Clinical Services Branch, is prepared in the event of a natural or manmade disaster or state or federally - declared emergency, in collaboration with other disaster response efforts at state and local levels within the National Incident Management System and NRS 414 Emergency Management.

3.0 SCOPE:

Division of Public and Behavioral Health, Clinical Services Branch

4.0 REFERENCES:

4.1 NRS 414.0335
4.2 NRS 414.0345
4.3 NRS 414.035
4.4 Nevada Behavioral Health Emergency Operations Plan
4.5 Emergency Preparedness: Preparing Hospitals for Disasters, California Hospital Association; http://www.calhospitalprepare.org/hazard-vulnerability-analysis
5.0 DEFINITIONS:

5.1 The Joint Commission (TJC): a United States-based nonprofit tax-exempt 501 (c) organization that accredits health care organizations and programs.

5.2 Centers for Medicaid and Medicare Services (CMS): Part of the U.S. Department of Health and Human Services which oversees many federal healthcare programs.

5.3 Disaster: Per NRS 414.0335 “Disaster” means an occurrence or threatened occurrence for which, in the determination of the Governor, the assistance of the Federal Government is needed to supplement the efforts and capabilities of state agencies to save lives, protect property and protect the health and safety of persons in this state, or to avert the threat of damage to property or injury to or the death of persons in this state.

5.4 Emergency: Per NRS 414.0345 “Emergency” means an occurrence or threatened occurrence for which, in the determination of the Governor, the assistance of state agencies is needed to supplement the efforts and capabilities of political subdivisions to save lives, protect property and protect the health and safety of persons in this state, or to avert the threat of damage to property or injury to or the death of persons in this state.

5.5 Emergency Management: Per NRS 414.035 “Emergency management” means the preparation for and the carrying out of all emergency functions, other than functions for which military forces are primarily responsible, to minimize injury and repair damage resulting from emergencies or disasters caused by enemy attack, sabotage or other hostile action, by fire, flood, earthquake, storm or other natural causes, or by technological or man-made catastrophes, including, without limitation, a crisis involving violence on school property, at a school activity or on a school bus. These functions include, without limitation:

5.5.1 The provision of support for search and rescue operations for persons and property in distress.

5.5.2 Organized analysis, planning and coordination of available resources for the mitigation of, preparation for, response to or recovery from emergencies or disasters.
5.6 National Incident Management System (NIMS) is a comprehensive, national approach to incident management that is applicable at all jurisdictional levels and across functional disciplines. It is intended to be applicable across a full spectrum of potential incidents, hazards, and impacts, regardless of size, location or complexity.

5.7 Hazard Vulnerability Assessment (HVA): a systematic approach to recognizing hazard that may affect demand for agency services or its ability to provide those services. The risks associated with each hazard are analyzed to prioritize planning, mitigation, response and recovery activities. The HVA serves as a needs assessment for the Emergency Management Operations Plan.

6.0 PROCEDURE:

6.1 Each facility, to include but not limited to Dini-Townsend Psychiatric Hospital of Northern Nevada Adult Mental Health Services (NNAMHS), Rawson-Neal Psychiatric Hospital of Southern Nevada Adult Mental Health Services (SNAMHS), Lakes Crossing Center, and Rural Counseling and Supportive Services, under the DPBH Clinical Services Branch shall maintain an All Hazards Emergency Operation Plan that is consistent with NIMS and based on annual HVA.

6.2 Each facility shall identify essential staff including a designated Emergency Management Coordinator and provide those staff with information regarding their responsibilities in preparation for possible disasters and in the event of a disaster.

6.3 The Emergency Operations Plan shall include appropriate training activities to ensure that staff is prepared to implement the plan in the event of a disaster.

6.4 The Joint Commission and CMS require psychiatric hospitals such as Dini-Townsend Psychiatric Hospital and Rawson-Neal Psychiatric Hospital to have an All Hazards Emergency Operations Plan, as well as multi-year emergency preparedness training plan for all staff.

6.5 Agencies may partner with other entities within their community and the State, as necessary to implement the plan. Such agreements must be approved by the appropriate Deputy Attorney General.
6.6 Emergency Operations Plans at each facility or agency level under the Clinical Services Branch, shall be reviewed and updated annually and be based on a Hazard Vulnerability Assessment.

6.7 Each agency or facility under the Clinical Services Branch will develop specific written procedures to implement this policy.

7.0 ATTACHMENTS:

7.1 HVA Tool

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:

DATE APPROVED BY DPBH ADMINISTRATOR:

DATE APPROVED BY THE COMMISSION ON BEHAVIORAL HEALTH:
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DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

Control #  Rev.  Title  Effective Date
GOV 1.2    New  Practitioner Fit for Duty  Next Review Date

1.0  POLICY:

It is the policy of the Division of Public and Behavioral Health (DPBH) Medical Staff to provide assistance and rehabilitation, rather than discipline, to aid a practitioner in retaining and regaining optimal professional functioning, consistent with the protection of patients.

2.0  PURPOSE:

To identify the process by which the DPBH Medical Staff provides education about physician health, addresses prevention of physical, psychiatric, or emotional illness, and facilitates confidential diagnosis, treatment and rehabilitation of Medical Staff practitioners who suffer from a potentially impairing condition.

3.0  SCOPE:

This policy applies to all Division Medical Staff Practitioners.

4.0  DEFINITIONS:

N/A

5.0  PROCEDURE:

5.1 The Medical Staff orientation process provides education to the Medical Staff about illness and impairment recognition issues.

5.2 The Division of Public and Behavioral Health shall establish a Practitioner Health subcommittee of the Medical Staff. The members will be selected by the Chief Medical Officer from the nominations made by the Medical Staff. The Subcommittee shall meet as needed and shall document its activity.
5.3 The Practitioner Health Subcommittee shall accept self-referred practitioners as well as referrals from other departments in the hospital relating to Medical Staff practitioners.

5.4 The Practitioner Health Subcommittee shall review the credibility of a complaint, allegation, or concern, the circumstances of the situation and make a referral for external diagnosis and treatment of the condition or concern if indicated. When external referral is not indicated, the Practitioner Health Subcommittee shall assign a member to work individually with the practitioner to address the issue.

5.5 The Practitioner Health Subcommittee will establish a plan for follow up, including but not limited to monitoring the affected practitioner and the safety of patients until the practitioner’s health status clears or until such time as the issue requires consideration by the Chief Medical Officer.

5.6 The Practitioner Health Subcommittee shall maintain strict confidentiality of the practitioner referred for assistance, except as permitted by law, ethical obligation, or when the safety of a patient is threatened. The practitioner’s supervisor shall be included in the process when treatment and follow up are indicated in order to arrange appropriate absences, request FMLA or reasonable accommodation, or other necessary actions.

5.7 The Practitioner Health Subcommittee shall report to the Chief Medical Officer on each referral.

5.8 If the practitioner’s health jeopardizes patient safety, the Chief Medical Officer shall initiate action per the Medical Staff Bylaws.

5.9 When a licensed independent practitioner fails to complete the required rehabilitation program, the subcommittee will notify the Chief Medical Officer.
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

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5.10 Upon closure of the issue, the Practitioner Health Subcommittee shall forward all documentation to the Credentialing Coordination for safekeeping. The information for the Practitioner Health Subcommittee shall be maintained in files separate for the Credential file.

5.11 When a complaint, allegation, or concern is related to the matters of individual health of a resident, a referral will be made to the University Of Nevada School Of Medicine.

6.0 REFERENCES:

6.1 Joint Commission manual. MS 11.01.01
6.2 State of Nevada Risk Management Division, Employee Fitness for Duty Exam, Policy/Procedures
6.3 UNSOM GME Fit for Duty policy/procedure

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

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

The Division of Public And Behavioral Health (DPBH) expressly prohibits the abuse or neglect of any person receiving services. It is the policy of DPBH that DPBH agency and contract staff will receive training about abuse and neglect of consumers that will focus on abuse and neglect prevention, identification, and reporting requirements. This policy also requires that immediate steps shall be taken to ensure that consumers are protected.

Any DPBH staff or contract staff found to be abusive or negligent of a consumer shall be disciplined up to and including termination.

2.0 PURPOSE:

The purpose of this policy is to prevent the abuse and/or neglect of consumers receiving Division services and to provide a process for reporting all allegations of abuse and/or neglect by Division or contract staff.

3.0 SCOPE:

Division wide, including contract providers and their staff

4.0 DEFINITIONS:

4.1 Abuse: any willful and unjustified infliction of pain, injury or mental anguish upon a person served by a DPBH or contract staff. Abuse includes, but is not limited to:

4.1.1 Sexual abuse: Examples of sexual abuse include but are not limited to: rape, sexual assault, sexual exploitation, sexually degrading language or gestures, sexual molestation, attempts to engage a person in sexual conduct, intimate touching or fondling, encouraging a person to sexually touch a staff member, other consumer, or himself, exposing one’s sexual parts to a person, encouraging a person to expose his sexual parts to others, encouraging a social or romantic attachment or relationship outside
of boundaries, encouraging the consumer to solicit for or engage in prostitution, or encouraging or allowing the viewing or production of pornographic material by minors.

4.1.2 Physical abuse: Examples of physical abuse include but are not limited to: any act that causes physical pain or injury to the consumer, hitting, slapping, bruising, kicking, hair pulling, shoving, pinching, cutting, burning, or the use of arm bars or other holds to inflict pain. An allegation of physical abuse may be substantiated without an observable injury.

4.1.3 Verbal abuse: Examples of verbal abuse include but are not limited to: verbal intimidation or coercion of a person without a redeeming purpose, name-calling, cursing, mocking, swearing, ridiculing, yelling, or using words or gestures that frighten, humiliate, intimidate, threaten or insult the person.

4.1.4 Emotional/Psychological Abuse: Examples include but are not limited to: actions or utterances that cause mental distress such as making obscene gestures to the person, or using other non-verbal gestures that frighten, humiliate, intimidate, threaten or insult the person, harassment, threats of punishment or deprivation, including threats to deny or withdraw services, sexual coercion, intimidation whereby a person would suffer psychological harm or trauma, and social isolation of an individual from family and friends or from normal activities.

4.1.5 Excessive force: The use of excessive force when placing a consumer in physical restraints or in seclusion.

4.1.6 Restraint: The use of physical, chemical or mechanical restraints or use of seclusion in violation of state and/or federal law.

4.1.7 Exploitation: any illegal or improper use of a consumer's funds, property, or assets resulting in monetary, personal, or other benefit, gain, or profit for the perpetrator, or resulting in monetary, personal, or property loss by
the consumer. Examples include but are not limited to: borrowing a consumer's money, taking a consumer's medication, accepting or coercing gifts from consumers, a consumer doing work for a staff (i.e. wash car) with or without compensation, consumer paying for items or activities that are for the benefit of staff, improper use of a consumer's Social Security number or funds, improper use of funds belonging to the consumer or diversion of state funds intended for consumer use, and those examples stated in Division Policy #4.037 Professional Behavior of Division Employees.

4.2 Neglect: any act or omission to act that causes injury or mental anguish to a consumer or that places the consumer at risk of injury whether due to indifference, carelessness or intention. Neglect includes but is not limited to:

4.2.1 Failure to establish or carry out an appropriate plan of treatment for which the person has consented, failure to follow the agency policies and procedures, failure to provide for basic needs (adequate nutrition, clothing, personal hygiene, shelter, supervision, education, or appropriate and timely health care including treatment and medication), failure to provide a safe environment, failure to respond to aggression between consumers served or to consumers engaging in self abusive behavior, and failure to act to stop abuse as defined above.

4.3 Staff: any DPBH or contract service provider staff, employee, or volunteer, unless stated otherwise.

4.4 Supervisor: any DPBH or contract service provider supervisor, unless stated otherwise.

5.0 PROCEDURE:

5.1 The Division of DPBH strictly prohibits abuse and neglect.

Any act of abuse or neglect of a consumer by a DPBH or contract provider staff shall result in disciplinary action up to and including termination.
Should the investigation indicate that abuse, as defined in NRS 433.554 has occurred, the agency director shall recommend termination of the employee and shall review all pertinent agency policies, treatment procedures, and staff orientation practices to determine if they need to be revised to reduce the likelihood of recurrence of similar incidents.

5.2 DPHB and contract staff shall receive training about abuse and neglect of consumers

5.2.1 Each DPHB agency director shall ensure that training is provided to all staff on abuse and neglect prevention, identification, and reporting requirements in accordance with agency policies.

5.2.2 Training shall be provided for new staff prior to their working independently with consumers receiving services.

5.2.3 Training will be required a minimum of biannually for all staff.

5.2.4 DPHB and contract agencies will document training for each staff member and will provide additional training as needed.

5.3 All allegations of abuse and/or neglect shall be reported by following the requirements below, which will be repeated in Policy CRR-1.4, Reporting Serious Incidents and Denials of Rights:

5.3.1 Any staff, upon observing, hearing of, or suspecting abuse and/or neglect of a person served by the Division will:

5.3.2 Make a verbal report to his supervisor immediately and in all instances within a maximum of one (1) hour from becoming aware of the suspected abuse and/or neglect. The report must be made through person-to-person contact; voice messages do not meet the reporting requirements;

5.3.3 Complete an Incident Report to their supervisor, or designee, detailing the information as soon as possible following the verbal report, and in all instances by the end of the staff’s workday, or if off duty within 16 hours;

5.3.3.1 Make all verbal and written reports to the supervisor’s supervisor if the direct supervisor is suspected of abuse or neglect;
5.3.3.2 Notify other applicable entities as appropriate or required (i.e. Child Protective Services, Aging Protective Services, law enforcement) within 24 hours, or discuss with their supervisor if the notification(s) is to be made by the supervisor; and

5.3.3.3 The DPBH or contract agency will ensure the immediate notification by agency staff of the person’s parents (if a minor) or guardian (if legally appointed).

5.3.4 The supervisor on receiving a report will:

5.3.4.1 Take immediate action to ensure the victim has received appropriate medical treatment and follow-up as applicable, and take prompt action to provide for the person’s welfare and safety;

5.3.4.2 Make a verbal report to the DPBH agency director, or designee, immediately, and in all instances within a maximum of one (1) hour from becoming aware of the suspected abuse and/or neglect.; and

5.3.4.3 Within twenty-four (24) hours of being apprised of suspected abuse and/or neglect, ensure that the written Serious Incident Report is submitted to the DPBH agency director or designee.

5.3.5 The DPBH agency director, or designee, receiving a report of alleged abuse and/or neglect will:

5.3.5.1 Immediately, and in all instances within 24 hours, ensure submission of the written Serious Incident Report to the Division Administrator, or designee;

5.3.5.2 Provide protection of the person, when determined necessary, by restricting access to the person by the alleged perpetrator;

5.3.5.3 If the alleged perpetrator is a staff of a contractor, the DPBH agency director, or designee, will ensure the contractor has taken prompt action to restrict access to the person by the alleged perpetrator.

5.4 Reporting abuse and/or neglect is absolutely required.

5.4.1 A staff that fails to report abuse or neglect shall be subject to disciplinary action, up to and including termination.
5.4.2 A staff that reports suspected abuse or neglect shall not be disciplined or receive any retaliation for making such a report, per NRS 433.536.

6.0 ATTACHMENTS:

N/A

7.0 REFERENCES

7.1 Nevada Revised Statues (NRS): 433.464; 433.482; 433.484; 433.504; 433.524; 433.554; 443A.360; 433A.460; 435.340; Division Policy #4.037, Professional Behavior of Division Employees.

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: 07/17/98

REVIEWED / REVISED DATE: 2/04/99; 07/18/01; 03/10/05; 05/09/07; 09/08/10

SUPERSEDES: Policy #2.003 Abuse or Neglect of Clients

APPROVED BY DPBH ADMINISTRATOR: 08/06/10

APPROVED BY DPBH COMMISSION: 09/17/10;
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

Control #    Rev.           Title:                  Effective Date: 4/2003
5.029         3/2017        WORKPLACE VIOLENCE       Next Review Date: 3/2019
               PREVENTION

1.0 POLICY:

The Division is committed to working with its employees to provide and maintain a work
environment free from violence, threats of violence, harassment, intimidation, and other
unnecessarily disruptive behavior.

2.0 PURPOSE:

To ensure optimally safe work and service delivery environments, and appropriate response
to workplace violence, including threats.

3.0 SCOPE:
Division of Public and Behavioral Health, Clinical Services Branch

4.0 DEFINITIONS:

4.1 Workplace: any location where an employee performs work-related duties and can
include, for example, parking lots, field locations, and consumer’s homes.
4.2 Acts of workplace violence include: causing or threatening to cause bodily injury, or
damage to the property of another person or substantial harm to the physical or mental
health or safety of a person.
4.3 Threats include expressing intentions that would cause a reasonable person to feel
frightened, intimidated or harassed.
4.4 Acts of workplace violence include but are not limited to: striking, shoving or
kicking another person; intentional physical injury; intentional or reckless damage to
another’s property; intimidating or menacing behavior; abusive statements; threats to
cause harm or damage; and reckless conduct that creates risk or threat of serious injury.

5.0 PROCEDURES:

5.1 General Provisions
5.1.1 Workplace violence issues may arise from consumers, from random acts of
individuals directed against the agency with or without apparent reason,
from current or former employees, or from employees' personal relationships, such as a former spouse or a friend.

5.1.2 Violence, threats, harassment, intimidation or other acts of aggression and disruptive behavior in the workplace will not be tolerated.

5.1.3 All reports of incidents will be seriously evaluated, and intervention will be initiated in accordance with the Division's Workplace Violence Prevention Program (Attachment I) and guidelines provided by the Risk Management Division (Attachment II).

5.2 Employee Responsibilities
5.2.1 Each employee's participation is needed to implement this policy effectively and maintain a safe working environment. It is expected that all employees will consistently treat other employees and all other persons contacted in the course of performing their job duties with dignity and respect.

5.2.2 If you observe or experience an act of workplace violence, it is your responsibility to immediately report the incident to your supervisor or manager or a designated agency representative.

5.2.3 If you are experiencing threats of violence from a domestic partner or other non-work related relationship, you are encouraged to report this to your supervisor/manager or designated agency representative so a plan can be developed to minimize the risk to you and others during working hours.

5.3 Agency Responsibilities
5.3.1 Supervisors/managers/agency representatives who receive reports of workplace violence must initiate appropriate action in response to the report, and ensure that the Workplace Violence Incident Report Form (Attachment III) is completed and forwarded to his/her supervisor.

5.3.2 The agency director and division administrator are to receive copies no later than the next working day after the incident.

5.3.3 If there is a direct and imminent threat of violence, a supervisor should call 911 or other appropriate law enforcement entity and, if appropriate, evacuate the work area.
5.3.4 If a crisis situation arises, the highest agency official available at the time must be called into the situation to implement appropriate intervention. See Attachment I, Workplace Violence Prevention Program, for additional detail.

5.4 Response to Acts of Violence
5.4.1 If you are placed in a position of fear due to an act of aggression or violence, you should remain calm, remove yourself from the area (or excuse yourself from the phone call) as soon as possible and report the incident to the most accessible supervisory representative available.

5.4.2 If you have advance knowledge of an encounter with a potentially aggressive individual, such as a meeting, notify your supervisor in advance so that preventive measures can be planned.

5.5 Consequences of Acts of Workplace Violence
5.5.1 An individual who commits an act of workplace violence may be subject to disciplinary action (if an employee), may be removed from the premises, and/or subject to criminal penalties.

Administrator

Effective Date: 4/18/03
Revised Date: 6/28/07
Approved by MHDS Commission: 4/18/03
Revised Date: 11/2016
Approved by the Commission on Behavioral Health 11/18/2016

6.0 ATTACHMENTS
6.1 Workplace Violence Prevention Program - Attachment I
6.2 Guidelines for Responding to Employee Threats of Violence/Fitness for Duty Issues – Attachment II
6.3 Workplace Violence Incident Report – Attachment III
6.4 Sample – Employee Security Survey – Attachment IV
6.5 NRS References – Attachment V
6.6 DHHS Workplace Violence Prevention Poster – Attachment VI
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ATTACHMENT I

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

WORKPLACE VIOLENCE PREVENTION PROGRAM

The Division of Public and Behavioral Health is committed to working with its employees to provide and maintain a work environment free from violence, threats of violence, harassment, intimidation, and other unnecessarily disruptive behavior.

1.0. TERMS

Acts of Workplace Violence

Workplace violence issues may arise from clients or customers, random acts of outside individuals or groups directed against the agency with or without apparent reason, from current or former employees, or from employee’s personal relationships such as a former spouse or partner, a relative or a friend.

Acts of workplace violence include causing or threatening to cause bodily injury, damage to the property of another person, or substantial harm to the physical or mental health or safety of a person. Threats include expressing intentions that would cause a reasonable person to feel frightened, intimidated or harassed.

Examples of acts of workplace violence include but are not limited to: striking, shoving or kicking another person; intentional physical injury; intentional or reckless damage to another’s property; intimidating or menacing behavior; abusive statements; threats to cause harm or damage; and reckless conduct that creates risk of serious injury.

Workplace

The “workplace” is defined as any location, either permanent or temporary, where an employee performs any work-related duty. This includes but is not limited to the buildings and the surrounding perimeters and parking lots, field locations, and clients’ homes or businesses. Workplace violence can also occur outside the workplace but while the employee is performing a job-related function.

Agency Threat Assessment Team

The agency threat assessment team consists of a group of individuals designated by the agency director, on a permanent or ad hoc basis, to assist in implementation of specific aspects of the agency’s workplace violence prevention program. Individuals on the team may include members of the agency’s safety committee.
2.0. RESPONSIBILITIES OF ALL STAFF

It is expected that all employees will consistently treat other employees and all other persons contacted in the course of performing their job duties with dignity and respect.

See also sections III through VI below for specific duties of agency administrators, employees, supervisors, and the agency assessment team.

3.0. AGENCY ADMINISTRATOR’S RESPONSIBILITIES

3.1. Adopt and communicate the workplace violence prevention policy, and promote a work environment free from violence.

3.2. Adopt or incorporate the Division’s workplace violence prevention program into the agency’s written safety program.

3.3. Ensure implementation and support of the workplace violence prevention policy and program within their agency.

3.4. In formulating the prevention and response aspects of the workplace violence prevention program, give special attention to positions which involve the following: exchange of money with the public; working alone or in small numbers; working late at night or early in the morning hours; working in a high crime area; guarding valuable property or possessions; working in a community or institutional setting.

3.5. Appoint staff members to an agency assessment team.

3.6. Take appropriate action to respond to reported incidents of workplace violence. Refer to Guidelines for Responding to Employee Threats of Workplace Violence prepared by the Risk Management Division (Attachment II). Note: The Risk Management Division indicates in this document that its guidelines are not binding, but represent options for consideration, since most situations are unique and require creative solutions. In cases where the Risk Management Division suggests placing an employee on administrative leave, please remember that this action requires the approval of the Division Administrator or Deputy Administrator. Reassignment may be a viable option in some cases, and should be considered first.

4.0. EMPLOYEE’S RESPONSIBILITIES

4.1. Immediately report acts or threats of workplace violence he/she observes or experiences to his/her supervisor, manager, or designated agency representative.

4.2. An employee who is experiencing threats of violence that may carry over into the workplace from a domestic partner or other non-work-related relationship is also encouraged to report this to his/her supervisor, manager, or designated agency representative so a plan of action to minimize risk to the employee and others during working hours may be developed.
4.3. Notify his/her supervisor if he/she has prior knowledge of an encounter with a potentially aggressive individual expected to occur while in work status.

5.0. SUPERVISOR’S RESPONSIBILITIES

5.1. Work in concert with the agency administrator to promote a work environment free from violence.

5.2. Initiate notification procedures to the agency administrator and document incidents as outlined in Section VII of this program.

5.3. Take appropriate action to respond to reported incidents or threats of workplace violence. (See Guidelines for Responding to Employee Threats of Workplace Violence prepared by the Risk Management Division, Attachment II).

6.0. AGENCY ASSESSMENT TEAM’S RESPONSIBILITIES

6.1. Participate in assessment and prevention activities as outlined in Section VIII of this program.

6.2. Recommend actions to the agency administrator to reduce the agency’s vulnerability to acts of workplace violence or, in response to acts of workplace violence, recommend actions to prevent similar incidents from occurring.

6.3. Participate in investigations of acts or threats of workplace violence, as requested by the agency or division administrator.

6.4. Assist in determining an appropriate course of action in response to an act or threat of workplace violence, as requested by agency administrator.

7.0. INCIDENT REPORTING AND INVESTIGATION

An employee who observes or experiences an act or threat of workplace violence must report it to his/her supervisor, manager or designated agency representative immediately. The person who receives the report must initiate appropriate action to respond to the incident and must report the incident to his/her next higher supervisor/manager. The supervisor/manager, in turn, must notify the agency director or his/her delegate. The agency director or delegate must notify the Division Administrator or delegate.

As noted in the Guidelines for Responding to Employee Threats of Workplace Violence (Attachment II), if there is a direct and imminent threat of violence, call 9-911 or the appropriate law enforcement entity and, if appropriate, evacuate the work area. If a crisis situation arises, the highest agency official available at the time must be called into the situation to implement appropriate intervention.

As warranted by the incident, the agency administrator or his/her designee is responsible for reporting the incident to the Capitol Police or the local law enforcement agency, if they have not been called, and for providing written documentation of the incident. The law enforcement
Agency will conduct further investigation and coordination with other agencies as necessary.

The agency administrator or his/her designee is responsible for contacting the Attorney General’s Office or the Risk Management Division if their assistance is required. If the incident occurs in a state building for which Capitol Police provides security, they are the responsible agency for further investigation and coordination with a local law enforcement agency, the Attorney General’s Office and the Risk Management Division. The Attorney General’s Office is responsible for investigating and prosecuting criminal offenses committed by state employees in the course of their duties or arising out of circumstances related to their positions (see Attachment V, NRS References).

A workplace violence incident report (Attachment III) must be completed by the supervisor/manager or agency designee for each incident reported to him/her and must be submitted to the division administrator no later than the next working day after the incident was reported. Statements from witnesses should be collected. The division administrator or delegate is to arrange an investigation. A copy of the incident report must be submitted by the division administrator to the Risk Management Division and to the division Personnel Officer within 5 working days after receipt of the report. Incidents involving employees or clients will be handled in accordance with applicable laws, policies and procedures which may preclude dissemination of confidential information to the Risk Management Division.

8.0. ASSESSMENT AND PREVENTION ACTIVITIES

The agency threat assessment team, appointed by the agency administrator, assists in the assessment of the vulnerability of the agency and its offices to workplace violence, recommends preventive actions and identifies training needs.

Activities to assess vulnerability to workplace violence should typically include the following:

Review previous acts of workplace violence within the agency.

Review and analyze existing records (e.g., past incident reports, worker’s compensation records, accident investigations, safety committee meeting minutes) to identify patterns that may indicate the causes and severity of incidents.

Inspect the workplace and review the work tasks of employees to identify conditions, facility layout, operational procedures, and other factors which may place employees at risk for acts of workplace violence.

Conduct post-incident reviews and discuss the causes of acts of workplace violence.

NOTE: A Hazard Identification and Control Checklist for use by the Threat Assessment Team is available on Risk Management’s website (www.risk.state.nv.us).

In addition, the team must survey employees, at least biennially, to identify the potential for acts of workplace violence and identify security measures which are in place (Sample Employee Security Survey – Attachment IV).
Based on the activities conducted, the agency assessment team will prepare written recommendations and provide those recommendations to the agency administrator for consideration.

9.0. TRAINING AND COMMUNICATION

At the time of appointment, each employee must be provided with a copy of the division’s workplace violence prevention policy (#5.029). Agencies may also include a poster (Attachment VI) on their office bulletin boards which summarizes policy provisions, including the persons to whom the employee can report acts of workplace violence.

The Risk Management Division of the Department of Administration offers periodic training classes regarding workplace violence prevention. A schedule of these classes is available on the Risk Management Division’s website. All supervisory personnel should be scheduled to attend training on this topic.

Training regarding the division’s specific policies and procedures and training regarding the use of security hardware, if applicable, should be provided to each employee. This may include initial orientation, periodic refresher training, on-the-job training, or formal training provided or coordinated by a safety coordinator, safety committee or training coordinator. Specialized training may be appropriate for employees in positions that place them at a higher risk for acts of workplace violence.

10.0. FITNESS FOR DUTY EVALUATION

If a supervisor/manager determines that an employee may have a medical or psychological condition that could result in a direct physical threat or other liability to him- or herself, a co-worker or the public, the Risk Management Division can coordinate a fitness for duty evaluation in accordance with Section 0521(8) of the State Administrative Manual. Notification must be made by the supervisor/manager to the agency administrator or designee and to the Division Personnel Officer of the reasons for the request. The agency personnel representative will make the necessary arrangements with the Risk Management Division. Procedures related to requesting a fitness for duty examination include providing a detailed explanation of the facts and circumstances precipitating the request and copies of documents that support the request.

11.0. PROGRAM ASSISTANCE/AUDIT

The Risk Management Division is available to review and assist with the development of the workplace violence prevention program. Sample forms to use in program development are available at their website (www.risk.state.nv.us). The Risk Management Division will periodically audit division/agency programs.
ATTACHMENT II
State of Nevada
Guidelines for Responding to Employee Threats of Workplace Violence/Fitness for Duty
Issues
Revised August 2001

Prepared by the Risk Management Division
“IMMEDIATE INTERVENTION”

Direct and Imminent Threat of Violence-DO ALL OF THE FOLLOWING:
(Employee or other person states he/she is on the way to commit an act of violence or indicates that he/she is going to get the means to commit the act and will be back.)

☐ Call 9-911 or other appropriate Law Enforcement Entity
☐ Notify affected employees—give option to go home on personal leave
  ♦ If appropriate, evacuate work area and send employees home on administrative leave
  ♦ If possible, inform the offending employee that they are being placed on administrative leave and are prohibited from returning to the worksite until further notice
  ♦ Contact the Investigations Division from the Attorney General’s Office to report the event
  ♦ Assemble a threat assessment team including the appropriate representative from Administration, Personnel, Employee Assistance Program, Attorney General’s Office and Risk Management to determine the best course of action.

Direct Threat without Imminent Event
(Employee states that he/she intends to commit an act of violence—one of these days)

♦ Place the employee on administrative leave (or in some cases sick leave) pending an investigation
♦ Notify the employee, verbally and in writing, that they are prohibited from coming to the worksite or other identified State property without prior approval and coordination with a designated agency representative
☐ Contact the Attorney General’s Office to initiate a criminal investigation
♦ Assemble a Threat Assessment Team, as noted above, to determine the best course of action

Indirect Threats, Stalking, Harassment, Bullying, Intimidation

☐ Confront and counsel the employee and state that the behavior must stop
♦ Make a formal referral to the EAP Services
♦ If the employee refuses to go to EAP Referral and/or the behavior does not cease, implement progressive disciplinary procedures - OR -
♦ Determine if conflict resolution needs to occur among employees to diffuse the situation - OR -
♦ If there are indications of a possible medical or psychological illness, either coordinate a “Fitness for Duty Exam” or direct the employee to obtain a work release from a personal physician and/or psychologist. Provide the employee with written instructions to have the physician review a letter that outlines the reasons for concerns and request the physician
to make a statement in regard to fitness for duty. Provide a copy of the employee’s job description -OR-

- If other employees are expressing concern for their safety or are indicating that they feel they are working in a hostile environment, the urgency of the follow-up must be escalated
- If appropriate, assemble Threat Assessment Team to determine best course of action

**Bizarre, Inappropriate or Unsafe Behavior**

- Confront and counsel the employee—give the employee an opportunity to explain reasons for the behavior
- Make a formal referral to EAP Services
- If the behavior does not improve and/or the employee refuses to utilize the EAP Services, consider following the guidelines for the Alcohol and Drug Testing Program and/or implement progressive disciplinary actions
- If appropriate, place the employee on sick leave and require him/her to obtain a release from personal physician. Provide the employee with written instructions to have the physician review a letter that outlines the reasons for concerns and request the physician to make a statement in regard to fitness for duty. Provide a copy of the employee’s job description.
- Require a 2nd opinion, if necessary -OR-
- Coordinate a “Fitness for Duty” Exam
- If appropriate, assemble a Threat Assessment Team to determine the best course of action

Most circumstances are unique and will require creative solutions to best fit the situation. These are only guidelines and options for consideration. It is often best to seek the consensus of a threat assessment team either within your agency or as coordinated through Risk Management if the situation does not improve or other employees are expressing concern for their safety.

**Attorney General’s Office- Investigation’s Division**
(775) 684-1150

**Capitol Police - Chief**
(775) 684-4542

**Employee Assistance Program**
(775) 684-0150
1-888 972-4732
(702) 486-2900
1-888 972-4732

**Risk Management Division**
(775) 687-3187

**Critical Incident Stress De-Briefing**
Contact the Risk Management Division
Guidelines for Responding to Threats of Workplace Violence/Fitness for Duty Issues
“IMMEDIATE INTERVENTION”

Is the act a “Direct and Imminent Threat of Violence” (e.g. The person states they are on the way to commit an act of violence or they are going to get the means to commit an act and will be back).

YES

Call 9-911 or other appropriate police entity

NO

Is the act a “Direct Threat without Imminent Event” (e.g. They state that one of these days I plan to…)

NO

Is this an indirect threat (e.g. stalking, harassment, bullying, and intimidation) or bizarre, inappropriate or unsafe behavior?

YES

Place Employee on Admin Leave (Sick Leave, if appropriate), pending investigation.

NO

Confront and counsel the employee

♦ Give the employee an opportunity to explain reasons for behavior.
♦ State that the behavior must stop

Make formal referral to EAP

Contact the Investigation Division of the Attorney General’s Office

Assemble Threat Assessment Team

1. If behavior does not improve or employee refuses to utilize EAP, implement progressive discipline, or;
2. Determine if conflict resolution needs to occur among employees to diffusing the situation, or;
3. If there is indication of a possible medical or psychological illness use “Bizarre, Inappropriate or Unsafe Behavior” Protocol, or;
4. If other employees are expressing concern for their safety or feel they are working in a hostile environment, the urgency of follow-up must be escalated, or;
5. If appropriate, assemble Threat Assessment Team

1. If behavior does not improve or employee refuses to utilize EAP, consider using Drug/Alcohol Testing guidelines and/or progressive discipline, or;
2. If appropriate, place employee on sick leave and require them to obtain a release from personal physician. Provide the employee with written instructions to have the physician review reasons for concern/ request statement regarding fitness for duty. Provide job description, or;
3. Require 2nd opinion, if necessary, or;
4. Coordinate “Fitness for Duty” exam, or;
5. If appropriate, assemble Threat Assessment Team
ATTACHMENT III

WORKPLACE VIOLENCE INCIDENT REPORT

DIVISION/AGENCY: ___________________________ TODAY'S DATE: ________________

ADDRESS/LOCATION WHERE INCIDENT OCCURRED:

________________________________________  ________________________________
Office                                             Street Address                          City, State

NAME/TITLE/PHONE NO. OF PERSON WHO REPORTED THE INCIDENT TO YOU:

________________________________________  __________________________
Name                                               Title                                     Telephone No.

DATE AND TIME OF INCIDENT: ___________________________ A.M./P.M.
                                        ____________________________
                                          Date & Day of Week                 Time

PERSON(S) WHO ENGAGED IN ACT OF WORKPLACE VIOLENCE:

________________________________________
Name(s)                                     Title(s)

PERSON(S) THE VIOLENCE WAS DIRECTED TOWARDS:

________________________________________
Name(s)                                     Title(s)

WAS THE PERSON INJURED? (If so, describe)

DESCRIBE THE INCIDENT (Detail what happened, actions, words that were used, weapon used etc.)

WHAT PRECIPITATED THE INCIDENT?
HOW DID INCIDENT CONCLUDE? (Incident defused, person escorted off premises, etc.)

OTHER PERSON(S) WHO WITNESSED THE INCIDENT:

Name(s)  Title(s)

HAS NOTIFICATION BEEN MADE TO ANOTHER ENTITY? (Capitol Police, Law Enforcement, Attorney General’s Investigation Division, etc.)

IF YES, TO WHOM WAS IT REPORTED AND WHEN?

ACTION BEING TAKEN BY ENTITY:

OTHER PERTINENT INFORMATION:

RECOMMENDATIONS OF HOW SIMILAR INCIDENTS COULD POSSIBLY BE AVOIDED IN THE FUTURE:

NAME/TITLE/PHONE NO. OF PERSON COMPLETING THE REPORT FORM:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Telephone No.</th>
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</thead>
<tbody>
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</table>

Signature  Date

*Provide copy of incident report to the division administrator or person designated by the administrator to serve in his/her stead no later than the next working day after the incident is reported.*

*Supervisor/manager should follow-up for witnesses' statements, as appropriate.*
ATTACHMENT IV

EMPLOYEE SECURITY SURVEY
(Please Print)

NAME/TITLE: ____________________________________________________________

DIVISION/AGENCY: ______________________________________________________

WORK LOCATION/ADDRESS: ____________________________________________

1. Do you work alone in your building during working hours?
   
   If yes, is notification given to someone when you finish work?

2. Have you experienced any problems as a result of working alone?
   
   If yes, please describe the problem and explain whether it is problematic at only certain times (e.g., weekends, daylight savings time).

3. Identify any issues/areas which cause you to be concerned with acts of workplace violence. Also, please specify if you have experienced or observed any incidents associated with these issues and when.

<table>
<thead>
<tr>
<th>Issues of Concern</th>
<th>Experienced? (Y/N)</th>
<th>Observed? (Y/N)</th>
<th>When?</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
4. Are there any areas/worksites where a violence-related incident would most likely occur? Please specify (entrance, parking lot, private office, bathroom, field location, etc.).

5. Do you know what to do if you observe or experience an act of workplace violence?

6. What security measures are in place at your office location?

   Have you received training on how to use/access/implement these measures?

7. Have you received training or assistance of any kind related to prevention of workplace violence?

8. Other comments.
### ATTACHMENT V

### NRS REFERENCES

<table>
<thead>
<tr>
<th>NRS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRS 33.200 – 33.360</td>
<td>Orders for Protection against Harassment in Workplace</td>
</tr>
<tr>
<td>NRS 199.300</td>
<td>Intimidating public officer, public employee, juror, referee, arbitrator, appraiser, assessor or similar person.</td>
</tr>
<tr>
<td>NRS 200.571</td>
<td>Harassment: Definition; penalties</td>
</tr>
<tr>
<td>NRS 200.575</td>
<td>Stalking: Definitions; penalties</td>
</tr>
<tr>
<td>NRS 201.255</td>
<td>Penalties. Obscene, Threatening or Annoying Telephone Calls.</td>
</tr>
<tr>
<td>NRS 202.840</td>
<td>Bomb threats prohibited; penalties</td>
</tr>
<tr>
<td>NRS 203.119</td>
<td>Commission of act in public building or area interfering with peaceful conduct of activities.</td>
</tr>
<tr>
<td>NRS 207.180</td>
<td>Threatening or obscene letters or writings.</td>
</tr>
</tbody>
</table>
Attachment VI

HELP PREVENT
WORKPLACE VIOLENCE

THE STATE OF NEVADA

is committed to working with its employees to provide and maintain
a work environment free from violence, threats of violence,
harassment, intimidation, and other disruptive behavior.

Acts of workplace violence include incidents such as:
• Causing intentional physical injury
• Striking, kicking or shoving
• Intentional or reckless damage to another’s property
• Menacing behavior
• Threats to cause harm or damage that would cause a reasonable
  person to feel frightened, intimidated or harassed.

An employee who engages in an act of workplace violence is subject to disciplinary action.

If you experience or witness an act of workplace violence, immediately
report the incident to your supervisor or manager or to:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
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</thead>
<tbody>
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</table>

If you need assistance to control anger or other behaviors,
you may contact the State of Nevada Employee Assistance Program (EAP)
for information or to schedule a consultation at the following numbers:

<table>
<thead>
<tr>
<th>Northern Nevada:</th>
<th>Southern Nevada:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(775) 687-3869</td>
<td>(702) 486-2929</td>
</tr>
<tr>
<td>(800) 398-3271 (Rural Areas)</td>
<td>(800) 278-1889 (Rural Areas)</td>
</tr>
</tbody>
</table>

EAP services are confidential, free, and available to any State employee
or family member living with the employee.

DPBH 2/17
1.0 POLICY:

The Department of Public and Behavioral Health takes an active role in supporting clients' civil rights by offering them the opportunity to register to vote. DPBH facilities will remain in compliance with all Federal, State, and County laws, as well as the National Voter Registration Act (NVRA).

2.0 PURPOSE:

To ensure the civil rights of clients by offering the opportunity to register to vote and to ensure employees follow all legal requirements of this process.

3.0 SCOPE:

Division of Public and Behavioral Health – Clinical Services Branch

4.0 DEFINITIONS:

4.1 Division Facility: Per NRS 433.094 “Division Facility” means any unit or subunit operated by the Division for the care, treatment and training of consumers.

4.2 NVRA: refers to the National Voter Registration Act of 1993.

4.3 VRA refers to a Voter Registration Agency (NRS 293.504) or the act of providing voter registration opportunities at a Voter Registration Agency

4.4 DHHS NVRA Coordinator: refers to the Nevada Department of Health and Human Services National Voter Registration Act Department Coordinator.

4.5 Division Coordinator: refers to the Nevada Department of Health and Human Services National Voter Registration Act Division Coordinator.

4.6 Site Coordinator: refers to the Nevada Department of Health and Human Services National Voter Registration Act local Site Coordinator.
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

Control # Rev. Date: Title: Effective Date: 11/2016
CRR 2.4 NEW VOTER REGISTRATION POLICY Next Review Date:

4.7 Voter Preference/Notice Form: means the form required pursuant to Section 7 of the NVRA, 52 U.S.C. § 20506(a)(6)(B), that includes boxes for Public Assistance Clients to check indicating whether the applicant would like to register or declines to register to vote and/or any version of a form asking Public Assistance Clients if they would like to register to vote.

4.8 Voter Registration Form or Voter Registration Application: means the Nevada voter registration application form prescribed in NRS 293.507 and Section 9 of the NVRA, 52 U.S.C. § 20508(a)(2).

4.9 Local Election Official: means all county clerks, all city clerks or all county election departments, including the officers, agents, employees and representatives of the same.

5.0 PROCEDURE:

5.1 Triggering Events:
5.1.1 Per the NVRA requirements, the voter registration process must occur when applications for benefits is requested. All clients will be asked the question if they want to register to vote during the below “triggering event(s)”:

5.1.1.1 New Application - During the outpatient initial intake interview (completing initial paperwork);

5.1.1.2 Recertification/Renewal - If the client completes paperwork to renew services (if applicable); and

5.1.1.3 Change of Information - If a client completes paperwork, or staff on the client’s behalf change the client’s name or address.

5.2 Language:
5.2.1 All Voter Registration forms are available through State Printing and may be ordered by notifying the Secretary of State NVRA Coordinator and DHHS NVRA Coordinator when supplies are low.

5.2.2 Forms are available in both English and Spanish.

5.2.3 Clients who request Tagalog may use the English or Spanish forms;
5.2.4 Staff or client may print “TAGALOG” at the top of the form and enter their personal and contact information.
5.2.5 The form will then be routed to the local election official
5.2.6 The client will be contacted by a Tagalog speaking staff who will assist the client in completing the forms.

5.3 Signage:
5.3.1 Signage is to be posted in all client waiting rooms and main lobbies notifying clients, visitors, and staff of the availability to register to vote.
5.3.2 Signage must be in a typed font no smaller than 12 points.
5.3.3 Signage must be in English, Spanish, and Tagalog.

5.4 Division Facility:
5.4.1 Once discharge is planned, assigned staff will offer and present the option for the client to register to vote. In the event the client response is “no”, the client is still offered the voter registration form to take with them.
5.4.2 The MHT IV will forward all voter registration paperwork daily, to include the Voter Registration Inquiry forms and Voter Registration forms to the Agency’s Voter Registration Coordinator for data collection and processing.

5.5 Outpatient Clinics:
5.5.1 The Voter Registration Inquiry Form and Voter Registration Form will be handed to the client separate from admission paperwork.
5.5.1.1 If the client needs assistance, they will be referred to the Consumer Service Assistance staff or designee.
5.5.1.1.1 The administrative staff at the front desk or designee will collect all Voter Registration forms and Voter Registration Inquiry forms and turn them into the AA III or designee for data collection and processing daily.
5.5.1.1.2 The assigned staff will forward all voter registration paperwork daily, to include the Voter Registration Inquiry forms and Voter Registration forms to the Agency’s Voter Registration Coordinator for data collection and processing daily.

5.6 Training:
  5.6.1 All DHHS staff who provide voter registrations services will be required to complete voter registration training twice a year, preferable in June and December.
  5.6.2 NVRA Training is available online via NVelearn (https://nvelearn.nv.gov/moodle/)
  5.6.3 Training logs must be completed and returned to the DHHS NVRA Department Coordinator no later than the last Friday in January each year.

6.0 Confidentiality:
  6.1 No information regarding a person’s declination to register to vote will be used for any purpose other than voter registration.
  6.2 If a client does register to vote, the voter registration application will not be publicly disclosed.
6.2.1 All Voter Registration Inquiry forms will be sent daily to the Medical Records Department and kept in an “umbrella” file.

6.3 Data Reporting:

6.3.1 DPHB facilities will have an internal data reporting process maintained by the Agency’s Voter Registration Coordinator.

6.3.2 Internal data will be reported to the Secretary of State’s Office through the DHHS NVRA Coordinator.

7.0 ATTACHMENTS:

7.1 Signage (English, Spanish)

7.2 Inquiry Form (English, Spanish)

7.3 Voter Registration Form (English, Spanish)

8.0 IMPLEMENTATION OF POLICY:

8.1 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.
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Southern Nevada Adult Mental Health Services
6161 W. Charleston Boulevard
Las Vegas, Nevada 89146-1126
(702) 486-6000

Voter Registration Inquiry Form

IF YOU ARE NOT REGISTERED TO VOTE WHERE YOU LIVE NOW, WOULD YOU LIKE TO REGISTER TO VOTE HERE TODAY?

(PLEASE CHECK ONE)

☐ YES ☐ NO

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

The NATIONAL VOTER REGISTRATION ACT provides you with the opportunity to register to vote at this location. If you would like help in filling out a voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the form in private.

IMPORTANT NOTICE: Applying to register or declining to register to vote WILL NOT AFFECT the amount of assistance you will be provided by this agency.

______________________________
Print name

______________________________
Signature Date

CONFIDENTIALITY: Whether you decide to vote or not, your decision will remain confidential.

IF YOU BELIEVE SOMEONE HAS INTERFERED with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with your county election office or the Secretary of State’s office by mailing a written complaint to: SOS, Nevada State Capitol Building, 101 N. Carson St., Suite 3, Carson City NV 89701, or email to sosmail@sos.nv.gov.
New Applicant  Re-open Applicant

Change of Address  Change of Name

PLEASE MARK ALL APPLICABLE BOXES:

☐ Client marked “Yes” on the Inquiry Form.
☐ Client marked “No” on the Inquiry Form.
☐ Client failed to check either box on the Inquiry Form.
☐ Client refused to complete Inquiry Form.
☐ Client requested assistance to complete the Voter Registration Application.
☐ Client took the Voter Registration Application with them.
☐ Voter Registration Application was sent in the mail to client.
☐ Voter Registration Application completed and turned in to Agency staff.

Staff Name ___________________________ Date Stamp ______________________________

PLEASE CHECK LOCATION:

☐ W. Charleston  ☐ ELV  ☐ Laughlin  ☐ Henderson  ☐ Rawson-Neal
☐ Mesquite
Voter Registration Inquiry Form: Spanish Version

SI NO ESTÁ REGISTRADO PARA VOTAR DONDE USTED VIVE AHORA, ¿LE GUSTARÍA REGISTRARSE PARA VOTAR HOY MISMO?

(Por favor marque uno)

☐ SI ☐ NO

SI NO MARCA NINGÚN CUADRO, SE CONSIDERARÁ QUE USTED NO DESEA REGISTRARSE PARA VOTAR EN ESTE MOMENTO.

La LAY NACIONAL DE REGISTRO DE VOTANTES le ofrece la oportunidad de registrarse para votar en este establecimiento. Si desea ayuda para llenar la solicitud de registro de votante, nosotros le ayudaremos. La decisión de solicitar o utilizar la ayuda es suya. Usted puede llenar la aplicación en privado.

AVISO IMPORTANTE: La solicitud de registrarse o no para votar NO AFECTARÁ la cantidad de asistencia que le brindará esta agencia.

Imprimir Nombre

Firma                        Fecha

CONFIDENCIALIDAD: Independientemente de si decide registrarse para votar o no, su decisión se mantiene confidencial.

SI CREE QUE ALGUIEN HA INTERFERIDO con su derecho de registrarse o su decisión de no registrarse a votar, o su derecho de escoger su partido político o su preferencia política, podrá presentar una queja con la oficina del Secretario del Estado, Nevada State Capitol Building, 101 N. Carson St, Suite 3, o email to sosmail@sos.nv.gov.
☐ New Applicant  ☐ Re-open Applicant

☐ Change of Address  ☐ Change of Name

PLEASE MARK ALL APPLICABLE BOXES:

☐ Client marked “Yes” on the Inquiry Form.

☐ Client marked “No” on the Inquiry Form.

☐ Client failed to check either box on the Inquiry Form.

☐ Client refused to complete Inquiry Form.

☐ Client requested assistance to complete the Voter Registration Application

☐ Client took the Voter Registration Application with them.

☐ Voter Registration Application was sent in the mail to client.

☐ Voter Registration Application completed and turned in to Agency staff.

Staff Name ________________________________  Date Stamp ________________

PLEASE CHECK LOCATION:

☐ W. Charleston  ☐ ELV  ☐ Laughlin  ☐ Henderson  ☐ Rawson-Neal

☐ Mesquite
**MODIFICADO: SE AÑADIRÁN CAMBIOS**

**SECRETARIO DE ESTADO BARBARA K. CEGAVSKE**

**ESTADO DE NEVADA**

**SOLICITUD DE INSCRIPCIÓN PARA VOTAR**

---

**CASILLA 2 - NOMBRE**
Escribe su nombre tal como aparece en su licencia de manejar o tarjeta de Identificación de Nevada o en su tarjeta del Seguro Social, indicada en la Casilla 8. Si no tiene ninguno de estos documentos de identidad, vea las instrucciones para la Casilla 3.

**CASILLA 9 - DIRECCIÓN RESIDENCIAL**
Su dirección residencial es la dirección asignada al sitio en que realmente vive. Si vive en un lugar que no tenga una dirección asignada, tendrá que proporcionar una descripción del sitio. No debe poner un apartado postal como dirección residencial si no tiene una dirección de empresa a maneras que realmente vive allí.

**CASILLA 10 - REQUISITOS DE IDENTIFICACIÓN**
La ley federal y estatal requiere que usted proporcione el número de su licencia de manejar de NV o de su tarjeta de identificación de NV. Si no tiene ninguna de las dos, debe poner los últimos 4 números de su número de Seguro Social. Si no tiene ninguna de estos tres documentos de identidad, llame al Secretario o Registrador de su condado después de llenar y entregar este formulario.

**CASILLA 11 - INSCRIPCIÓN DE PARTIDO**
Marque su selección de un partido calificado, "No Partidario" o "Otros." Si marca "Otros," puede poner el nombre de un partido no calificado. Si se inscribe en un partido político menor como no partidario, recibirá una boleta no partidaria para la elección primaria.

---

**CASILLA 14 - AYUDA PARA LLEVAR ESTE FORMULARIO**
Si ayuda a una persona a inscribirse para votar, debe llenar la Casilla 14. EL NO hacerlo ES un delito mayor.

**FECHAS LÍMITES PARA ENTREGAR LA SOLICITUD**
- Por correo — con sello postal para el sábado, 31 días antes de una elección.
- En persona en el DMV — para el sábado, 21 días antes de una elección.
- En línea — el martes, 21 días antes de una elección.
- En persona en la oficina del Secretario o Registrador del condado — para el martes, 21 días antes de una elección (para elecciones municipales, en persona en la Secretaría Municipal).
- Elecciones especiales o de distinción — comuníquese con el Secretario o Registrador del condado.

**AVISO**
Se le exhorta a entregar su solicitud de Inscripción para votar personalmente o por correo al Secretario o Registrador del condado. Si decide den su solicitud a otra persona para que la entregue al Secretario o Registrador del condado y esa persona no la entregue al Secretario o Registrador del condado, no estará inscrito para votar. Favor de guardar la copia o recibo de su solicitud de inscripción para votar.

**LE INTERESA TRABAJAR EN LAS MESA ELECTORALES?**
Favor de llenar a la oficina de su Secretario o Registrador del condado local. Vea el reverso de esta página.
BOX 3 - NAME Please write your name exactly as it appears on the Nevada driver's license, ID card, or Social Security card referenced in Box 8. If you do not have any of these forms of identification, please see the instructions for Box 8.

BOX 4 - HOME ADDRESS Your home address is the street address assigned to the location at which you actually reside. If you reside at a location that has not been assigned a street address, a description of the location at which you actually reside must be provided. A P.O. Box cannot be listed as a home address.

BOX 5 - IDENTIFICATION REQUIREMENTS Federal and state law require you to provide your NV driver's license or NV ID number. If you do not have either, you must provide the last 4 digits of your social security number (SSN). If you do not have any of these three forms of identification, please contact your County Clerk/Registrar after you have completed and returned this form.

BOX 11 - PARTY REGISTRATION Mark your choice of a qualified party. "Nonpartisan" or "Other." If you mark "Other," you may print the name of an unlisted political party. If you register with a minor political party or as a nonpartisan, you will receive a nonpartisan ballot for the Primary Election.

☐ CHECK THIS BOX TO RECEIVE A SAMPLE BALLOT IN LARGER TYPE

USE BLACK INK — PLEASE PRINT CLEARLY

1. Are you a citizen of the United States of America? 
   Yes ☐ No ☐

2. Will you be 18 years of age or over on or before Election Day? 
   Yes ☐ No ☐

3. Last Name (Only) First Name (Only) Middle Name (Only) Jr. Sr. II III IV

4. Home Street Address (No P.O. Box/Business Address, See Instructions.) Apt. # City State Zip Code

5. Mailing Address—If different from above. (P.O. Box or Mail Service Address) Apt. # City State Zip Code

6. NV Driver's License No./NV ID Card No./Last 4 of SSN Telephone No. (Opt.) E-mail Address (Opt.)

7. Party Registration—Check Only One Box
   - Democratic Party
   - Independent American Party
   - Libertarian Party
   - Nonpartisan (no party affiliation)
   - Republican Party
   - Other Party — Write In Below

8. Place of Birth (State or Country) Birth Date (MM/YY)

9. SIGNATURE OF APPLICANT (REQUIRED) DATE (REQUIRED)

10. Your name and residence address where you were last registered to vote. (Name Used, Street, Apt. #, City, State & Zip Code of Former Residence)

11. If you are assisting a person to register to vote and you are not a field registrar appointed by a County Clerk/Registrar or an employee of a voter registration agency, you MUST complete the following. Your signature is required. Failure to do so is a felony.

Name Mailing Address City/State/Zip Code Signature

VALIDATING AGENCY USE ONLY. DO NOT WRITE IN THE SHADeD AREA BELOW.

DATE STAMP

APPLICANT NO. HZ

NAME OF PERSON RETAINING THIS APPLICATION

ELECTION OFFICIAL OR AGENCY

VOTER APPLICATION RECEIPT

(Revised 7.2015)
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 to ensure the 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 and/or restraint is not driven by diagnosis. It is driven by client assessment that indicates that a less intrusive measure poses a greater risk of harm to self or others than the risk of using seclusion and/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 and/or restraint events shall be terminated when the behaviors that necessitated the seclusion and/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 and/or restrained. This policy is designed to maximize the safety of people served, and staff 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 immobile. 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 spit hood.

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.

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.

4.1.3.2 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.

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

4.1.3.4 NRS 433.5503 states that a chemical restraint may be utilized on a person with a disability who is a client if:

4.1.3.5 The client has been diagnosed as mentally ill, as defined in NRS 433A.115, and is receiving mental health services from a facility;

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

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

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

4.1.3.8.1 The physician or psychiatrist who signed the order required pursuant to paragraph (d) immediately above examines the patient/client no later than one (1) working day immediately after the administration of the chemical restraint and;

4.1.3.8.2 The chemical restraint is administered by a person licensed to 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 patient’s medical records; or

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

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

4.2 Seclusion: Seclusion is the involuntary confinement of a patient/client in a locked room (or unlocked with employee used to prevent exit) or a specific area from which the patient/client is physically prevented from leaving. Seclusion does not include confinement on a locked unit or ward, where the patient/client
is with others. Seclusion is not just confining a patient/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 patient/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 patient’s/client’s behavior is violent or aggressive.

4.2.2 Time Out: Time out means allowing a patient/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. Patients/clients may not be forced or coerced to go to voluntary time out. Patients/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 patient/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 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 the Department of Health and Human Services, Division of Public and Behavioral Health. Forensic technicians and correctional officers employed by the Division of Public and Behavioral Health 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 patient/client or other patients that requires physical contact; a hands-on safety examination of the patient’s/client’s clothed body.

4.3 Philosophy of Care:

4.3.1 The Division of Public and Behavioral Health recognizes that seclusion and/or 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 and/or restraint will be used only when there exists an imminent risk of danger to the patient/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 and/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:

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

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

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

4.3.5.4 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 patient/client served or others.

4.3.5.5 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 emphasizes prevention strategies.

4.4.3 Training shall include:

4.4.3.1 Division and agency philosophy regarding restraint and seclusion;

4.4.3.2 Prevention strategies that will focus on assisting patients/clients to maintain control and learn safer ways to deal with difficult feelings;

4.4.3.3 Emphasis on patient/client safety during restraint and/or 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 patients/clients 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.

4.4.7 Training shall include:
4.4.7.1 Best practices and philosophy of the use of seclusion and/or restraint;
4.4.7.2 Prevention strategies that focus on assisting patients/clients to maintain;
4.4.7.3 Emphasis on safety during restraint and/or seclusion;
4.4.7.4 Development of skills and abilities to assess risk and trauma; and
4.4.7.5 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 patients/clients placed in seclusion and/or restraints, and documented accordingly.

5.0 RESTRAINT/SECLUSION FOR NON – FORENSIC PSYCHIATRIC HOSPITALS.

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

5.1.1 The dignity, privacy and safety of patients/clients will be preserved;
5.1.2 Seclusion and/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 patient’s/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 Patients/clients placed in seclusion and/or restraint will be appropriately communicated with verbally and monitored at a minimum of required intervals;
5.1.7 All seclusion and/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 Patients/clients who have been secluded and/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/or 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 and/or restraint within the timeframe agreed to by the family and to participate in the patient’s/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 (NDALC) 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 patient/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 patient/client that avoids placing physical or mechanical restraint or excessive pressure on the chest or back of the patient/client or inhibits or impedes the patient's/client's ability to breathe. In general, the patient's/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 patients/clients in a manner to minimize potential medical complications.

5.2.5 Staff plans to mitigate the potential negative impact of seclusion and/or 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 patient/client with handwashing 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/patient’s verbalization of feelings;
5.3.2.2 Verbal reassurance/redirection given to patient/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 patient/client;
5.3.2.6 Limit setting;
5.3.2.7 Time Out offered to the patient/client;
5.3.2.8 Medication offered to the patient/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 and/or restraint is necessary, a physician order is obtained. The RN notifies the physician of the patient’s/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/or 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/or Restraint Order Form and place the form in sequence in the order section of the patient’s/client’s medical record.

5.4.1.2 No application of seclusion and/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 and/or 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 patient/client may not be in restraints longer than eight (8) hours.

5.4.1.7 If continued seclusion and/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 and/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 the 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:

5.4.1.11 An assessment of the patient’s/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.

5.4.1.12 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.)

5.4.1.13 The treatment techniques attempted prior to using seclusion and/or restraint (e.g., administration of medication, counseling, quiet time). Criteria for termination of seclusion and/or restraint shall be explained to the patient/client. his shall include the behavior that will determine their readiness for release from seclusion and/or restraint.

5.4.1.14 A description of interventions implemented to assist the patient/client in marketing the release criteria.

5.3.1.15 A summary of the patient’s/client’s current physical assessment, including vital signs.

5.4.1.16 Continuation of seclusion and/or restraint is determined by need:

5.4.1.16.1 The patient/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 patient’s/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 and/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 patient/client in accomplishing the emergency behavioral plan.

5.6 Patient/client in seclusion or restraint at shift change: If a patient/client remains in seclusion and/or restraint when a nursing shift ends, the RN going off duty and the RN coming on duty must assess the patient/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 patient/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 patients/clients in seclusion and/or restraint, including the physician’s assessment of the patient/client, the clinical reason for seclusion and/or restraint order and documentation of all criteria involved.
5.9 Patient/Client and Staff Debriefing:

5.9.1 An initial staff debriefing shall occur immediately after the seclusion and/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 patient/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 patient/client.

5.9.2 If the patient/client refuses to participate in the debriefing, a licensed mental health professional shall meet separately with the patient/client following release from seclusion and/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:

5.10.1 For incidents of seclusion and/or restraint that exceed twelve (12) hours, or a patient/client that experiences more than two separate episodes of seclusion and/or restraint within a 24-hour period, agency administration and clinical leadership shall be notified within one (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 patients/clients placed in seclusion and/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 or designee will forward copies of the orders to the DPHP Administrator for review. Seclusion and/or restraint events that exceed 12-hours, or more than two separate episodes of seclusion and/or restraint within a 24-hour period will be forwarded by close of business 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/or 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 patients/clients placed in seclusion and/or restraint.
5.10.8 The DPBH Administrator or designee will review and report seclusion and/or restraint orders to the Commission on Behavioral Health.

5.10.9 The Commission on Behavioral Health will forward the seclusion and/or 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 Care Quality and Compliance any death that occurs while a client is restrained and/or in seclusion, or a death that occurs within one (1) week of a seclusion and/or restraint in which it is reasonable to assume that an patient/client death is a result of seclusion and/or restraint.

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. {22 CFR §482.13[g]}

5.11.2 Staff must document in the patient/client’s medical record the date and time that the death was reported to CMS. {22 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 clinically indicated.

5.12.1 **Prevention of restraint and/or 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 and/or restraint will focus on de-escalating the patient/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 patient/client private time to re-think his/her behavior. Patients/clients participate in time-out voluntarily; force or intimidation will not be used to initiate time-out.

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 patients/clients being served, those providing services and the facility. When the nurse, in consultation with the Forensic Specialist/Shift Supervisor or designee, determines the patient/client has gained a sufficient degree of control the patient/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 patient/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 patient/client.

5.14 **Procedures to be followed during implementation:**

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

5.14.2 Seclusion and/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 patient/client’s safety and the significant medical and behavioral risk inherent in the interventions; privileged psychiatrist 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 Patients/clients placed in seclusion and/or restraint will be appropriately communicated with verbally and monitored at a minimum of required intervals;

5.14.2.2 All seclusion and/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 staff, 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 patient/client to notify family members or their attorney if clinically 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 patients/clients to plan to avoid future events and trauma.

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 patient/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/or restraint of patients/clients.

6.0 PROCEDURE:

6.1 Restraint:

6.1.1 If restraint is used:

6.1.2 Restraint shall be implemented in a manner designed to protect the patients/clients safety, dignity and emotional well-being.

6.1.3 Restraint procedures must provide only the minimum amount of restriction necessary as a protective measure and shall only be applied until the patient/client no longer poses a danger to self or others.

6.1.4 As determined by the patient/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.

6.1.5 Usage, Tracking and Reporting:

6.1.5.1 Physical and mechanical Restraints may be used, per NRS 433.5486-433.5499 inclusive), for the following reasons:
6.1.5.2 As a last resort, for protection of the person or others in an emergency:
6.1.5.2.1 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.
6.1.5.2.2 The restrain shall be employed for only the period of time necessary for the person to become calm
6.1.5.2.3 Physical restraint may also be used to escort or carry a person to safety
6.1.5.3 Mechanical restraint may also be used to enable treatment of the medical needs of a person
6.1.6 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.
6.1.7 Mechanical supports used for the following purposes are not considered restraint and do not require the completion of Denial of Rights paperwork:
6.1.7.1 Protect a person from injury because of lack of coordination or frequent loss of consciousness, and
6.1.7.2 For the purpose of body alignment/positioning as noted in a plan of treatment.
6.1.7.3 Safety searches are to be used to prevent harm to the patient/client 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 patient/client/guardian is not considered a chemical restraint.
6.2.5 Any use of chemical restraint on a patient/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 patient/client to notify family members or their Attorney if clinically 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
REVIEWED / 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, 08/23/11
SUPERSEDES: 2.005 SECLUSION/RESTRAINTS OF INDIVIDUALS
APPROVED BY MHDS ADMINISTRATOR: 7/27/10, 08/25/11
APPROVED BY MHDS COMMISSION: 1/30/98, 09/16/11

DATE APPROVED BY DPBH ADMINISTRATOR:

DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH:
1.0 POLICY:
The Division of Public and Behavioral Health (DPBH) provides a process that supports and protects all of the rights granted to people receiving services from Division agencies through Nevada Revised Statutes chapters, 433.003, 433.456-433.536, 433A.

2.0 PURPOSE:
DPBH is committed to ensuring that DPBH staff, contract service provider staff, and consumers have all the necessary information about consumer rights. Consumer rights are an essential feature of all services and cannot be denied without due process. Division programs are expected to demonstrate knowledge of and respect for consumer rights through supportive staff interaction with consumers.

3.0 SCOPE:
Division wide including services by contract providers

4.0 REFERENCES:
4.2 DPBH Policy #2.014 Labor of Persons Receiving Services
4.3 DPBH – Clinical Services Branch HIPAA Manual 2016

5.0 PROCEDURE:
5.1 Staff Education Regarding Consumer Rights
5.1.1 Each DPBH agency employee or contract service provider staff will be apprised of this policy in orientation and educated in its implications prior to working independently with consumers. Through this education, each staff member or provider staff will be knowledgeable about the consumer rights as defined. Documentation of this training will be maintained within the agency.

5.1.2 Each employee will receive a minimum of annual training on consumer rights. Documentation of this training will be maintained within the agency.

5.2 Consumer Education Regarding Consumer Rights
5.2.1 Each consumer will be given a list, during the admission process, of the rights granted to them and a copy of the agency’s policies regarding when these rights can be suspended (NRS 433.531). The Division and/or provider agency staff member will review these rights with the consumer and/or legal representative or guardian, as appropriate, within a reasonable time following admission. This will be documented by having the consumer sign a statement that they have reviewed these rights, and being countersigned by the admitting staff (NRS 433.533).

5.2.2 A list of the rights of all consumers receiving services will be prominently posted in all agencies providing services, and all policies regarding the rights of consumers of the agency are to be prominently posted in the agency (NRS 433.531, 433.484, 433.472).

5.3 Reporting violations and Denials of Rights
All violations and denials of rights must be reported per Policy CRR-1.4 Reporting Denials of Rights (NRS 433.543, 433.5493, 433.5499, 433.5503, 433.551, and 435.350).

5.4 Consumer Rights:
  5.4.1 Dispose of property
  5.4.2 Marry
  5.4.3 Execute instruments
  5.4.4 Make Purchases
  5.4.5 Enter into contractual relationships
  5.4.6 Vote
  5.4.7 Hold a driver’s license
  5.4.8 Freedom of religion
  5.4.9 Free association

5.5 The rights of a consumer can only be denied for cause to protect the consumer’s health and safety or to protect the health and safety of others, or both (NRS 433.534, 435.350).

5.6 Right to habeas corpus unimpaired (NRS 433.464).

5.7 Rights concerning admission and discharge (NRS 433.471).
  5.7.1 Right not to be admitted to the agency under false pretenses.
  5.7.2 The right to receive a copy, upon request, of the criteria upon which the agency makes admission and discharge decisions.
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<td></td>
<td>5.8</td>
<td>Rights concerning involuntary commitment (NRS433.472):</td>
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<td>5.8.1</td>
<td>Right to request and receive a second evaluation by a psychiatrist or psychologist who does not have a financial interest in the agency.</td>
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<td>5.8.2</td>
<td>Right to receive a copy of the procedure of the agency regarding involuntary commitment and treatment.</td>
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<td>5.8.3</td>
<td>Right to receive a list of consumer rights concerning involuntary commitment or treatment.</td>
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<td>5.9</td>
<td>Personal Rights (NRS 433.482):</td>
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<td>Right to wear his/her own clothing, to keep personal possessions (unless they may be used to endanger his/her or another’s life), and to keep and spend a reasonable sum of his/her own money.</td>
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<td>5.9.2</td>
<td>Right to have access to individual space for storage for his/her private use.</td>
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<td>5.9.3</td>
<td>Right to privacy regarding the consumer’s program.</td>
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<td>Right to see visitors daily.</td>
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<td>5.9.5</td>
<td>Right to have reasonable access to a phone to make and receive confidential calls.</td>
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<td>5.9.6</td>
<td>Right to ready access to materials for writing letters, including stamps.</td>
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<td>5.9.7</td>
<td>Right to send and receive unopened correspondence (not packages). Correspondence containing checks payable to the consumer may be subject to safekeeping by the Agency Director or designee, as specified in the service plan.</td>
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<td>5.9.8</td>
<td>Right to reasonable access to an interpreter if the consumer does not speak English or is hearing impaired.</td>
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<td>5.9.9</td>
<td>Right to have information presented in a manner that meets their specific needs.</td>
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<td>5.9.10</td>
<td>Right to designate a person to be kept informed of the consumer’s condition by the agency.</td>
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<td>5.9.11</td>
<td>Right to deny access to the medical records to any person other than a member of the staff of the agency or related medical personnel, as appropriate, persons with a waiver from the consumer, and persons with a court order.</td>
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<td>5.10</td>
<td>Rights concerning care, treatment and training (NRS 433.484):</td>
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<td>5.10.1</td>
<td>Right to medical, psychosocial and rehabilitative care, and treatment and training, including prompt and appropriate medical treatment and care.</td>
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5.10.2 Before instituting a plan of care, express and informed consent must be obtained in writing from the consumer, the parent or legal guardian of a minor consumer, or the legal guardian of a consumer adjudicated incompetent.

5.10.3 Right to be free from abuse, neglect, and aversive interventions.

5.10.4 Right to consent to transfer from one agency to another.

5.10.5 Right to be respected for cultural and personal values, beliefs, and preferences.

5.10.6 Right to an individualized written plan of care that provides for the least restrictive treatment that may reasonably be expected to benefit the consumer;

5.10.7 The plan must be current and modified when indicated by the consumer’s change of circumstances, and thoroughly reviewed at least every three (3) months.

5.10.8 The plan must be developed with the input and participation of the consumer to the extent that they are able to participate.

5.10.9 The plan must designate the individual that is in charge of implementing the plan (NRS 433.494).

5.10.10 Right to participate in decisions about his/her care.

5.11 Right to information (433.504):

5.11.1 A consumer must be permitted to inspect his/her records.

5.11.2 A consumer must be informed of his/her clinical status at reasonable intervals, no longer than every three (3) months, in a manner appropriate to his/her clinical condition.

5.11.3 Consumers are entitled to a copy of their clinical records unless a psychiatrist has made a specific note to the contrary in the record or if the information is created for litigation compiled in anticipation of use in a civil, criminal, or administrative proceeding.

5.12 Medication (NRS 433.514):

5.12.1 Attending psychiatrist or physician will be responsible for all medications given to the consumer.

5.13 Labor by consumers (NRS 433.524):

5.13.1 Consumers may perform labor at Division agencies per Policy 2.014 Labor of Persons Receiving Services.

5.13.2 Consumers must voluntarily agree to perform labor.
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5.14 Right to counsel (NRS 433A.270):

5.14.1 In any proceeding before a district court related to an involuntary court ordered admission, the person alleged to have a mental illness has a right to counsel.

5.15 Right to be present and testify at hearing (NRS 433A.290):

5.15.1 In proceedings for an involuntary court ordered admission, the person has a right to be present and testify.

### 6.0 IMPLEMENTATION OF POLICY:

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

Cody Phinney
ADMINISTRATOR

EFFECTIVE DATE: 04/30/98
Supersedes: Policy 2.001 Consumer Rights
DATE APPROVED BY MHDS ADMINISTRATOR: 08/06/10, 3/15/2013
DATE APPROVED BY MHDS COMMISSION: 09/17/2010
DATE APPROVED BY DPBH ADMINISTRATOR:
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH:
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