



DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

Control #	Rev. Date:	Title:	Effective Date: 10/16
A 1.1	10/16	POLICY DEVELOPMENT AND REVIEW PROCESS	Next Review Date: 10/18

1.0 POLICY:

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

2.0 PURPOSE:

To establish a system for the development, review, approval and communication of Division policies

3.0 SCOPE: Clinical Services Branch

4.0 REFERENCES:

NRS 433.314(1) (2)

5.0 DIFINITIONS:

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



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- 5.6 Writer: Assigned by the document owner to write or collaborate in writing a document.
- 5.7 Reviewer: An individual assigned by the document owner to review a document for content accuracy and to provide input during the document development process.
- 5.8 Approver: The approver has final authority and responsibility for approving a policy for adoption by the division or agency.
- 5.9 Reader: A user assigned to read the policy. Readers have a responsibility to read policies as assigned and mark the policy as read to acknowledge that they have read and understand the contents of the policy. Policies may have short quizzes that must be completed prior to submitting "mark as read".
- 5.10 Reports: Policy Tech has the capacity to produce reports sorted by reader (employee) or document. Reports by **reader** allow a supervisor or other authority to view a list of all the documents "marked as read" by an employee. Reports by document allow management to view a list of all of the readers (employees) who have responsibility to read and acknowledge by "mark as read" that they read and understand a policy or procedure.
- 5.11 Document Control Administrator (DCA): Individuals assigned with the responsibility to manager user accounts (set user names, passwords and assign roles), upload and manage policies and procedures and create "reader groups."
- 5.12 Review Cycle: All DPBH policies, protocols and procedures will be reviewed on a reoccurring two (2) year cycle; except for Emergency Management and Specific Communicable Disease policies, which will be reviewed every one (1) year.

6.0 PROCEDURES:

- 6.1 A new policy can be initiated by a Division Agency or by the Clinical Services Statewide Policy and Procedure Manager.
- 6.2 To avoid duplication of efforts, notify the Clinical Services Statewide Policy and Procedure Manager of the intention to develop the policy, and the proposed title or subject of the policy.



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- 6.3 The Clinical Services Statewide Policy and Procedure Manager will forward the draft for next agenda to the DPBH Clinical Services Policy Committee, ensure that the policy meets all regulatory and NRS requirements, and prepare it for submission to the Deputy Attorney General and the Commission on Behavioral Health for final review and approval.
- 6.4 When the policy is related to direct client or clinical care, the policy will be submitted for review by the Statewide Medical Director for Adult Mental Health Services.
- 6.5 The Clinical Services Branch Statewide Policy and Procedure Manager will provide the initiating agency with:
- 6.5.1 Electronic copies of the format to be used (Attachment A);
- 6.5.2 Policy Review Form (Attachment B); and
- 6.5.3 Considerations for Policy Development and Review (Attachment C).
- 6.6 Development of policy content will be enhanced by an inclusive process that provides an opportunity for review and comment from the range of staff within the agencies that are affected by the policy.
- 6.7 Cited referenced must be current and five (5) years or less.
- 6.8 The draft of the policy is submitted to the Clinical Services Statewide Policy and Procedure Manager for further review, approval, and distribution process.
- 6.9 The document is to be marked "DRAFT," provided electronically in the specified format (Attachment A.). The policy originator's contact information is to be included. Do not include any dates at the conclusion of the policy; the appropriate date(s) will be added by the Clinical Services Statewide Policy and Procedure Manager.
- 6.10 The Clinical Services Statewide Policy and Procedure Manager will assign a policy number and submit the policy electronically to the DPBH Policy Committee for their opportunity for review and comment.
- 6.11 Members of the DPBH Policy Committee will share the draft policy for review with members of their constituency and will be the single voice to bring that input back to the committee.



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- 6.12 Revision recommendation for the new policy must be received by the Clinical Services Statewide Policy and Procedure Manager using “track changes” by close of business the first Wednesday of each month for prior to review at next scheduled DPBH Policy Committee meeting.
- 6.13 Upon edit, review and approval of the policy, the Clinical Services Statewide Policy and Procedure Manager will submit the draft policy to the assigned Deputy Attorney General for review and input.
- 6.14 When the policy is related to clinical care it will also be submitted to the Chief Medical Officer and Statewide Psychiatric Medical Director. In the absence of a response from the Chief Medical Officer and the Statewide Psychiatric Medical Director in seven (7) calendar days, the policy will be deemed appropriate to move forward to the Deputy Attorney General for final review.
- 6.15 Upon final review by the Deputy Attorney General, the Clinical Services Branch Deputy Director will have final review.
- 6.16 In the absence of revisions that affect intent or process, the policy will then be prepared for submission at the next DPBH Commission on Behavioral Health for final approval.
- 6.17 When there are changes that affect intent or process, the policy will be routed for re-review by the DPBH Policy Committee.
- 6.18 Upon completion of all reviews, the policy will be submitted to the DPBH Commission on Behavioral Health.
- 6.19 In the event that a policy needs to be implemented between Commission on Behavioral Health meetings, the DPBH Administrator has the authority to approve the policy on an “expedited” basis provided the policy is then reviewed by the Commission for approval at the next meeting.
- 6.20 To meet open meeting law requirements, policies must be submitted to DPBH Administration no later than three (3) weeks prior to the Commission meeting. If received after that, they will be held for the next Commission meeting.



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- 6.21 Upon approval by the Commission, the Clinical Services Statewide Policy and Procedure Manager will process the policy including ensuring that the policy is in the appropriate format, adding the approval date, and facilitating placement of the policy in Policy Tech.
- 6.21.1 To ensure communication about the new policy, the Clinical Services Statewide Policy and Procedure Manager will assign the policy to all appropriate reader's groups in Policy Tech.
- 6.21.2 It is the responsibility of each Agency Director and the DPBH Policy Committee Members to ensure that agency Policy Tech reader's groups are kept current.
- 6.22 The policy identification convention is described below;
- 6.22.1 Policies are divided into six (6) categories:
- 6.22.1.1 Consumer Rights and Responsibilities (CRR)
- 6.22.1.2 Services and Programs (SP)
- 6.22.1.3 Communicable Disease Management (CD)
- 6.22.1.4 Information Management, Records, and Technology (IMRT)
- 6.22.1.5 Human Resources (HR)
- 6.22.1.6 Administrative (A)
- 6.22.1.7 Fiscal (F)
- 6.23 The policies will be identified with the letter or letters of the appropriate category, a number to indicate the topic, and a number following a period to indicate the specific policy; the title of the policy will follow. Example: This policy, A –1.1 Policy Development and Review Process is labeled: Administrative (A), the topic (1) is policies, and after the period is the number (1) of the specific policy, which is followed by the title of the policy.

7.0 ATTACHMENTS:



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A. DPBH Clinical Services Policy Template

- 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: 11/20/06

REVIEWED / REVISED DATE: 11/13/07, 08/06/10, 10/2016

SUPERSEDES: #4.066 Policy Development and Review Process

APPROVED BY MHDS ADMINISTRATOR: 08/06/10

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

APPROVED BY THE DPBH COMMISSION ON BEHAVIORAL HEALTH: 11/2016



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

Control #	Rev.	Title:	Effective Date:
A 5.1	New	Division Level II Incident Report Management and Closure process	03/01/2018
			Next Review Date 03/01/2020

1.0 POLICY:

The Department of Public and Behavioral Health (DPBH), Clinical Services Branch monitors, tracks and evaluates all Level II Incidents.

2.0 PURPOSE:

To provide a standardized process for reviewing and closing Division Level II Incident reports.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

- 4.1 **Division Level II Incident** is a serious incident that may represent a high risk to the safety of consumers or staff or liability to the State. Such incidents are reported to the Administrator of the Division to ensure that appropriate safeguards are implemented and all level II incidents are evaluated and addressed by the Division Incident Report Committee.
- 4.2 **Patient Safety Officer** as used in this policy references NRS. 439.815 means a person who is designated pursuant to NRS 439.870.
- 4.3 **Division Incident Report Committee** is a Clinical Services Branch Committee consisting of membership of each agency's Patient Safety Officer (PSO) or Quality Assurance Specialist (QAS).
- 4.4 **Closed Chart:** A Medical Record that has been reviewed and all forms, documents and signatures are completed by clinical staff. Inpatient paper/hard copy charts are uploaded into Avatar and the paper chart is filed as a closed chart.
- 4.5 **Locked Chart:** A Medical Record both electronic and hard/paper copy are secured by Health Information Services (HIS). The Avatar record is locked and the hard/paper copy is secured separately from open or closed charts.

5.0 PROCEDURE:

- 5.1 Division Incident Report Committee meetings will be convened on a periodic Basis, approximately every two (2) months by teleconference.



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Control #	Rev.	Title:	Effective Date:
A 5.1	New	Division Level II Incident Report Management and Closure process	03/01/2018
			Next Review Date 03/01/2020

- 5.2 Prior to each meeting, PSO or QAS will be given assignments to review and report with recommendation for further review or closure of each of their assigned Level II Division incidents.
- 5.3 Incidents will not be assigned for review that are not at least three (3) months old. This will allow time for Root Cause Analysis (RCA), investigations or other necessary research to be completed.
- 5.4 Members of the Division Incident Report Committee will have access to closed and locked medical records both electronic and paper/hard copy on request. This will allow them to do the necessary research to determine the status of an open Division Level II Incident.
- 5.5 At each meeting, the PSO or QAS will report on each of their assigned incidents to include the following:
- 5.5.1 A brief summary of the incident;
 - 5.5.2 A recommendation for further review and research; or
 - 5.5.3 A recommendation to "close" the incident in Avatar.
- 5.6 After review and discussion the Committee will agree on the status of the incident approving either further research or closure.
- 5.7 Incidents not approved for closure by committee consensus will remain open for further research and committee review.
- 5.7.1 The Agency Manager or delegee will ensure that a final incident note be recorded in Avatar prior to closure of the indent.
 - 5.7.2 Level II Division Incidents may only be closed at the recommendation of this committee and by a committee member.
 - 5.7.3 Incidents not approved for closure remain on subsequent agendas until they are approved for closure.
 - 5.7.4 When incidents that remain on the agenda for more than three (3) months, the committee will work with the DPBH Deputy Administrator to resolve issues and facilitate closure.



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5.8 The PSO or QAS assigned will close each of their assigned incidents approved for closure by the committee.

5.9 The Committee will focus on identifying trends that would point to opportunities for system improvements through out the Division and make recommendations for further action or analysis.

6.0 REFERENCES:

6.1 NRS. 439.815

6.2 NRS 439.870

6.3 DPBH Clinical Services Branch CRR .014 Risk Management and Reporting Serious Incidents

7.0 ATTACHMENTS:

7.1 CRR .014 Risk Management and Reporting Serious Incidents Attachment A

8.0 IMPLEMENTATION OF POLICY:

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

EFFECTIVE DATE:

DATE APPROVED BY DPBH ADMINISTRATOR:

DATE APPROVED BY THE COMMISSION ON BEHAVIORAL HEALTH:



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

Control #	Rev.	Title	Effective Date
A 7.0	New	Travel Safety: Motor Pool, Agency Owned and Private Vehicles.	Next Review Date

1.0 POLICY:

The Division of Public and Behavioral Health (DPBH) Clinical Services Branch encourages the use of safety precautions for personnel that are engaged in automobile travel on state business.

2.0 PURPOSE:

To provide guidelines and safety tips for personnel traveling in an automobile on state business and to provide the highest possible level of safety and security.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 Personnel: All Clinical Services Branch employees and contracted staff.

5.0 REFERENCES:

- 5.1 Consumer Reports: What to Do in a Roadside Emergency, Safety should be your main concern. November 25, 2017.
- 5.2 Automotive Fleet Magazine, August 2013: What to do and not do after a Highway Breakdown.

6.0 PROCEDURE:

- 6.1 Before you leave:
 - 6.1.1 Plan and know your route
 - 6.1.2 Leave your itinerary with a trusted colleague or family member
 - 6.1.3 Make sure you have a method to communicate in an emergency; this can include a personal or state issued cell phone (with charger), a state issued satellite phone.
 - 6.1.4 Make sure you know how to operate your communication device and have contact emergency phone numbers.
 - 6.1.5 Carry a small flashlight with you.



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A 7.0	New	Travel Safety: Motor Pool, Agency Owned and Private Vehicles.	Next Review Date

6.1.6 Know your vehicle:

6.1.6.1 Before starting a trip or accepting a Motor Pool, State Agency, Rental car, or Private Vehicle walk around the vehicle and note any damage on the paper work, if possible take pictures.

6.1.6.2 Visibly check the tires to be sure they are well inflated and do not have uneven wear.

6.1.6.3 Check the odometer, a rental car with more than 25, 000 miles is considered a senior car.

6.1.6.4 Open the trunk and check for a properly inflated spare, verify that there is a jack, lug wrench and emergency reflectors.

6.1.6.5 Open the hood and check fluid levels if you know how, otherwise to a quick visual check.

6.1.6.6 Turn the car on let it warm up while you check the gas gauge and look for warning lights that might alert you to a problem.

6.1.6.7 Become familiar with the vehicle controls and signals before you leave the lot.

6.1.6.8 If you want music, figure out the radio before you leave the lot

6.1.6.9 Adjust the seat and mirrors, check window controls, windshield wipers, turn signals and lights.

6.2 Take the car for a quick spin around the lot turning, braking, and listening.

6.2.1 If you have concerns – DO NOT accept the car.

6.3 Before you leave, ask the representative who you should call in an emergency or if the car breaks down, make sure the phone numbers are on the rental agreement or in your phone.

6.4 Be sure you have the after-hours emergency contacts as well.

6.5 If your vehicle breaks down:

6.5.1 Get off the road – pull your car as far off the road as possible.

6.5.2 Call for help if you have a method of communication.

6.5.1 If your vehicle is near traffic and you can **safely** walk to another location – do it!

6.5.3 Lock the vehicle and leave a note and phone number on the windshield in case roadside assistance or the police find the car.

6.6 If your vehicle is not near traffic or a populated area – **do not leave the vehicle.**

6.6.1 Make sure your vehicle is as visible as possible:



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A 7.0	New	Travel Safety: Motor Pool, Agency Owned and Private Vehicles.	Next Review Date

- 6.6.1.1 Display a distress signal (an emergency reflector if you have one)
- 6.6.1.2 Raise the hood and tie a white cloth on it if you have one.
- 6.6.1.3 Turn on the hazard lights
- 6.6.2 If your vehicle is in a safe location, stay in the vehicle.
 - 6.6.2.1 Keep the doors locked
 - 6.6.2.2 Keep safety belts fastened.
- 6.7 Exercise caution:
 - 6.7.1 Use judgement in accepting help from strangers,
 - 6.7.2 If someone suspicious stops, lower the window enough to talk, thank them and ask them to make a call for you.

7.0 ATTACHMENTS:

8.0 IMPLEMENTATION OF POLICY:

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

EFFECTIVE DATE:

DATE APPROVED BY DPBH ADMINISTRATOR:

DATE APPROVED BY THE COMMISSION ON BEHAVIORAL HEALTH:



**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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Control #	Rev. Date:	Title:	Effective Date:
A 7.2	New	Healthcare Professional Licensing Requirement	Next Review Date:

1.0 POLICY:

To provide guidelines for insuring current licensure credentials of Clinical Health Services staff.

2.0 SCOPE: Clinical Services Branch

3.0 PURPOSE:

Health professionals, who are employed on a full-time basis, or under contractual arrangement, will comply with appropriate state and federal licensure, certification, or registration requirements. Verification of current licensure credentials will be maintained on file in the appropriate Human Resource Office for the agency.

Any person employed as a certified nursing assistant (CNA), Advanced Practice Registered Nurse (APRN), Physician Assistant (PA), Physician (M.D., D.O.) must be licensed by the appropriate state licensing board for their respective profession.

4.0 DEFINITIONS:

- 4.1 Licensure: a process by which an agency of government regulates a profession by granting an individual authority to engage in an occupation if the applicant has attained and maintains the qualifications.
- 4.2 Professional licensure: protects the public by enforcing standards that restrict practice to qualified individuals who have met specific qualifications in education, work experience, and exams.
- 4.3 Credential: a qualification, achievement, personal quality, or aspect of a person's background, typically used to indicate that they are suitable for something, a document or certificate proving a person's identity or qualifications.
- 4.4 Credentialing: the process of obtaining and reviewing documentation to determine qualifications to practice in a position that requires professional licensure or certification.
- 4.5 The documentation may include, but not be limited to, the applicant's education, training, clinical privileges, experience, licensure, accreditation, certifications,

professional liability insurance, malpractice history and professional competence.

4.5.1 Generally, the terms credentialing and re-credentialing include the review of the information and documentation collected, as well as verification that the information is accurate and complete.

5.0 REFERENCES:

5.1 NRS 433.265

5.2 NAC 284.546

5.3 NAC 632.890

6.0 PROCEDURE:

6.1 Per NRS 433.265, any person employed as a psychiatrist, psychologist, marriage and family therapist (MFT), clinical professional counselor, registered nurse (RN) or social worker (SW) must be licensed by the appropriate state licensing board for their respective profession.

6.2 Any person employed as a certified nursing assistant (CNA), Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA) must be licensed by the appropriate state licensing board for their respective profession.

6.3 Requirement to Maintain Licensure

6.3.1 All individuals applying for positions that requires professional licensure will be credentialed on hire.

6.3.2 Individuals who do not hold appropriate professional licensure will not be hired for positions requiring professional licensure.

6.3.3 Individuals holding positions which require periodic renewal of a professional license are responsible for continuing to meet renewal qualifications and providing evidence of **current** licensure to their respective agency on or before the date of expiration of their existing license.

6.3.3.1 Individuals may not practice in any professional capacity at DPBH Clinical Service Branch facilities without current licensure beyond the date of expiration of a current license.

6.3.3.2 Individuals who do not maintain professional licensure may be required to:

6.3.3.2.1 Use annual leave until their license is restored and they provide documentation to the respective personnel office.

6.3.3.2.2 In the absence of accrued annual leave the employee will remain on leave without pay status until their licensure is restored or there is a personnel action terminating employment.

6.4 Social work Interns working toward licensure as an underfill must work under professional supervision and must complete their required hours toward licensure within three (3) years.

6.5 Psychological Assistants working toward licensure as an underfill under the supervision of a Psychologist and must complete their required hours and pass licensing exams within three (3) years.

6.6 Dismissals

6.6.1 Per NAC 284.646 an appointing authority may immediately dismiss an employee for the following causes:

6.6.1.1 The suspension, revocation or cancellation (expiration) of a professional or occupational license, certificate, permit or driver's license if the possession of such professional or occupational license, certificate, permit or driver's license is a requirement of the position at the time of appointment as stated in the standards of work performance, essential functions or class specifications for the position and/or in other documentation provided to the employee at the time of appointment or is required thereafter pursuant to federal or state laws.

6.6.1.2 If an employee fails to report suspension, revocation or cancellation (expiration) of a professional or occupational license, certificate, permit or driver's license, the appointing authority may immediately dismiss the employee pursuant to NAC 284.646 or appropriate disciplinary or corrective action may be taken against the employee pursuant to NAC 284.650.

6.6.1.3 Unprofessional conduct .

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 protocols as necessary to do so effectively.

Effective Date:

Approved by Administrator:

Approved by Commission:



DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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Control #	Rev.	Title	Effective Date
A7.3	New	<u>Prevention and Control of Legionella in DPBH Facilities</u>	Next Review Date

1.0 POLICY:

It is the policy of the Department of Public and Behavioral Health (DPBH) establishes guidelines and process to address prevention and mitigation of risk from legionella exposure in DPBH Hospitals and Forensic facilities

2.0 PURPOSE:

To take precautions to protect persons occupying, working and visiting DPBH Hospitals and Forensic facilities from exposure to Legionella species that may propagate in water environments in buildings and pose a risk of disease.

3.0 SCOPE: Division of Public and Behavioral Health Facilities

4.0 DEFINITIONS:

- 4.1 **Legionella:** common aquatic bacteria occurring naturally in freshwater environments. Legionella bacteria become a concern when there are favorable conditions to colonize and grow such as institutional water systems.
- 4.2 **Legionnaire's Disease:** a serious type of pneumonia caused by bacteria, called *Legionella*, that live in water. *Legionella* can make people sick when they *inhale* contaminated water from building water systems that are not adequately maintained. Legionella will proliferate in water systems held at temperatures between 20°C and 45°C.
- 4.3 **Dead Legs:** are areas of a piping system that rarely see flow, yet are still exposed to process, even if not explicitly cut off. Dead legs are often lines closed by welded caps, flanges, or other fittings. Though they can also take the form of blanked branches, lines with normally closed block valves, lines with one end blanked, pressurized dummy support legs, stagnant control valve bypass piping, spare pump piping, level bridles, relief valve inlet and outlet header



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pipng, pump trim bypass lines, high-point vents, sample points, drains, bleeders, and instrument connections.

- 4.4 **Calorifier:** a heat exchanger which heats water indirectly by circulating over a heating coil or multiple coils. The source of heat can be water or steam, heated by an external heat source, contained within a pipe immersed in the water.

5.0 REFERENCES:

- 5.1 **CMS Ref: S&C 17-30-Hospitals/CAHs/NHs REVISED 06.09.2017**
<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-30.pdf>
- 5.2 42 CFR §482.42 for hospitals:
“The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.”
- 5.3 42 CFR §483.80 for skilled nursing facilities and nursing facilities:
“The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.”
- 5.4 42 CFR §485.635(a)(3)(vi) for critical access hospitals (CAHs):
CAH policies must include: “A system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel.”
- 5.5 Guidelines
Guideline 12—Minimizing the Risk of Legionellosis Associated with Building Water Systems, ASHRAE, Published 2000
www.techstreet.com/ashrae/products/232891 (currently under revision)



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5.6 Legionellosis Guideline: Best Practices for Control of Legionella Cooling Technology Institute, Published 2008 www.cti.org/downloads/WTP-148.pdf

5.7 ELITE Program: Centers for Disease Control and Prevention and Wisconsin State Laboratory of Hygiene wwwn.cdc.gov/ELITE/Public/EliteHome.aspx

6.0 PROCEDURE:

- 6.1 Infection Prevention and Facilities staff will work cooperatively to conduct an annual risk assessment using the CDC Toolkit.
- 6.2 A site survey of water systems will include:
 - 6.2.1 A list of all associated plant equipment such as calorifiers, boilers and pumps
 - 6.2.2 Schematics that show the configuration of the system and indicate normal operating parameters, maintenance schedules and
 - 6.2.3 Corrective action to be taken when abnormal situations occur.
- 6.3 All taps, outlets, dead legs or other associated components or associated pipework which are not used or are under-used should be removed.
- 6.4 Taps, outlets and dead legs that cannot be removed should be monitored for corrosion, isolated and drained at a minimum of every six (6) months.
- 6.5 The Facility Managers will perform semi-annual sampling of all water sources, taps, outlets, and other components or pipework inclusive of:
 - 6.5.1 Cooling Towers
 - 6.5.2 HVAC plant and ductwork
 - 6.5.3 Hot and Cold-Water Systems
 - 6.5.4 Showers and spray heads
 - 6.5.5 Water-hammer arrestors
 - 6.5.6 Pipes, valves and fittings
 - 6.5.7 Expansion tanks
 - 6.5.8 Water filters
 - 6.5.9 Faucet flow restrictors



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A7.3	New	<u>Prevention and Control of Legionella in DPBH Facilities</u>	Next Review Date

- 6.5.10 Misters, atomizers, air washers and humidifiers
- 6.5.11 Non-steam generating humidifiers
- 6.5.12 Eyewash stations
- 6.5.13 Ice machines
- 6.5.14 Dead Legs

6.6 Any facility or unit that has been closed for 30 days or more must have water systems including showerheads, Hot water tanks, water filters, faucet flow restrictors, ice machines and any other equipment connected to the water system.

6.7 The results will be reviewed by:

- 6.7.1 The Director of Laboratory Services, Infection Control and Employee Health
- 6.7.2 The Infection Preventionist
- 6.7.3 The Consultant for Communicable Disease Control (as available)
- 6.7.4 The Hospital Administrator
- 6.7.5 The Medical Director
- 6.7.6 The Director of Nursing

6.8 The action in response to Legionella counts in hot and cold-water systems:

Legionella/ Litre	Proportion of site/s positive	Action
$< 10^2$	0 – 50%	Maintain normal controls
$< 10^2$	> 50%	Review controls, consider additional measures, examine outlets in detail, retest, consider disinfection
$10^2 - 10^3$	0 – 50%	Review controls, consider additional measures, examine outlets in detail, disinfect system and retest, alert clinicians
$10^2 - 10^3$	60 – 100%	Review controls, consider additional measures, examine outlets in detail, disinfect system and retest, alert clinicians



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

Control #	Rev.	Title	Effective Date
A7.3	New	<u>Prevention and Control of Legionella in DPBH Facilities</u>	Next Review Date

> 10 ³	10 – 20%	Review controls, consider additional measures, strip down all positive outlets replacing synthetic rubber components with new and cleaning and disinfecting the other components, disinfection of the system and retest, alert clinicians
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- 6.9 Discussion regarding the interpretation and action of sampling results will be documented in a semi-annual report and maintained with the Department of Infection Prevention.

7.0 ATTACHMENTS:

- 7.1 Centers for Disease Control and Prevention, Legionella Environmental Assessment Form;
www.cdc.gov/legionella/outbreak-toolkit/

8.0 IMPLEMENTATION OF POLICY:

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

EFFECTIVE DATE:

DATE APPROVED BY DPBH ADMINISTRATOR:

DATE APPROVED BY THE COMMISSION ON BEHAVIORAL HEALTH:



DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

Control #	Rev. Date:	Title:	Effective Date: 09/1998
2.002	2/2018	Denial of Rights in Civil and Forensic Clients	Next Review Date: 2/2020

1.0 POLICY:

DPBH Clinical Services Branch ensures that the rights of clients are maintained and ensure due process and review in the event that denial of any right is proposed.

2.0 PURPOSE:

The purpose of this policy is to protect the rights and safety of consumers by ensuring that due process procedures are followed.

3.0 SCOPE: DPBH Civil and Forensic settings.

4.0 DEFINITIONS:

- 4.1 **Consent to Treatment** – Informed consent requires that the consumer has been adequately informed as to the nature of his/her condition and the nature and purposes of the proposed treatment including its reasonable risks and benefits, alternative treatment options available and the potential consequences if treatment is refused. If the consumer refuses to sign consent documents but gives verbal consent to treatment, one (1) witnesses must indicate by signature they have witnessed this statement.
- 4.2 **Medical Staff** - Medical Staff members include, physicians, advance practice registered nurses and physician's assistants who are licensed, credentialed and privileged to perform patient care duties within their scope of practice.
- 4.3 **Emergency Treatment** – Emergency treatment allows for the administration of psychotropic medication for consumers who are refusing psychotropic medication and are acting in a manner that poses an imminent danger to themselves or others, or who are suffering from an acute illness, disease or condition, if within a reasonable degree of medical certainty, delay in the initiation of emergency medical care or treatment would endanger the health of the consumer and for who a Denial of Right to Refuse Medication has been reported pursuant to NRS 433.535.4 4.

4.3.1 The Administration of psychotropic drugs under these circumstances shall not extend beyond a period of an emergency without the consumers consent or the meeting of the committee and administrative review as detailed in this policy.

5.0 REFERENCES:

- 5.1 DPBH Policy CRR 1.1
- 5.2 DPBH Policy CRR 1.2 Prohibition or Abuse and Neglect and Reporting Requirements
- 5.3 DPBH Policy SP 3.1 Involuntary Administration of Medications in Civil Clients
- 5.4 NRS 433A.115 – 433A.490
- 5.5 NRS 433.94
- 5.6 NRS 433.454
- 5.7 NRS 433.531

6.0 PROCEDURE:

- 6.1 The rights of a consumer must not be denied except to protect the consumer's health and safety or the health and safety of others.
- 6.2 Any staff member who witnesses a violation of a consumer's rights by another staff member, must report that violation to the Agency Director and complete a Serious Incident Report by the end of their shift.
- 6.3 Any denial of rights in any DPBH civil facility must be entered into the consumer's record of treatment.
- 6.4 A notice of the denial of rights must be forwarded to the facility's Administrative Officer.
- 6.5 Failure to report a Denial of Rights may be grounds for dismissal.
- 6.6 Recommendation for Denial of Rights:
 - 6.6.1 The treating medical staff must determine that the consumer suffers from a mental illness and is gravely disabled, or poses a likelihood of serious harm to himself or others, requiring treatment.
 - 6.6.2 The treating medical staff must explain to the consumer the purpose, risks and benefits of proposed treatment including alternative treatments, and the potential consequences if treatment is refused.
 - 6.6.3 The consumer then provides written informed consent to treatment.
 - 6.6.4 This process shall be reflected in the consumer's medical record.
- 6.7 Determination of the need for involuntary treatment:

- 6.7.1 If the consumer refuses treatment or if the medical staff determines to a reasonable degree of medical certainty that the consumer lacks capacity to understand and appreciate the nature of his/her condition and the nature of proposed treatment a denial of rights process will be initiated.
- 6.7.2 The Report of Denial of Rights for Persons with Mental Illness form must be completed by the attending medical staff.
- 6.7.3 The denial of rights form must be forwarded to the Medical Director and Administrator/Designee for approval.
- 6.7.4 If the Denial of Rights episode includes the need for involuntary administration of medication refer to DPBH policy SP 3.1 for process and documentation specific to involuntary administration of medication forms.
- 6.7.5 Persons that receive outpatient, community-based services also have rights that may include the right:
 - 6.7.5.1 To be treated with consideration and respect for personal dignity, autonomy, and privacy,
 - 6.7.5.2 To have the opportunity to consult with an independent treatment specialist or legal counsel, at one's own expense,
 - 6.7.5.3 To confidentiality of communications and of all personal identification information within the limitation and requirements for disclosure of various funding and/or certifying sources, state or federal statutes, unless release of information is specifically authorized,
 - 6.7.5.4 To one's own psychiatric, medical or other treatment records, unless access to particular identified item of information is specifically restricted for clear treatment reasons (severe emotional damage),
 - 6.7.5.5 To be informed in advance of the reasons(s) for discontinuance of service provision, and to be involved in planning for the consequences,
 - 6.7.5.6 To not be discriminated against in the provision of services on the basis or religion, race, color, creed, gender, national origin, age, lifestyle, physical or mental handicap, developmental disability, or inability to pay,
 - 6.7.5.7 To know the cost of services,
 - 6.7.5.8 To be fully informed of all rights and to exercise any/all rights without reprisal in any form, including continued and

- uncompromised access to service.
- 6.7.6 To be free from mental and physical abuse,
 - 6.7.7 To file a grievance and to have oral and written instructions for filling a grievance,
 - 6.7.8 Besides rights that are provided without limitation (habeas corpus admission/discharge, involuntary commitment, care/treatment/training, individualized plan of services).
 - 6.7.9 each person served has personal rights that include (and must be posted in all inpatient facilities), but are not limited to:
 - 6.7.9.1 To wear his/her own clothing, keep and use his/her own possessions and keep and be allowed to spend a reasonable sum of his/her own money.
 - 6.7.9.2 Access to individual space for storage for his/her private use.
 - 6.7.9.3 See visitors each day.
 - 6.7.9.4 Have reasonable access to telephones, both to make and receive confidential calls.
 - 6.7.9.5 Access to materials for writing letters, including stamps, and to mail and receive unopened correspondence (not including packages or checks subject to safekeeping by the administrative office – please see NRS 433.482).
 - 6.7.9.6 Have Reasonable access to an interpreter if the client does not speak English or is hearing impaired.
 - 6.7.9.7 Designate a person who must be kept informed by the facility of the clients medical and mental condition (Release of Information required).
 - 6.7.9.8 Access to his/her medical records denied to any person other than:
 - 6.7.9.8.1 Member of the staff of the facility or related medical personnel.
 - 6.7.9.8.2 Person who obtains a waiver by the client of his/her right to keep the medical records confidential.
 - 6.7.9.8.3 Person who obtains a court order authorizing access.
 - 6.7.10 Other personal rights as specified by regulation of the commission.
 - 6.7.11 There are also specific rights related to care and treatment. These rights must also be provided to each person served and posted at each facility and include the right to:
 - 6.7.10.1 Receive service in a humane setting which is the least restrictive feasible as defined in the treatment plan;
 - 6.7.10.2 To be informed of one's own condition, of proposed or current services;

- 6.7.10.3 Treatment or therapy, and to be informed of the alternatives;
- 6.7.10.4 To consent to or refusal of any service, treatment or therapy upon full explanation of the expected consequences of such consent or refusal;
- 6.7.10.5 To a current, written, individualized service/treatment plan that addressed one's own mental health, physical health, social and economic needs, and that specifies that provision of appropriate and adequate services, as available, either directly or by refusal;
- 6.7.10.6 To active and informed participation in the prompt establishment, periodic review, and reassessment of the service/treatment plan;
- 6.7.10.7 To freedom from unnecessary or excessive medication;
- 6.7.10.8 To refuse proposed treatment or withdraw consent, in writing, at any time;
- 6.7.10.9 To a safe treatment environment which provides one with reasonable protection from harm;
- 6.7.10.10 To participate in any appropriate and available agency services, regardless of refusal of other service(s) unless there is a valid and specific necessity which precludes and/or requires the participation in other services.
- 6.7.10.11 To be informed of any unusual or hazardous treatment procedures.
- 6.7.10.12 To be advised of and refuse observation by techniques such as one-way vision mirrors, tape records, television, movies, or photographs or have students involved in their care.
- 6.7.10.13 To receive an explanation of the reasons for denial of service(s) or rights.
- 6.7.12 When a client is denied their rights as stipulated in NRS and Division policy, an appropriate Denial of Rights form must be sent to the Division of Public and Behavioral Health Administrator (or designee) and will be forwarded on to the Commission on Behavioral Health for review and approval.
- 6.7.13 When it is necessary (e.g., safety, treatment, etc.) for a staff member to deny a client their rights, an appropriate Denial of Rights form must be completed and sent to the Division Administrator.
- 6.7.14 Each Division agency shall develop and maintain a database to capture each occurrence of a denial of rights. Information from the database shall be sent to the Division Central Office Program and Evaluation Unit on a quarterly basis and include:

6.7.14.1 Name of Agency

6.7.14.2 Date of Report

6.7.14.3 Client Name

6.7.14.4 Client Age

6.7.14.5 Reporting Staff

6.7.14.6 Denial of Rights

6.7.15 When a possible violation of a person's rights is inflicted by a staff member that violation must be reported immediately, by whomever witnessed or received the report of said violation, to their immediate supervisor who will then notify the agency director (or designee). Failure to do so may be grounds for dismissal (NRS 435.350).

6.7.16 Upon such notification of a possible violation of a client's rights by a staff member, the agency director will immediately implement the provisions of Division Policy CRR 1.2 - Abuse and Neglect of Clients.

6.7.17 Retrievable records of all grievances and complaints made by clients will be maintained at each agency.

6.7.18 Each agency shall forward a complete and appropriate Denial of Rights form to the Division Administrator (or designee) within seven (7) working days of the generation of the form.

6.7.19 For those persons in long-term restraints, a Denial of Rights form will be completed every 90 days, from the date of the doctor's order, and forwarded to the Division Administrator (or designee).

6.7.20 The Division Administrator (or designee) shall review the form for appropriateness of action taken and forward the form to the Commission for its review and approval.

6.7.21 Either the Division Administrator or the Commission may return the forms to the agency director for clarification, review, or investigation of the denial of rights if there is questions regarding entries on the form and/or the appropriateness of the action taken in denying the client's rights.

6.7.22 When the Commission has reviewed the Denial of Rights, the Chairman of the Commission (or designee) shall complete the STATEMENT OF DENIAL OF RIGHTS REVIEW and return a copy of the form to the agency director originating the report for his/her information/action.

6.7.23 Should either the Division Administrator or the Commission request further information regarding the denial or an investigation of the denial, the agency director shall provide, or cause to be provided, additional information or investigate, or cause to be investigated, the

denial and provide requested action within one (1) week of receiving the request.

7.0 ATTACHMENTS:

- 7.1 The Report of Denial of Rights for Persons with Mental Illness Form
- 7.2 Rationale for seclusion and/or restraint (MR 191)
- 7.3 Report of Denial of Rights for Persons with Mental Illness
- 7.4 Commission's Statement of Denial of Rights Review

8.0 IMPLEMENTATION OF POLICY:

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

Effective Date: 4/30/98

Date Revised: 2/04/99, 5/17/00, 9/28/01, 2/7/02

MHDS Commission Approval: 2/8/02

DBH Commission on Behavioral Health Approval:

Attachments (4):



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

Control #	Rev.	Title:	Effective Date
CRR 1.2	New	Health Care and Psychiatric Advance Directives	
			Next Review Date

1.0 POLICY:

It is the policy of the Division of Public and Behavioral Health (DPBH) to preserve client autonomy and dignity by maintaining the client's legal and ethical rights to make decisions regarding treatment as defined by the Patient Self Determination Act of 1990.

2.0 PURPOSE:

This process establishes a guidelines for DPBH facilities to use in establishing protocols for informing and assiting clients who wish to make Advance Health Care or Psychiatric Health Care Directives.

3.0 SCOPE: DPBH Statewide

4.0 DEFINITIONS:

- 4.1 Advance Directive is a written executed document that expresses a client's wishes in advance about what types of healthcare treatments, services or other assistance they might want in a health care crisis.
- 4.2 Psychiatric Advance Directive (PAD) for mental health care means a written executed document in which a competent client makes a declaration of instructions, information and preferences regarding acceptance or refusal of particular types of mental health treatment and intervention during a future mental health crisis and or to appoint a proxy decision maker to carry out their wishes.
- 4.3 The Patient Self Determination Act (PSDA) is a federal law that ensures a client's right to self-determination in healthcare decisions is both communicated and protected. PSDA applies equally to psychiatric and general health care facilities.



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

Control #	Rev.	Title:	Effective Date
CRR 1.2	New	Health Care and Psychiatric Advance Directives	
			Next Review Date

4.4 Durable Power of Attorney for Health Care: a document delegating authority to an agent to make health care decisions in case the individual delegating that authority subsequently becomes incapacitated.

4.5 Living Will: a document allowing a person to state in advance his/her wishes regarding life sustaining treatment if they has a terminal condition and are unable to make decisions at that time.

4.6 Attending physician has the meaning ascribed to it in NRS 449.550.

4.7 Principal means the person who has executed an advance directive for psychiatric care.

4.7.1 A person of sound mind and 18 or more years of age and all persons who have been declared emancipated pursuant to NRS 129.080 to 129.140 may execute at any time an advance directive for health care and psychiatric care.

4.7.2 The principal may designate another natural person of sound mind and 18 or more years of age to make decisions governing the provision of health care and psychiatric care.

4.7.3 The advance directive must be signed by the principal, or another at the principal's direction, and attested by two witnesses.

4.8 Provider of health care has the meaning ascribed to it in NRS 449.581.

4.9 Psychiatric care means the provision of psychiatric services and psychiatric treatment and the administration of psychotropic medication.

4.10 A person of sound mind who is 18 or more years of age or who has been Declared emancipated pursuant to NRS 129.080 to 129.140, inclusive, may execute at anytime an advance directive for general health care and psychiatric care.

4.11 The principal may designate another natural person of sound mind and 18 or more years of age to make decisions governing the provision of psychiatric care.

4.12 The advance directive must be signed by the principal, or another at the principal's direction, and attested by two witnesses.

4.12.1 Neither of the witnesses may be:



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

Control #	Rev.	Title:	Effective Date
CRR 1.2	New	Health Care and Psychiatric Advance Directives	
			Next Review Date

- 4.12.1.1 The attending physician or provider of health care;
- 4.12.1.2 An employee of the attending physician or provider of health care;
- 4.12.1.3 An owner or operator of a medical facility in which the principal is a patient or resident or an employer of such an owner or operator; or
- 4.12.1.4 A person appointed as an attorney-in-fact by the advance Directive

5.0 REFERENCES:

- 5.1 Patient Self Determination Act (PSDA)
- 5.2 National Resource Center on Psychiatric Advance Directives

6.0 PROCEDURE:

- 6.1 On admission to any DPBH facility clients will be asked if they have Advance Health Care or Psychiatric Advance Directives.
 - 6.1.1 Clients will be informed that under state law they have the right to make decisions concerning their own health care and psychiatric health care, including the right to accept or refuse treatment and the right to formulate advance directives;
 - 6.1.2 Psychiatric Advance health Care Directives become effective on execution and expire two years from that date.
- 6.2 Staff must document in the patient's current medical record whether or not the patient has an Advance Health care or Psychiatric Health Care directive; if the client states that they do have Health Care or Psychiatric Health Care Directives but do not have a copy, notify the Social Work Department.
 - 6.2.1 The Social Work Department will work to secure a copy of the Advance Directive for Health Care and /or Psychiatric care within three (3) working days.
- 6.3 Clients must be informed of their rights in writing, including the right to prepare advance health care and psychiatric health care directives.
- 6.4 Provide education for staff on issues concerning advance health care and psychiatric health care directives (United States Code, 2000).



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

Control #	Rev.	Title:	Effective Date
CRR 1.2	New	Health Care and Psychiatric Advance Directives	
			Next Review Date

- 6.5 Advance Directives do not relieve healthcare providers and facilities of their responsibility to treat patients according to the appropriate standard of care.
- 6.6 Healthcare providers and facilities cannot use their obligation to treat patients appropriately as an excuse to override advance directives.

7.0 ATTACHMENTS:

8.0 IMPLEMENTATION OF POLICY:

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

EFFECTIVE DATE:

DATE APPROVED BY DPBH ADMINISTRATOR:

DATE APPROVED BY THE COMMISSION ON BEHAVIORAL HEALTH:



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

Control #	Rev. Date:	Title:	Effective Date: 04/1998
CRR 1.7	03/2013	Trust Fund Management for Consumers in Residential Placements	Next Review Date:

1.0 POLICY:

The Division of Public and Behavioral Health (DPBH) will establish a trust account for all consumers in division funded residential placements for consumers who have any outside income, if the division is payee for any benefits, or if the division or division funded residential placement receives any funds on behalf of the consumer. Trust funds may be established for other consumers as deemed necessary to assist the consumer in the management of funds.

2.0 PURPOSE:

To ensure proper fiscal management of consumer funds.

SCOPE: Clinical Services Branch

3.0 DEFINITIONS: N/A

4.0 REFERERNCES:

N/A

5.0 PROCEDURE:

- 5.1 Any income received by the division on behalf of a consumer must be deposited in the consumer's trust fund prior to any expenditure of funds on behalf of that consumer. No check or cash will be given directly to the consumer, his/her guardian, or paid on account without first being deposited in the consumer's trust fund.
- 5.2 Trust fund deposits and withdrawals must be clearly documented using:
 - 5.2.1 Receipt forms that have been numerically sequenced;
 - 5.2.2 All numbers accounted for, including spoiled or voided receipts;
 - 5.2.3 Adequate explanation must be made on all voided receipts and verified by a person not responsible for the voiding;
 - 5.2.4 Deposits must be reconciled to the receipt; and
 - 5.2.5 Receipts must be written when currency and/or coin are received by mail.



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

Control #	Rev. Date:	Title:	Effective Date: 04/1998
CRR 1.7	03/2013	Trust Fund Management for Consumers in Residential Placements	Next Review Date:

- 5.3 All sales receipts to support purchase from consumer trust accounts must be retained.
- 5.4 Consumers, parents or legal guardians must be notified in advance and written acknowledgement obtained whenever money is taken from a trust account. If the State is the consumer's payee for benefits, then no consumer authorization is required.
- 5.5 Rent and utilities paid from a trust fund separately from the amount specified in a provider contract must be clearly documented.
- 5.6 When a consumer is on a waiver, a monthly report on waiver consumers' trust accounts is required to include:
- 5.6.1 Waiver consumer's name;
 - 5.6.2 Deposits to trust account;
 - 5.6.3 Source of deposit (SSI, SSA, etc.); and
 - 5.6.4 Expenditures from trust account, amount, and purpose
- 5.7 Case managers must monitor trust account balances of \$1600 or more. The case manager shall review the needs of the consumer to ensure they are being met. If a trust account exceeds \$2,000, SSI and Medicaid waiver benefits are no longer available to that consumer for the time his/her account exceeds \$2,000.
- 5.8 Consumers receiving services under the Community and Home Based Waiver may be billed for the following services from their trust account:
- 5.8.1 Expenditures for room and board;
 - 5.8.2 Personal and incidental expenses; and
 - 5.8.3 Expenditures for services not covered by the Medicaid waiver (rent, utilities, special transportation paid from RFP budget, but not otherwise reimbursed).
- 5.9 All agencies will review their consumers' trust fund accounts to determine whether their balances would merit placement in an interest-bearing commercial account. If this is the case, these trust fund accounts will be transferred to an interest-bearing account. These accounts will be treated as a savings account, with earned interest deposited back into each respective consumer's account.



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

Control #	Rev. Date:	Title:	Effective Date: 04/1998
CRR 1.7	03/2013	Trust Fund Management for Consumers in Residential Placements	Next Review Date:

6.0 ATTACHMENTS:
N/A

7.0 IMPLEMENTATION OF POLICY:

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

Effective Date:

Date Revised:

Date Approved by DPBH Commission:



DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

Control #	Rev.	Title	Effective Date
FS 3.0	New	Nevada Disability Advocacy Law Center (NDALC) Visitation in Forensic Facilities	Review Date

1.0 POLICY:

Forensic Facilities establish reasonable guidelines for allowing the Nevada Disability Advocacy Law Center (NDALC) to interact with clients placed in secure residential units and to access medical records.

2.0 PURPOSE

To balance the needs of NDALC to carry out its' duties with the needs of the facility to provide efficient administration of programs and optimal treatment to its' residential clients.

3.0 SCOPE This policy applies to forensic inpatient settings within DPBH.

4.0 DEFINITIONS

Forensic Facility – A secure facility of the Division of Public and Behavioral Health of the Department of Health and Human Services for offenders and defendants with mental disorders.

NDALC – Nevada Disability Advocacy Law Center

Forensic Client – A client who is committed by the court for evaluation and/or restoration to competency for trial. Update definition

5.0 REFERENCES: N/A

6.0 PROCEDURE

6.1 NDALC access to clients and agency facilities:

6.1.1 NDALC staff may see clients and visit the agency during the following hours;

6.1.1.1 Lakes Crossing Center: 9:00 to 11:00 am, 6:00 to 8:00 pm Monday through Sunday.

6.1.1.2 Stein Hospital/C-Pod: 9:00 to 11:00 am, 6:00 to 8:00 pm Monday through Sunday.



DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

Control #	Rev.	Title	Effective Date
FS 3.0	New	Nevada Disability Advocacy Law Center (NDALC) Visitation in Forensic Facilities	Review Date

1. Exceptions to the above hours shall be made only for emergency situations and shall require notice to the agency administrator or his/her designee by NDALC staff. Emergency situations include the investigation of abuse and neglect as defined by Nevada Statutes and any situation that involves the imminent danger to the health and welfare of a client.
2. When visiting the facility or conversing with clients via mail or telephone, NDALC staff members shall not interfere with ongoing therapeutic activities and shall refrain from giving therapeutic advice to clients in regard to taking prescribed medications or cooperating with treatment.
3. Because residential clients are all in custody, no passes may be granted for NDALC to take clients out of the facility.
4. Notification of Presence on the Unit:
 - A. Prior to entering a forensic residential unit, NDALC staff shall notify the agency administrator or his/her designee.
5. NDALC access to buildings and other areas:
 - A. Under no circumstances shall agency staff give NDALC staff keys to any agency buildings.
 - B. NDALC staff will gain access to the unit by being admitted by agency staff.
 - C. NDALC staff are not allowed in the nurse's stations.
6. Access to Records:
 - A. Health Information Management
 - i. All requests for copies of client records must be made to the agency Health Information Department.
 - ii. All records shall be reviewed in the presence of Health Information staff and respective Treatment Team Leaders or their clinical designee.
 1. A release of information that follows the Division policy for releases shall be presented to the Agency Director executed by director of NDALC certifying that there is probable cause to believe and setting out the basis for his/her belief, that the individual subject to NDALC's services has been the victim of abuse or neglect as defined by NRS 433.554.
 - B. Records other than medical:
 - i. Requests for any documentation, other than medical, by NDALC staff shall be handled by the Agency Director or designee.



DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

Control #	Rev.	Title	Effective Date
FS 3.0	New	Nevada Disability Advocacy Law Center (NDALC) Visitation in Forensic Facilities	Review Date

- ii. If any agency staff other than the Agency Director receives a request for such information, it shall be referred to the Agency Director or designee.
 - iii. Reports prepared for purposes of quality assurance, denials of rights, and incident reports (sentinel events), shall not be available to NDALC staff.
7. Client Access to NDALC:
- A. The agency shall not impede any of its clients from having regular and frequent access on their living units to NDALC staff for the purpose of obtaining information on legal rights and self-advocacy during the hours noted in Section 1 of this policy.
 - B. All residents shall have access to a telephone to call NDALC by making a local, toll-free or collect call without monitoring by, or permission from agency staff.
 - C. Agency shall post NDALC's rights poster with the telephone numbers in a conspicuous place in its facility.
8. NDALC Investigations
- A. Agency shall cooperate with any investigations of abuse and neglect by NDALC staff.
 - B. When conducting an investigation of abuse or neglect of a client, NDALC staff shall be allowed to interview witnesses, inspect the premises and review individual records pertinent to the investigations.
9. Protection and Retaliation:
- A. There shall be no retaliation against any individual for having filed a complaint with, or provided information to, NDALC or an NDALC representative.
10. Comments and Concerns:
- A. NDALC staff shall refrain from commenting to any agency staff other than the Agency Director or designee on such matters that pertain to medical treatment, staffing levels, and the conduct of agency staff.
 - B. Agency staff shall bring any concerns they may have about the conduct of NDALC staff and/or violations of this policy to the attention of their own supervisors, who will transmit the information through the agency chain of command to the appropriate Agency Director or designee.



DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

Control #	Rev.	Title	Effective Date
FS 3.0	New	Nevada Disability Advocacy Law Center (NDALC) Visitation in Forensic Facilities	Review Date

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY:

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

EFFECTIVE DATE:

DATE APPROVED BY DPBH ADMINISTRATOR:

DATE APPROVED BY THE COMMISSION ON BEHAVIORAL HEALTH:



DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

Control #	Rev.	Title	Effective Date
FS 3.0	New	Nevada Disability Advocacy Law Center (NDALC) Visitation in Forensic Facilities	Review Date



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

Control #	Rev.	Title	Effective Date:
	New	Employee use of Personal Adaptive Equipment in Client Care Areas	Next Review Date:

1.0 POLICY:

DPBH is committed to providing an accessible work environment for employees while maintaining safety for both employees and clients.

2.0 PURPOSE:

To provide guidance regarding employee use of Personal Assistive Devices (PAD) in Clinical Services Branch Facilities.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

- 4.1 Essential job functions are the fundamental duties of a position: the things a person holding the job absolutely must be able to do. Essential job functions are used to determine the rights of an employee with a disability under the Americans with Disabilities Act (ADA).
- 4.2 Mobility Impairment: refers to the inability of a person to use one or more of his/her extremities, or a lack of strength to walk, grasp, or lift objects also defined as the state in which an individual has a limitation in independent, purposeful physical movement of the body or of one or more extremities.
- 4.3 Personal Assistive Devices: are products used either temporarily or permanently to assist persons with disabilities. PADs include a wide range of products such as wheelchairs, walkers, scooters (manual or electric), white canes, oxygen tanks, orthopedic assistive devices such as; boots, slings, braces, casts, boots or other products not listed here.
- 4.4 Return to work light-duty programs include temporary light-duty, limited-duty or modified-duty assignments.



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- 4.5 Light duty: typically involves excusing an employee from performing certain tasks that he or she would normally perform.
- 4.6 Limited duty reduces the number of hours an employee normally works in a day.
- 4.7 Modified duty eliminate some tasks and replace them with others more suitable for the employee's physical limitations in the employee's normal position.
- 4.8 Release to Work can be a written or typed note signed by the employee's healthcare provider on the provider's letterhead, outlining when the employee can return to work and with what restrictions, if any. his or her job duties or what limitations pose a threat to the safety of the employee or others.
- 4.9 Family and Medical Leave Act (FMLA) generally requires an employee to be restored to his or her former position upon return, restoration is not necessarily required under the FMLA if the employee is physically unable to perform the essential functions of his or her position.
- 4.9.1 Under FMLA, an employer also is not required to create a new position simply to accommodate the employee's need for light duty. As FMLA regulation 825.215, paragraph (c) states: If the employee is unable to perform an essential function of the position because of a physical or mental condition, including the continuation of a serious health condition or an injury or illness also covered by workers' compensation, the employee has no right to restoration to another position under the FMLA.
- 4.9.2 The employer's obligations may, however, be governed by the Americans with Disabilities Act (ADA), as amended.
- 4.9.3 Light duty should not be confused with a reduced or intermittent leave schedule.

5.0 REFERENCES:

- 5.1. Society for Human Resource Management (2015 May) How to Create a Return to Work Light Duty Program. Retrieved from www.shrm.org
- 5.2 State of Nevada ; Employee Handbook; Department of Administration, Division of Human Resource Management.
- 5.3 NAC 284.6014-284.6019



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6.0 PROCEDURE:

- 6.1 Early Return to Work Program
 - 6.1.1 The supervisor evaluates the information on the Physical Assessment form and determines if a light duty assignment is necessary.
 - 6.1.2 If the employee will not be performing their regular job duties, the supervisor shall contact the agency HR office to coordinate an early return to work program.
 - 6.1.3 Supervisors will follow procedures identified in the State of Nevada Early Return to Work program guidelines prepared by the Risk Management Division. Guidelines for supervisors are available in the agency personnel office.
 - 6.1.4 Supervisors will continue to code timesheets using appropriate codes.
 - 6.1.5 If an employee has been taken off work and/or if a modified duty assignment is not available, HR and the supervisor shall continue to communicate with the employee on a regular basis and initiate return to work efforts in collaboration with the agency HR office.
- 6.2 Modified Duty
 - 6.2.1 When a supervisor is notified of the need for modified duty, the supervisor must notify HR
 - 6.2.1.1 The supervisor is responsible for providing all worker's comp paperwork to HR.
 - 6.2.1.2 The employee must provide copies of all doctor visits to HR as soon as possible.
 - 6.2.2 HR will send a confirmation email to all parties (dept. heads, supervisors, staffing, temp supervisor and the employee), outlining the assignment and any restrictions and modified light duty requirements.
- 6.3 Responsibilities
 - 6.3.1 Employees
 - 6.3.1.1 Ensure client and staff safety and promote a safe working environment.
 - 6.3.1.2 Follow established safety rules and policies for job/work location.
 - 6.3.1.3 Report all work-incurred injuries, accidents or illness whether directly involved or witnessed, to their supervisor immediately.
 - 6.3.1.4 Employees must accurately report and correctly code any work related absences in their NEATS timesheet.



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6.3.1.5 Cooperate with the intent and requirements of the Early Return to Work Program.

6.3.1.6 Follow up with the healthcare provider as needed and forward paperwork to the supervisor and or the HR Worker's Comp. Liaison.

6.3.2 Supervisors

6.3.2.1 Ensure client and staff safety and maintain a safe work environment.

6.3.2.2 Follow established safety rules and policies for job/work location.

6.3.2.3 Provide information and guidance to employees regarding safety rules and injury reporting procedures,

6.3.2.4 Report all work-incurred injuries, accidents or illness whether directly involved or witnessed, to their supervisor immediately.

6.3.3. Release to return to work

6.3.3.1 When an employee is released to work with retriCTION that will not allow them to perform the essential functions of their position, HR will determine whether reasonable accommodation can be made.

6.3.3.2 If reasonable accommodation cannot be made, every effort will be made to place the employee in a vacant position for which they are qualified and which accommodates the stated work conditions.

6.3.3.3 Employees may be reemployed into a position that they qualify for and their restrictions DO NOT preclude them from performing the essential functions of the job.

6.3.3.4 Employees may be reemployed at or below their pre-injury position grade level. (NAC 284.6014-284.6019)

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY:

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

EFFECTIVE DATE:

DATE APPROVED BY DPBH ADMINISTRATOR:

DATE APPROVED BY THE COMMISSION ON BEHAVIORAL HEALTH:



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Control #	Rev. Date:	Title:	Effective Date: 11/2013
SP 1.16		Mental Health Court Program	Next Review Date:

1.0 POLICY:

The Division of Public and Behavioral Health Clinical Services Branch collaborates with the criminal justice system through the Specialty Courts known as Mental Health Court; the State Department of Parole and Probation, Public Defender, and community service providers.

The Division coordinates a Mental Health Court Program to facilitate assessment, treatment, and monitoring of persons over whom the court has jurisdiction and who the court has determined suffers from a mental illness as defined in NRS 178.3986. This program provides opportunity for people with misdemeanor and minor felony criminal charges who would benefit from psychiatric/behavioral health treatment.

2.0 PURPOSE:

The Mental Health Court (MHC) Program is a specialized court docket, which employs a problem-solving approach, rather than the traditional court procedures for defendants with mental illnesses, to promote engagement in treatment, improve quality of life, decrease recidivism, and increase community safety. The Mental Health Court Program (MHC) provides alternatives to incarceration under ongoing judicial supervision and pertains to district courts.

Mental Health Court adheres to nationally accepted principles of specialty courts. These principles include voluntary participation, early intervention, establishing relationships with treatment providers, involvement in a judge-centered court, respect for public safety, emphasizing client accountability through close monitoring, and commitment to a dedicated team approach.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

- 4.1 Mental disorder” defined. NRS 178.3985 Mental disorder” means a mental illness that results from a psychiatric or neurological disorder that so substantially impairs the mental or emotional functioning of the person as to make care or treatment necessary or advisable for the welfare of the person or for the safety of the person or property of another and includes, without limitation, intellectual disabilities and related conditions. (Added to NRS by 2007, 1424, 1777; A 2013, 689)



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- 4.2 Person with mental illness” defined per NRS 178.3986 - Person with mental illness means a person who has a mental disorder (Added to NRS by 2007, 1424)
- 4.3 Client: Any person over whom the court has jurisdiction and who the court has determined suffers from mental illness.
- 4.4 SNAMHS – Southern Nevada Adult Mental Health Services.
- 4.5 NNAMHS – Northern Nevada Adult Mental Health Services.
- 4.6 RNBHC – Rural Nevada Behavioral Health Centers.

5.0 REFERERNCES:

NRS 178.3986

6.0 PROCEDURE:

- 6.1 This policy follows the service coordination model with caseload size of one (1) psychiatric case worker to 25 client ratio. This ratio ensures that clients obtain benefits; comply with court ordered treatment, medication management, and substance abuse recovery.
- 6.2 Admission: Clients needing Mental Health Court supervision will be identified by a variety of referral sources including: Public Defender, Municipal or Justice Court, other Specialty Court, jail, court services, relatives, self, District Courts, local law enforcement, parole and probation, and/or mental health agencies.
 - 6.2.1 These clients will be admitted to the agency in the jurisdiction of the court (NNAMHS, SNAMHS, RNBHC). Each agency will follow the admission procedures and protocols outlined for their agency.
 - 6.2.2 A release of information will be obtained from the client upon opening to MHC and for every additional 12 month period thereafter as needed.
- 6.3 Comprehensive Coordination of Care: Once a client is accepted into MHC, he/she is assigned to an MHC Service Coordinator. The MHC Service Coordinator will:



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- 6.3.1 Work with clients to establish a therapeutic alliance.
- 6.3.2 The MHC Service Coordinator will assist the client in finding appropriate housing and entitlements, (SSDI, SSI, Medicare/Medicaid, Welfare, other benefits, referrals),
- 6.3.3 Conduct a LOCUS assessment and develop a plan of care within 30-days. This plan will address criminal charges (i.e., domestic violence counseling, substance abuse treatment or anger management classes) as well as their mental health and/or substance abuse issues,
- 6.3.4 The MHC Service Coordinator shall review and update the LOCUS and the plan of care every 90-days.
- 6.3.5 The goal of the program is to divert these individuals from the criminal justice system, increase public safety, reduce recidivism, and increase quality of life.
- 6.4 The client is asked to return to court for regular status checks and monitoring where:
 - 6.4.1 The judge addresses the individual and the progress made in their treatment plan;
 - 6.4.2 As the client continues to make progress toward their treatment goals, status checks are required less frequently;
 - 6.4.3 As prescribed by the court, MHC Service Coordinators will provide a report to the court on a course of treatment and rehabilitation on a regular basis.
- 6.5 Progress will be monitored through the clients' participation in the MHC Program.
 - 6.5.1 Client cases are staffed weekly by the treatment team.
 - 6.5.2 Documentation of progress will be maintained in the Avatar (electronic medical record system).
- 6.6 Individuals participate in Mental health Court for a minimum of one (1) year depending upon their charges, progress made toward their treatment goals and jurisdiction.



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- 6.7 Clients must be in compliance with all MHC rules, probation rules and agency (NNAMHS, SNAMHS, RBHC) rules.
- 6.7.1 Must keep all treatment, court and probation appointments;
 - 6.7.2 Must take medication as prescribed
 - 6.7.3 Must maintain sobriety;
 - 6.7.4 Must comply with curfews;
 - 6.7.5 Must complete court or MHC prescribed community service;
 - 6.7.6 Must maintain living quarters and personal hygiene;
 - 6.7.7 Must apply for entitlements (State Agency as Payee for SSA benefits);
 - 6.7.8 If able, just seek volunteer or paid work;
 - 6.7.9 Must not incur new criminal charges;
 - 6.7.10 Must present a plan for continuing treatment and financial support in order to graduate MHC.
- 6.8 Client may be terminated from participation in MHC in one (1) of the following manners:
- 6.8.1 Graduation from MHC Program – the client must participate for a minimum of one (1) year.
 - 6.8.1.1 Client will successfully demonstrate an increased/improved level of independence, mental health stability, drug/alcohol free living, absence of new convictions, structured daily living, medication and/or treatment adherence.
 - 6.8.1.2 In preparation of graduation from MHC all Clients will prepare for continuing care. The client will work in conjunction with their service coordinator to prepare a written continuing care plan. This plan will include provisions to continue medications and treatment once the client completes the MHC program.
 - 6.8.1.3 Once a plan has been developed it will be presented to the judge. Upon approval by the judge, the client will then be scheduled for graduation
 - 6.8.1.4 Completion of MHC Program – A determination may be made to allow the client to complete the program although they have not successfully met all the above criteria.
 - 6.8.1.4.1 In this case, clients have typically met the time criteria for participation in MHC; however, they have generally not made sufficient or significant progress in other areas to warrant being granted the ability to “graduate” from the program



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- 6.8.2 Termination – Through collaboration of the MHC team the client may be terminated from MHC for any number of reasons including:
- 6.8.2.1 Accruing new charges,
 - 6.8.2.2 Unsuccessfully engaging in MHC services,
 - 6.8.2.3 Repeated substance relapses despite numerous attempts to offer addiction treatment,
 - 6.8.2.4 Failure to appear in court (AWOL), by client or attorney request, etc.
 - 6.8.2.5 In the case where a client is terminated from MHC for reason other than successful graduation, all attempts will be made to educate the client about his or her ability to continue treatment through the State agency or other community agency/services.
 - 6.8.2.6 The Service Coordinator will document instructions given and terminate MHC supervision once the client is no longer eligible for participation in the program.
 - 6.8.2.7 In cases where the client wishes to continue mental health treatment, the client will be closed to the MHC episode only
 - 6.8.2.8 In those cases where the client will not be engaging in services at the State Mental Health Agency (i.e., being sentenced to prison), a full case closure will be done according to agency policy.
- 6.8.3 The client may be closed to MHC service coordination upon graduation from MHC and implementation of the continuing care plan in accordance with agency policy.

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY:

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

Effective Date: 11/15/13

Approved by Administrator: 11/15/13

Approved by Commission: 11/15/13



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SP 3.1	10/16	Involuntary Administration of Medication in Civil Clients	Next Review Date: 10/18

1.0 POLICY:

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

2.0 PURPOSE:

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

3.0 SCOPE:

This policy applies to civil inpatient settings within DPBH.

4.0 DEFINITIONS:

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

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

5.0 PROCEDURE:

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



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reasonable degree of medical certainty that the consumer lacks capacity to understand and appreciate the nature of his/her condition and the nature of proposed treatment, medical staff shall complete Form 1, "Recommendation for Administration of Medication."

- 5.2.2 A copy of the completed Form 1 shall be given to the consumer's social worker who will meet with the consumer to explain Form 1 and this policy.
- 5.2.3 The social worker will notify the consumer of the right to receive assistance from an advisor for the hearing.
- 5.2.4 In the event the consumer still indicates an unwillingness to take the medication and declines to sign consent, the social worker shall then assist him/her in filling out Form 2 "Notice to Consumer of Intention to Medicate and Request for Review."
- 5.2.5 If the consumer refuses to meet with the advisor, the social worker will assist in completing the form.
- 5.2.6 The social worker shall give the completed Form 2 to the Medication Hearing Coordinator who shall schedule the hearing, notify the advisor, and at least twenty-four (24) hours prior to the hearing, and provide the consumer with written notice of their rights related to the process.

5.3 Consumer Rights Related to the Hearing:

- 5.3.1 The consumer will be notified no less than twenty-four (24) hours in advance of the hearing.
- 5.3.2 The consumer may not be medicated during this twenty-four (24) hour period absent of an emergency.
- 5.3.3 The consumer has a right to be informed of the diagnosis, the factual basis for the diagnosis, and why the treatment team believes medication is necessary.
- 5.3.4 The consumer has the right to attend the hearing if they so desire.
- 5.3.5 The consumer may cross examine any staff witnesses the committee interviews.



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



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- 5.5.2.1 Consumer's stated objections, if any , to the medications;
- 5.5.2.2 Any and all documents or evidence offered by the consumer's behalf
- 5.5.2.3 Whether the consumer will harm himself or others without the medication;
- 5.5.2.4 Whether the consumer cannot improve without the medication, or whether the consumer would improve but at a significantly slower rate;
- 5.5.2.5 Whether there are less restrictive means that would accomplish the same or similar results;
- 5.5.2.6 The consumer's prior experience with the proposed medications; and
- 5.5.2.7 Other factors deemed relevant by the committee and noted in its decision.
- 5.5.2.8 The committee may interview any persons it feels may be of assistance in conducting its review and/or receive any additional documents offered on behalf of staff or the consumer.
- 5.5.3 The decision of the committee involves the following:
 - 5.5.3.1 To approve use of the medication, the majority, which must include the psychiatrist, must find that the consumer suffers from a mental illness as defined in NRS 433A.155 and that the consumer is a danger to self or others or is gravely disabled.
 - 5.5.3.2 The vote of the committee will be noted in the consumer's chart.
 - 5.5.3.3 The committee will complete Form 3, "Committee Review and Findings." A copy of Form 3 will be given to the social worker who will review the form with the consumer and assist him/her in filling out Form 4, "Notice of medication Review Committee and Request for Review." In the event the consumer refuses to consent to medication and refuses to fill out Form 4, the social worker will complete the form and indicate that the consumer has refused to sign the request. The social worker will explain that the consumer



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has a right to appeal the decision of the committee to the Medical Director.

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

5.5.5 Consumer's presence at hearing:

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

5.6 Review by Medical Director/Designee:

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

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

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

5.6.4 The same factors considered by the committee shall be reviewed by the medical director or designee, in addition to:

5.6.4.1 Whether the proper procedures were followed by the committee;

5.6.4.2 Whether the proposed medication is medically appropriate based on the consumer's diagnosis, and medical history;

5.6.4.3 Whether medication is the least restrictive mean of treatment; and

5.6.4.4 Any other factors deemed relevant by the medical director or designee.



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5.6.4.5 The medical director or designee shall review the chart and any other documents that were present to the committee during the review.

5.6.4.6 If it is deemed necessary, the medical director or designee may interview any persons he/she feels may assist in conducting the review, and may conduct an independent examination of the consumer.

5.6.4.7 The medical director or designee may approve the medication as prescribed, limit the dosage of the prescribed medication or disapprove the medication altogether.

5.6.4.8 The medical director or designee shall enter his decision on Form 5, a copy shall be given to the social worker as well as the treating medical staff. The social worker shall transmit a copy of Form 5 to the consumer within one working day of receiving Form 5 from the medical director or designee.

5.6.4.9 The social worker is responsible for notifying the consumer of the medical director's decision and explaining the right to request judicial review. This process is to be documented on Form 6. If the consumer requests judicial review, the social worker will fax the Denial of Rights (DOR) to the Attorney General's office immediately.

5.7 Administration of Medication

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

5.7.2 Before administering the medication, the treating medical staff shall initiate a Denial of Right to Refuse Medication form to which all forms



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referred to in this policy shall be attached, and which will be reviewed by the Commission on Behavioral Health pursuant to NRS 433.534.

5.7.3 The administration of the medication does not have to await Commission on Behavioral review.

5.8 Continuation of Medication

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

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

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

5.9 Documentation

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

6.0 ATTACHMENTS:

6.1 Form 1: Recommendation for Administration of Medication

SP 3.1 Involuntary Administration of Medication in Civil Clients Attachment A

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

SP 3.1 Involuntary Administration of Medication in Civil Clients Attachment B



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- 6.3 Form 3: Committee Review and Findings
SP 3.1 Involuntary Administration of Medication in Civil Clients Attachment C
- 6.4 Form 4 Notice of Recommendation for Medication Review Committee and Request for Review
SP 3.1 Involuntary Administration of Medication in Civil Clients Attachment D
- 6.5 Form 5 Decision of Medical Director page 1
SP 3.1 Involuntary Administration of Medication in Civil Clients Attachment E
- 6.6 Form 6 Decision of Medical Director page 2
SP 3.1 Involuntary Administration of Medication in Civil Clients Attachment F

7.0 Implementation of Policy:

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

Policy: It is the Division of Public and Behavioral Health (DPBH) policy to ensure that the prescribing, dispensing and administering of PRN psychotropic medications is done in an appropriate, safe and effective manner.

Purpose: To define the process for safe and effective use of PRN (Pro re nata or "as needed") psychotropic medications at DPBH.

Scope: Statewide

Procedures:

I. Definitions

- A. PRN (Abbreviation for pro re nata, a Latin phrase meaning "as needed");
- B. The times of administration of a prn medication order are determined by the needs of the individual, providing a flexible and timely mechanism for nursing staff to respond to dynamic clinical circumstances.
- C. "Psychotropic Medications" includes antipsychotics, mood stabilizers, antidepressants, anxiolytics, stimulants and hypnotics.
- D. "NTE"= not to be exceeded.

II. Operations

- A. Orders for psychotropic PRN medication shall include:
 - 1. the generic or brand name of the medication;
 - 2. the dosage expressed in the metric system, except where the dosage is commonly expressed otherwise;
 - 3. the route of administration;
 - 4. frequency of administration;
 - 5. the therapeutic indication for writing the order, e.g. for agitation, for depression, etc.
 - 6. the signature of licensed professional authorized to write orders or take telephone medication orders;
 - 7. the signature of the authorized prescriber to initiate the order;
 - 8. the maximum number of doses not to be exceeded (NTE) in 24 hours is required for all psychotropic PRN medication orders, e.g. Ativan 0.5 mg po q3h prn agitation NTE 3 doses in 24 hours).

9. the time limit for the order limited to fourteen days (14) days or less, e.g. Ativan 0.5 mg po q3h prn agitation NTE 3 doses in 24 hours x 3 days).
 - a. All psychotropic PRN medication orders shall have an automatic stop order of fourteen (14) days.

Administrator

Effective Date:

Approved by DPBH Administrator:

Date Approved by Commission of Behavioral Health:



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

Control #	Rev. Date:	Title:	Effective Date: 12/1997
SP 4.18 (4.018)	09/2007	Admission Criteria and Process for Consumer Admission	Next Review Date:

1.0 POLICY:

It is the policy that psychiatric inpatient admissions be based on established criteria and statute.

2.0 PURPOSE:

This policy specifies procedures for admitting consumers to state psychiatric inpatient facilities both civil and forensic while ensuring their safe and legal treatment.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 Person with Mental Illness (NRS 433A.115) means any person whose capacity to exercise self-control, judgment and discretion in the conduct of the person's affairs and social relations or to care for his or her personal needs is diminished, as a result of a mental illness, to the extent that the person presents a clear and present danger of harm to himself or herself or others, but does not include any person in whom that capacity is diminished by epilepsy, intellectual disability, dementia, delirium, brief periods of intoxication caused by alcohol or drugs, or dependence upon or addiction to alcohol or drugs, unless a mental illness that can be diagnosed is also present which contributes to the diminished capacity of the person.

4.1.1 A person presents a clear and present danger of harm to himself if, within the immediately preceding 30 days, the person has, as a result of a mental illness:

4.1.1 Acted in a manner from which it may reasonably be inferred that, without the care, supervision or continued assistance of others, the person will be unable to satisfy their need for nourishment, personal or medical care, shelter, self-protection or safety, and if there exists a reasonable probability that the person's death, serious bodily injury or physical debilitation will occur within the next following 30 days unless he or she is admitted to a mental health facility pursuant to the provisions of NRS 433A.115 to 433A.330, inclusive, and adequate treatment is provided to the person;

4.1.3 Attempted or threatened to commit suicide or committed acts in furtherance of a threat to commit suicide, and if there exists a reasonable probability that the person will commit suicide unless he or she is admitted to a mental health facility pursuant to the provisions of NRS 433A.115 to 433A.330, inclusive, and adequate treatment is provided to the person; or



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4.1.4 Mutilated himself or herself, attempted or threatened to mutilate himself or herself or committed acts in furtherance of a threat to mutilate himself or herself, and if there exists a reasonable probability that he or she will mutilate himself or herself unless the person is admitted to a mental health facility pursuant to the provisions of NRS 433A.115 to 433A.330, inclusive, and adequate treatment is provided to the person.

4.1.5 A person presents a clear and present danger of harm to others if, within the immediately preceding 30 days, the person has, as a result of a mental illness, inflicted or attempted to inflict serious bodily harm on any other person, or made threats to inflict harm and committed acts in furtherance of those threats, and if there exists a reasonable probability that he or she will do so again unless the person is admitted to a mental health facility pursuant to the provisions of NRS 433A.115 to 433A.330, inclusive, and adequate treatment is provided to him or her.

4.2 Mental disorder per **NRS 178.3985** means a mental illness that results from a psychiatric or neurological disorder that so substantially impairs the mental or emotional functioning of the person as to make care or treatment necessary or advisable for the welfare of the person or for the safety of the person or property of another and includes, without limitation, intellectual disabilities and related conditions.

4.3 Legal 2K – an application for emergency admission

4.2 Types of admission to Mental Health Facilities

4.4.1 Voluntary

4.4.2 Emergency

4.4.3 Involuntary

5.0 PROCEDURE:

5.1 Division psychiatric facilities provide full service treatment to people with mental illness who are capable of participating in a treatment program, including inpatient and psychiatric emergency care in Rapid Stabilization Units (RSUs) .

5.2 Division forensic mental health service provide a range of services to individuals in the criminal justice system including assessment and treatment to competency.

5.3 Inpatient civil psychiatric facilities shall accept for admission individuals who are referred pursuant to NRS 433A.150, voluntary, emergency, or involuntary admissions.



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

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SP 4.18 (4.018)	09/2007	Admission Criteria and Process for Consumer Admission	Next Review Date:

- 5.4 Forensic facilities shall accept consumers referred under NRS 178 and NRS 175.539 and administrative transfers.
- 5.5 DPBH clinical services inpatient Units, have no acute detoxification, maternity (including post partum), surgical or medical capabilities, child, and adolescent capabilities. Mobile Crisis team and admissions department will screen for exclusion criteria as listed in 5.5.1-5.5.6 and 5.6.1 as well as medical condition complexity that exceed the agency's capacity to provide proper care. :
- 5.5.1 Individuals only diagnosed with organic brain syndromes;
- 5.5.2 Individuals with repeated utilization reviews and diagnosis indicating malingering behaviors; ie.) a lone diagnosis of a personality disorder
- 5.5.3 Individuals diagnosed with primary diagnosis of substance abuse with repeated refusal to engage in a residential or outpatient treatment programs.
- 5.5.4 Individuals with known infectious diseases.
- 5.6 The primary diagnoses of record shall be consistent with the Diagnostic and Statistical Manual of Mental Disorders –V (D.S.M. V) & (ICD – 10 – CM).
- 5.6.1 The following Diagnoses shall not be utilized as the primary diagnosis for admitting individuals to civil inpatient services, however may be primary for forensic admissions:
- 5.6.1.1 Alcohol Use Disorder
- 5.6.1.2 Substance Use Disorder
- 5.6.1.3 Adjustment Disorder
- 5.6.1.4 Malingering
- 5.6.1.5 Personality Disorder
- 5.6.1.6 Academic Problem
- 5.6.1.7 Acculturation Problem
- 5.6.1.8 Age Related Cognitive Decline
- 5.6.1.9 Autism Spectrum Disorder
- 5.6.1.10 Major and Minor Neurocognitive Disorders
- 5.6.1.11 Intellectual and/or Developmental Disabilities (Individuals cooperatively served by DHHS agencies shall have the permission of the Medical Director)
- 5.6.1.12 Z-codes in general for primary diagnosis.
- 5.6.2 These diagnoses may, however, be secondary to another acceptable primary D.S.M. 5 / ICD – 10 - CM Psychiatric Diagnosis.
- 5.7 The usual route of admission to civil units will be through the Rapid



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Stabalization Unit (RSU).

5.8 Admission to the forensic unit occurs only via a court order per NRS 178 or 175

Administrative Transfer approved by the DPBH Administrator.

5.9 Division agencies shall use the proper form pursuant to NRS 433A.130 for consumers admitted under emergency hospitalization. If the referring agency does not have the appropriate form, the Division agency will provide the necessary forms. Every effort shall be made to assist the referring agency with admission standards before a consumer is denied admission.



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SP 4.18 (4.018)	09/2007	Admission Criteria and Process for Consumer Admission	Next Review Date:

- 5.10 Forensic facilities do not accept emergency admissions.
- 5.11 Individuals who present at admission will be assessed and processed by the DPBH admission staff in a timely and courteous manner.
- 5.11.1 Each Division agency will develop a quality assurance tracking system that will be able to track how long it takes individuals to be evaluated and admitted or refused admission.
 - 5.11.2 The quality assurance system shall include a consumer satisfaction survey.
 - 5.11.3 In the case of forensic facilities, this survey shall include periodic surveys of the courts.
- 5.12 Consumers admitted to DPBH facilities, pursuant to NRS 178, 433A.150, 433A.310, are to be closely supervised and monitored to prevent escape or elopement from any and all activities.
- 5.12.1 Agencies will develop/implement the necessary protocols and procedures that address staff duties and responsibilities regarding consumer escapes, elopements or conditional leave.
- 5.13 No Division-employed Medical Stafft may refuse to admit an individual who is being referred for emergency admission only if the referring physician is contacted and the case is discussed.
- 5.13.1 If the referring physician is not available, the referring facility will be contacted and the case will be discussed and/or confirmation will be made that all documentation and/or information has been received from the sending facility. This procedure must be documented.
- 5.14 No consumer referred on a court order will be denied admission.
- 5.14.1 If the admission staff or agency director feel that the court order is clinically inappropriate or that the court order is in conflict with Nevada Revised Statutes or existing cooperative transfer agreements, they should contact the Division Administrator.
 - 5.14.2 The Division Administrator shall refer the matter to the Deputy Attorney General for a legal opinion.
 - 5.14.3 In no instance shall any agency violate or fail to comply with the court order which has been issued.
 - 5.14.4 Forensic facilities shall admit consumers in the sequence the court order was filed, as well as, based on consideration of acuity.
 - 5.14.4.1 Consumers shall not be admitted to forensic facilities in excess



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of the allotted bed census.

5.15 Agencies or programs who are referring consumers for inpatient services shall establish policy and procedures that ensure forms are properly completed, evaluations are conducted, treatment plans are enacted and clinical progress notes are faxed to the admission office.

5.16 Each agency who receives crisis calls after normal working hours shall establish appropriate procedures to ensure that calls are expeditiously handled. Procedures should include provisions for a telephone service log, follow-up intervention, staff training, etc.

5.16.1 The telephone service log should include date and time of call, name of caller, staff time spent on call and staff member's name, whether or not caller was homicidal or suicidal, and a brief statement of caller's problem and disposition of the case.

5.17 Agencies shall ensure that any consumer who is being transferred by the police or sheriff's office receives priority admission service so that officers are not unduly delayed.

5.18 Agencies shall have COBRA procedures in place.

5.19 If after the evaluation process it is determined that the individual does not require hospitalization, an appropriate referral shall be made and documented.

6.0 ATTACHMENTS: N/A



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Control #	Rev. Date:	Title:	Effective Date: 12/1997
SP 4.18 (4.018)	09/2007	Admission Criteria and Process for Consumer Admission	Next Review Date:

7.0 REFERENCES:

- 7.1 NRS 125C.0605 Adult defined
- 7.2 NRS 433A.115 Mentally ill person defined
- 7.3 NRS 433A.120 Types of admission
- 7.4 NRS 433A.130 Forms of admission
- 7.5 NRS 433A.140 Voluntary admission
- 7.6 NRS 433A.150 Emergency admission procedure

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: 12/31/97

Date Revised: 1/15/99; 4/3/00; 5/11/01; 5/16/02; 6/24/03; 7/1/03; 8/26/05;
9/27/07



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

Control #	Rev. Date:	Title:	Effective Date: 10/2003
SP 4.56	02/2018	DPBH Communicable Infectious Disease Policy	Next Review Date:

1.0 POLICY:

The Division of Public and Behavioral Health Clinical Services Branch has a Communicable Infectious Disease policy that includes restriction criteria for admission into in-patient services when a severe active communicable infectious disease is present or suspected.

2.0 PURPOSE:

The purpose is to ensure the safety of consumers and staff by minimizing exposure to communicable infectious diseases

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

- 4.1 Infectious Disease per NRS 441A.063 means a disease which is caused by a pathogenic microorganism, including without limitation, bacteria, viruses, parasites or fungi which spread, either directly or indirectly from one person to another.
- 4.2 Communicable Disease per NRS 441A.040 is a disease which is caused by a specific infectious agent or its toxic products, which can be transmitted, either directly or indirectly, from a reservoir of infectious agents to a susceptible host organism.
- 4.3 Medical Staff: Medical staff members include: physicians, advance practice registered nurses, and physician's assistants who are licensed, credentialed and privileged to perform patient care duties within their scope of practice.

5.0 REFERENCES: N/A

6.0 PROCEDURE:

- 6.1 No client will be admitted to a Clinical Services Branch in-patient service who is found to have communicable infectious disease.
- 6.2 No employee found to have a severe active communicable infectious disease will be permitted to return to work until a signed release is presented from a licensed



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SP 4.56	02/2018	DPBH Communicable Infectious Disease Policy	Next Review Date:

physician and, when appropriate, consultation with the Agency Medical Physician, the Agency Medical Director or the State Medical Director.

- 6.3 Agencies within DPBH are not required to provide in-patient treatment to consumers who require more than commonly accepted standard precaution techniques for the prevention of the spread of disease. This precludes treatment where isolation techniques are necessary.
- 6.4 Clients admitted will be screened for the presence of severe active communicable disease prior to admission and denied admission when such illness is found to be present.
- 6.5 Screening for medical clearance prior to admission of clients suspected of having a severe active communicable disease is the responsibility of medical staff charged with the medical care of clients admitted.
- 6.6 No client suspected of having a severe active communicable disease shall be admitted without consultation and agreement between medical staff providing care for consumers within the agency and the Agency Director of Nursing.
- 6.7 No client suspected of having a severe active communicable disease will be admitted without notification and the agreement of the Agency Medical Director and the Agency Director.
- 6.8 In situations where there are unanswered questions as to the severity or active nature of the communicable disease or the risk of spread of infection, no admission will occur without the notification and agreement of the Chief Health Officer and Division Administrator.
- 6.9 Any client admitted to an in-patient facility who is found to have a severe active communicable disease will be immediately transferred to an appropriate medical facility that is equipped to provide adequate care for that individual.



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Control #	Rev. Date:	Title:	Effective Date: 10/2003
SP 4.56	02/2018	DPBH Communicable Infectious Disease Policy	Next Review Date:

6.10 In the case of a reportable infectious disease of a consumer or employee, the agency will promptly notify appropriate public health officials and take all necessary steps to determine the risk of spread of infection to remaining consumers and staff and facilitate adequate screening and treatment opportunity.

6.11 DPBH facilities will comply fully with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) pertaining to disabilities, including AIDS, HIV and related conditions.

7.0 ATTACHMENTS:

- 7.1 Reportable Diseases, Conditions and Events,, Clark County
- 7.2 RReportable Diseases, Washoe County

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: 10-23-03

Review Date: 06-01-07

Date Approved by DPBH Commission:

Reportable Diseases, Conditions and Events

Clark County, Nevada

The Nevada Administrative Code Chapter 441A and county disease reporting regulations require reports of specified diseases, foodborne illness outbreaks and extraordinary occurrences of illness be made to the local Health Authority (Southern Nevada Health District [SNHD]). Disease reporting allows SNHD to rapidly respond and prevent additional illness, recognize trends in diseases of public health importance and to intervene in outbreak or epidemic situations

Physicians, veterinarians, dentists, chiropractors, registered nurses, directors of medical facilities, medical laboratories, blood banks, school authorities, college administrators, directors of child care facilities, nursing homes, parole and probation officers, pharmacists, insurers and correctional institutions are required to report. Failure to report is a misdemeanor and may be subject to an administrative fine of \$1,000 for each violation.

Contact Numbers for Reporting Diseases and Conditions

Diseases to Report	Phone	Fax	Animal Bites	Phone
HIV/AIDS	(702) 759-0727	.....(702) 759-1454	Clark County.....	(702) 455-7710, x1
Sexually Transmitted Infections	(702) 759-0727	.....(702) 759-1454	Las Vegas.....	(702) 229-6444, x2
Tuberculosis	(702) 759-1015	.....(702) 759-1435	North Las Vegas	(702) 633-1750
Other Reportable Diseases	(702) 759-1300, x2	.....(702) 759-1414	Henderson.....	(702) 267-4970, x4
Outbreaks.....	(702) 759-1300, x2	.....(702) 759-1414	Boulder City	(702) 293-9283
Extraordinary Occurrences of Disease	(702) 759-1300, x2	.....(702) 759-1414	Mesquite	(702) 346-5268

The following must be reported by the next SNHD business day, unless otherwise noted:

<p>AIDS</p> <p>☒ Amebiasis</p> <p>☒ Animal bite from a rabies susceptible species</p> <p>☒ Anthrax</p> <p>† Arsenic: Exposures and elevated levels</p> <p>☒ Botulism</p> <p>② Brucellosis</p> <p>Campylobacteriosis</p> <p>CD4 lymphocyte counts*</p> <p>Chancroid</p> <p>Chlamydia</p> <p>② Cholera</p> <p>Coccidioidomycosis</p> <p>Cryptosporidiosis</p> <p>☒ Diphtheria</p> <p>† Drowning</p> <p>Ehrlichiosis/Anaplasmosis</p> <p>Encephalitis</p> <p>Enterohemorrhagic</p> <p>Escherichia coli (STEC, E. coli O157:H7)</p> <p>† Exposures of large groups of people to disease-causing agents</p> <p>☒ Extraordinary occurrence of illness (Dengue, Typhus Fever)</p> <p>Giardiasis</p> <p>Gonorrhea</p> <p>Granuloma inguinale</p> <p>② Haemophilus influenzae (invasive)</p> <p>Hansen's Disease (leprosy)</p>	<p>Hantavirus</p> <p>Hemolytic-uremic syndrome (HUS)</p> <p>② Hepatitis A and E</p> <p>Hepatitis B, C, D and unspecified</p> <p>HIV infection</p> <p>Influenza</p> <p>☒ Novel influenza (known or suspect pandemic strain)</p> <p>† Lead: Exposures and elevated levels</p> <p>Legionellosis</p> <p>Leptospirosis</p> <p>Listeriosis</p> <p>Lyme Disease</p> <p>Lymphogranuloma venereum</p> <p>Malaria</p> <p>☒ Measles (rubeola)</p> <p>Meningitis (specify type)</p> <p>☒ Meningococcal Disease</p> <p>† Mercury: Exposures and elevated levels</p> <p>② Mumps</p> <p>☒ Outbreaks of communicable disease</p> <p>☒ Outbreaks of foodborne disease</p> <p>② Pertussis</p> <p>☒ Plague</p> <p>☒ Poliomyelitis</p> <p>Psittacosis</p> <p>Q Fever</p> <p>☒ Rabies (human or animal)</p> <p>Relapsing Fever</p>	<p>Respiratory Syncytial Virus infection (RSV)</p> <p>Rotavirus</p> <p>② Rubella (including congenital)</p> <p>Salmonellosis</p> <p>☒ SARS</p> <p>Severe Reaction to Immunization</p> <p>Shigellosis</p> <p>☒ Smallpox (variola)</p> <p>Spotted fever Rickettsiosis (e.g., Rocky Mountain Spotted Fever)</p> <p>Streptococcal toxic shock syndrome</p> <p>Streptococcus pneumoniae Invasive Disease</p> <p>Syphilis (including congenital)</p> <p>Tetanus</p> <p>Toxic Shock Syndrome</p> <p>Trichinosis</p> <p>② Tuberculosis</p> <p>☒ Tularemia</p> <p>② Typhoid Fever</p> <p>Vancomycin-intermediate Staphylococcus aureus (VISA) infection</p> <p>Vancomycin-resistant Staphylococcus aureus (VRSA) infection</p> <p>Vibriosis, Non-Cholera</p> <p>☒ Viral hemorrhagic fever</p> <p>West Nile Virus</p> <p>Yellow Fever Infection</p> <p>Yersiniosis</p>
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☒ Report immediately by phone ② Report within 24 hours; use after-hours reporting system if needed † Report when suspect (do not wait for lab confirmation)
 ‡ Reportable in Clark County only *Currently <500/μL (under legislative review to make all counts reportable)

Southern Nevada Health District Office of Epidemiology • <http://www.southernnevadahealthdistrict.org/disease-reporting/disease-reporting.php>

24-HOUR PUBLIC HEALTH EMERGENCY LINE (702) 759-1300, OPT. 2



REPORTING REQUIREMENTS

Updated January 2017

PLEASE FAX REPORTS TO (775) 328-3764

Physicians, laboratories, and other health care providers are required to report suspected and confirmed diagnoses of the following diseases and conditions to the Washoe County Health District, pursuant to Nevada Administrative Code Chapter 441A. Other persons with obligations to report suspected or confirmed disease include persons in charge of schools, child care facilities, or correctional facilities.

REPORTABLE DISEASE LIST – Report within 24 hours unless otherwise noted below

Acquired immunodeficiency syndrome (AIDS)	Hemolytic-uremic syndrome (HUS)	POLIOMYELITIS*†
Amebiasis	Hepatitis A	Psittacosis
Anaplasmosis	Hepatitis B	Q Fever¶
Animal bite from a rabies susceptible species	Hepatitis C	Rabies, animal
ANTHRAX*†¶	Hepatitis Delta	RABIES, HUMAN*†
BOTULISM *†¶	Hepatitis E	Relapsing fever
Brucellosis¶	Hepatitis, unspecified	Respiratory syncytial virus infection (RSV)
Campylobacteriosis¶	Human immunodeficiency virus infection (HIV)	Rotavirus
Carbapenem resistant organisms ▲§¶	ILLNESS KNOWN OR SUSPECTED TO BE	Rubella (including congenital)†
CD4 lymphocyte counts▲	THE RESULT OF INTENTIONAL	Salmonellosis¶
Chancroid	TRANSMISSION OR BIOTERRORISM*†	Severe reaction to immunization
<i>Chlamydia trachomatis</i> genital tract infection	Influenza	Shigellosis¶
Cholera	Legionellosis¶	Spotted fever rickettsioses (including RMSF)
Coccidioidomycosis	Leptospirosis	<i>Staphylococcus aureus</i> (vancomycin-intermediate or vancomycin-resistant)¶
Cryptosporidiosis	Listeriosis¶	<i>Streptococcus pneumoniae</i> (invasive)
Diphtheria†¶	Lyme disease	Syphilis (including congenital)
Ehrlichiosis	Lymphogranuloma venereum	Tetanus¶
Encephalitis	Malaria¶	Toxic shock syndrome
Enterohemorrhagic <i>Escherichia coli</i> (shiga toxin-producing <i>E. coli</i> , including <i>E. coli</i> O157:H7)¶	Measles (rubeola)†	Trichinosis
EXTRAORDINARY OCCURRENCE OF ILLNESS (E.G., SMALLPOX, SARS, ZIKA)*†	Meningitis (specify type)	Tuberculosis†¶
Giardiasis	MENINGOCOCCAL DISEASE*†¶	TULAREMIA*†¶
Gonococcal infection	Mumps	Typhoid fever
Granuloma inguinale	OUTBREAKS, ALL (E.G., FOODBORNE, HEALTHCARE-ASSOCIATED, NOROVIRUS)	Vibriosis¶
<i>Haemophilus influenza</i> , invasive disease¶	*†	VIRAL HEMORRHAGIC FEVER*†
Hansen's Disease (leprosy)	Pertussis¶	West Nile Virus
Hantavirus	PLAGUE*†¶	Yellow fever
		Yersiniosis¶

*MUST REPORT IMMEDIATELY, anytime, day or night, including weekends and holidays, by calling (775) 328-2447

†Must report when suspect ▲Laboratories only must report ¶ Isolates must be submitted to Nevada State Public Health Lab

§Reporting of carbapenem-resistant Enterobacteriaceae (CRE), carbapenem-resistant pseudomonas aeruginosa (CRPA), and other carbapenem-resistant Gram negative bacilli (CRGNB) is now being requested pursuant to NAC 441A.235-3(a) from all hospital laboratories in Washoe County.

REQUIRED INFORMATION FOR REPORTS

- | | | |
|--------------------------------|---------------------------------------|--|
| ◆ Disease or suspected disease | ◆ Date of birth (if known) | ◆ Health Care Provider's name & contact information |
| ◆ Patient's full name | ◆ Sex, Race (if known) | ◆ Any other information requested by the health authority, if available. |
| ◆ Address | ◆ Occupation, Employer (if known) | |
| ◆ Telephone number | ◆ Date of disease onset and diagnosis | |

CONTACTS FOR DISEASE SPECIFIC QUESTIONS

AIDS, HIV, CD4	Sonya Smith, RN , 328-6142; Jennifer Howell, RN, 328-6147; Samantha Beebe, RN, 328-6164	Disease Intervention Specialist
Sexually Transmitted Diseases	Angela Penny, RN, 328-6151; Cory Sobrio, RN, 328-2475	Disease Intervention Specialist
TB	Diane Freedman, RN, 785-4787	TB Control Program Coordinator
TB	Judy Medved-Gonzalez, RN, 785-4788	TB Control Program Case Manager
All other reportable diseases	On-call Staff Member, 328-2447	Public Health Investigator or Epidemiologist



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

Control #	Rev. Date:	Title:	Effective Date: 1/06
SP 4.61 (4.061)	3/18/10	UTILIZATION MANAGEMENT	Next Review Date:

1.0 POLICY:

DPBH Clinical Services Branch requires that each hospital agency implements a Utilization Management Program.

2.0 PURPOSE:

- 2.1 The purpose of the program is to maximize the efficiency of service provision and to ensure that services are appropriate, necessary, and effective.
- 2.2 Utilization Management is a Performance Improvement process.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

Utilization management is the evaluation of the appropriateness, medical need, and efficiency of health care services, procedures, and facilities according to established criteria. Typically, it includes new activities or decisions based upon the analysis of a case.

Utilization management describes proactive procedures including discharge planning, concurrent planning, pre-certification, and clinical case appeals. It also covers proactive processes such as concurrent clinical reviews and peer reviews, as well as appeals introduced by the provider, payer, or patient.

5.0 REFERENCES: N/A



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

Control #	Rev. Date:	Title:	Effective Date: 1/06
SP 4.61 (4.061)	3/18/10	UTILIZATION MANAGEMENT	Next Review Date:

6.0 PROCEDURE:

- 6.1 Each hospital agency will establish a Utilization Management Plan to meet the goals of the program.
- 6.2 The plan will include the establishment of a standing committee, the Utilization Management Committee. The Committee is responsible for the maintenance and implementation of the Utilization Management Plan.
 - 6.2.1 The Utilization Management Committee will meet regularly to conduct business.
 - 6.2.2 Minutes will be recorded in the approved format for the meeting. The minutes will include summaries of findings/conclusions and reports presented.
 - 6.2.3 The Utilization Management Committee will submit quarterly reports to the Director of Program Planning.
 - 6.2.4 Format developed by the Planning office.
- 6.3 The Utilization Management Plan must include the following elements:
 - 6.3.1 The composition of the Utilization Management Committee.
 - 6.3.2 The responsibilities of the Utilization Management Committee.
 - 6.3.3 The process by which cases are analyzed.
 - 6.3.4 The process by which data from case analyses are aggregated.
 - 6.3.5 The process by which the Utilization Management Committee will effect necessary changes to policy or procedure of the agency.
 - 6.3.6 The frequency and content of reports to the agency leadership.
 - 6.3.7 The process by which the Division reporting requirements are met.



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

Control #	Rev. Date:	Title:	Effective Date: 1/06
SP 4.61 (4.061)	3/18/10	UTILIZATION MANAGEMENT	Next Review Date:

- 6.4 The Agency is funded by the State of Nevada. Therefore, employees do not have a financial interest except to be as cost effective as possible.
- 6.5 The function of reviewing patient cases, including patients eligible for Medicare and Medicaid, shall be in compliance with applicable Medicare and Medicaid Utilization Review criteria.
- 6.6 All information generated from Utilization Management Reports and analyses shall be considered confidential and privileged information.

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY:

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

Effective Date: 1/20/06
Date Revised: 12/21/07, 3/18/10
Date Reviewed:
Date Approved by DPBH Commission: 1/20/06, 3/18/10



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

Control #	Rev. Date:	Title:	Effective Date: 1/2010
SP 4.078	New	Generation of Medication Savings	Next Review Date:

1.0 POLICY:

The Division directs DPBH agencies to develop procedures to maximize savings in the medication budget category (Category 40), through the utilization of established clinical, procedural, inventory management and cost-containment processes.

2.0 PURPOSE:

To ensure maximize cost savings in medication for the DPBH agencies.

3.0 SCOPE: DPBH Clinical Services Branch

4.0 DEFINITIONS: N/A

5.0 PROCEDURE:

5.1 Clinical Procedure:

5.1.1 Savings shall be captured through the following process

5.1.1.1 The utilization of patient assistance programs, voucher programs and scholarship programs;

5.1.1.2 The utilization of manufacturers' drug samples when appropriate

5.1.1.3 The utilization of generic drugs when available;

5.1.1.4 The surveillance of poly-pharmacy through monitoring for use of more than two (2) antipsychotics, or more than two (2) mood stabilizers, or more than two (2) benzodiazepines;

5.1.1.5 The monitoring of off-label use of pharmaceuticals;

5.1.1.6 The monitoring of non-formulary drug use;

5.1.1.7 The monitoring of drug orders and prescriptions with doses greater than the FDA-approved maximum dose.

5.1.2 Monitoring of medical staff prescribing patterns:



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

Control #	Rev. Date:	Title:	Effective Date: 1/2010
SP 4.078	New	Generation of Medication Savings	Next Review Date:

- 5.1.2.1 To insure adherence to the DPBH Clinical Services Branch formulary;
- 5.1.2.2 To identify poly-pharmacy situations that require peer review and follow-up consults;
- 5.1.2.3 To identify patients whose total cost of monthly maintenance medications are equal to or greater than one thousand dollars (\$1,000) for off-label use and have such patients' medication orders peer-reviewed to insure evidence-based prescribing support;
- 5.1.2.4 To monitor physician prescribing practices that fall out of the norm and analyze these through a Peer Review system.
- 5.1.3 To require patients who qualify for other medication insurance coverage to use that as their primary insurance coverage: and require insurances are verified at clinics before requesting medications from a DPBH pharmacy.
 - 5.1.3.1 Medicaid and Medicaid-eligible patients;
 - 5.1.3.2 Medicare Part D patients;
 - 5.1.3.3 Private insurance patients; and
 - 5.1.3.4 Non-indigent patients
- 5.1.4 Use of Prior Authorization and Consultation forms:
 - 5.1.4.1 Poly-pharmacy;
 - 5.1.4.2 Off-label use of pharmaceutical agents;
 - 5.1.4.3 Non-formulary drug requests;
 - 5.1.4.4 DPBH Clinical Services Branch formulary drugs on restricted status; and
 - 5.1.4.5 Daily doses of drugs greater than FDA-approved maximums.
- 5.2 Inventory Management:
 - 5.2.1 The Pharmacy and the Rural Clinics shall maintain optimal inventory level but no less than a 96 hour supply:



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

Control #	Rev. Date:	Title:	Effective Date: 1/2010
SP 4.078	New	Generation of Medication Savings	Next Review Date:

5.2.1.1 Develop an inventory worksheet to document inventory transactions;

5.2.1.2 Perform scheduled inventories;

5.2.1.3 Perform contract value analysis to document on-contract purchases

5.2.2 The reports from above shall be

5.2.2.1 Available for the ASO's to reconcile their records;

5.2.2.2 Shall be discussed at the P&T Committees and the Pharmacy Leadership Oversight meetings, when appropriate.

5.3 Each agency shall formulate protocols and procedures to implement the provisions in this policy or shall incorporate this policy into its protocol and procedure manual.

6.0 ATTACHMENTS: N/A

7.0 IMPLEMENTATION OF POLICY:

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

Effective Date: 1/21/10

Date Revised:

Date Reviewed:

Date Approved by DPBH Commission: 1/21/10