Division of Public and Behavioral Health
Clinical Services

Control # Revised
SP 4.17 01/08

Title: Division Response to Urgent and Emergency Calls Received by the Governor's Office

Effective Date:

Next Review Date:

1.0 POLICY:
DPBH Agencies will provide on-call personnel able to receive information and act to assist and support the Governor's Office in responding to calls in the best interest of the public.

2.0 PURPOSE:
To provide availability of personnel to respond 24/7/365

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS: N/A

5.0 REFERENCES: N/A

6.0 PROCEDURE:

6.1 Each Agency Director will serve as the contact person for the Governor's Office:

6.2.1	DPBH Administration	XXX-XXX-XXXX
6.2.2	Lakes Crossing	XXX-XXX-XXXX
6.2.3	Northern Nevada Adult Mental Health	775-688-2011
6.2.4	Rural Clinics	775-687-7503
6.2.5	Southern Nevada Adult Mental Health	702-486-6238
6.2.6	Stein Forensic Facility	XXX-XXX-XXXX

6.2 Reports of actions taken shall be forwarded to Administration DPBH within one (1) working day.

6.3 Calls received at the Division Administration Office shall be handled by the AA IV or designee.

6.3.1 These calls will be brought to the attention of the administrator or deputy Administrator and routed to the proper agency for handling.

6.4 Each Division Agency shall develop specific written protocls to implement this policy and shall incorporate this policy into the agency'

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Effective Date:

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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: 5/19/98
Date Revised: 1/25/08
Date Reviewed: 4/30/99, 03/10/05
Date approved by the Commission on Behavioral Health:

Division of Public and Behavioral Health
Clinical Services

Control # Revised
SP 4.24

Title: Biennial Review of All Departmental Workloads and Staffing Patterns

Effective Date: 12/31/97

Next Review Date: 02/03/99

1.0 POLICY:

It is the policy of the Division of Public and Behavioral Health (DPBH) that all agencies conduct biennial reviews of all departmental workloads and staffing patterns.

2.0 PURPOSE:

3.0 SCOPE: Clinical Service Branch

4.0 DEFINITIONS:

5.0 REFERENCES:

6.0 PROCEDURE:

6.1 Agencies shall institute procedures and a process for reviewing departmental workloads and staffing patterns in concert with budget development activities.

6.1.1 Reviews shall occur bwtween July and March immediately following a legislative session.

6.1.2 The review shall include at a minimun:

6.1.2.1 Review each department's current and anticipated workloads by identified;

6.1.2.2 Identify the manpower required to maintain current functions and identify staff increases/decreases by job classified to meet projected needs; and

6.1.2.3 A report is to be submitted to the agency administrator by March 1st of each year following closure of the legislative session, which outlines the findings of (A) and (B) above.

6.2 Each division agency shall develop specific written procedures to implement the provisions of this policy or shall incorporate this policy into the agency policy manual.

Control # Revised
SP 4.24

Title: Biennial Review of All Departmental Workloads and Staffing Patterns

Effective Date: 12/31/97

Next Review Date: 02/03/99

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.

NO electronic copy

Policy: **It shall be the policy of the Division that all MHDS mental health agency staff follows guidelines for providing service coordination activities and specific procedures for billing for services.**

Purpose: **To define Service Coordination activities and outline procedures for Service Coordination billing for Division mental health agencies (this MHDS Policy #3.002 includes, and therefore obsoletes, MHDS policy #4.036).**

Procedure: **MHDS Service Coordination procedures are addressed In terms of objectives, activities, assessment, treatment plans, documentation and billing definitions and procedures.**

I. Service Coordination Defined:

Service Coordination is a process in which the Service Coordinator assists persons in gaining access to medical, psychosocial, educational, financial, housing, employment, transportation, crisis intervention and other support services.

II. Service Coordination Objectives/Mission:

A. Work with people to maximize their strengths and preferences to motivate the person to work toward their goals of recovery and self-sufficiency; and
B. Arrange access to needed services for persons served; and
C. Assure efficient and timely coordination of services; and
D. Limit unnecessary restrictive treatment; and
E. Mobilize the support of family, friends, and advocates.

III. Service Coordination Activities:

A. Assessment of individual needs;
B. Coordinate the development of a plan of care;
C. Inform each person served of service and provider options;
D. Locate, coordinate, and develop resources to meet each individual's needs;
E. Arrange services and transportation to services;
F. Provide information to service providers about the medical history and level of functioning of the person served as necessary to plan, deliver, and monitor services;
G. Inform service providers of any changes in condition on the part of the person served;
H. Coordinate or participate in interdisciplinary team meetings;

I. Coordinate, develop and implement training programs designed to assist each individual in the various skills for daily living;
J. With client consent, inform members of the person's family or other caretakers of support necessary to obtain optimal benefits of prescribed medical services;
K. Assist persons in getting needed services;
L. Court appearances and time spent in preparation for court appearances on behalf of the client if such appearances will assist the person served in gaining access to needed services.

IV. Admission to Service Coordination Services:

All clients referred for admission to service coordination services within MHDS mental health agencies shall be assessed for appropriateness, using the following criteria:

A. Adults with serious mental illness (SMI) are defined as persons who:
   1. Are at least 18 years of age and older;
   2. Who currently, or at any time during the past year (continuous 12 month period) have;
      a. A diagnosable mental, behavioral, or emotional disorder that meets the coding and definition criteria specified in the Diagnosis and Statistical Manual of Mental Disorders (DSM-IV) (excluding substance abuse or addictive disorders, irreversible dementias as well as mental retardation, unless they co-occur with another serious mental illness that meets DSM-IV criteria);
      b. Resulting in functional impairment which substantially interferes with or limits one or more major life activities; and
   3. Has a functional impairment that affects their ability to function successfully in several areas such as psychological, social, occupational or educational. It is seen on a hypothetical continuum or mental health – illness and is viewed from the individual's perspective within the environmental context. Functional impairment is defined as difficulties that substantially interfere with or limit an adult from achieving or maintaining housing, employment, education, relationships or safety.

B. Children who are severely emotionally disturbed (SED) are defined as persons who:
   1. Are less than 18 years old;
   2. Who currently, or at any time during the past year (continuous 12 month period) have;

a. A diagnosable mental, behavioral or emotional disorder that meets the coding and definition criteria specified within the Diagnosis and Statistical Manual of Mental Disorders (DSM-IV) (excluding substance abuse or addictive disorders, irreversible dementias as well as mental retardation and V codes, unless they co-occur with another serious mental illness that meets DSM-IV criteria);
b. Resulting in functional impairment which substantially interferes with or limits the child's role or functioning in family, school or community activities;

3. Have a functional impairment addressing the ability to function successfully in several areas such as psychological, social, cognitive, occupational or educational. It is seen on a hypothetical continuum or mental health – illness and is viewed from the individual's perspective within the environmental context. Functional impairment is defined as difficulties that substantially interfere with or limit an adult from achieving or maintaining housing, employment, education, relationships or safety.
4. Have exhibited signs of being emotionally disturbed for more than one year.

The determination for mentally ill adults will be made by a psychiatrist, licensed to practice medicine in Nevada, who is eligible for certification by the American Board of Psychiatry and Neurology, by a psychologist licensed to practice in Nevada, by a clinical social worker licensed to practice in Nevada, or a marriage and family therapist who is licensed to practice in Nevada.

Mentally developmentally delayed adults and children are defined as persons with significantly sub-average general intellectual functioning (IQ of 70 or less), with concurrent deficits in adaptive behavior, and with the disability manifested during the developmental period. This determination is made by a person who is qualified to work with persons with developmental disabilities as defined in 42 CFR 483.430.

C. Persons with DSM IV Axis II diagnosis may also qualify if there are sufficient functional difficulties, an extended duration of problems or illness, and continued reliance upon publicly funded services and supports;

D. There is a history of high-risk behaviors that include risk of harm to self and others;

E. The treatment/service must be clinically necessary and there is reasonable expectation that the service coordination intervention/support will:
   1. Remediate and/or reduce symptoms;
   2. Improve behaviors necessary for optimal functioning;
   3. Increase the potential for recovery; and
   4. Maintain current levels of functioning without which decompensation or relapse will result.

F. All adult clients admitted into the Service Coordination shall be assessed using the Level of Care Utilization (LOCUS) standardized assessment tool, and shall received service coordination commensurate with the assessed level of care (see Appendix A). All children served by Rural Clinics shall be assessed using the Child and Adolescent Services Intensity Instrument (CASII) (formerly CALOCUS) standardized assessment tool, and shall receive services commensurate with the assessed level of care(see Appendix A).

G. The caseload for each Service Coordinator should not exceed the amount indicated by the legislatively approved staffing ratios (which is currently 35).

H. The waiting list for service coordination shall be triaged, by service coordination supervisors, on a monthly basis, and assignments will be made on client need.

I. Supervisory review of caseloads shall address consumers who have remained in the same category for over six months and consumers who receive service delivery hours significantly more or less than recommended.

V. Assessment:

Service Coordinator must either complete or coordinate with the primary clinician, an appropriate assessment of each individual's level of functioning and full range of treatment needs using appropriate assessment forms (see policy #4.053), including evaluation of functionality and symptom severity of all individuals admitted to the agency's Service Coordination program. Forms will be administered in accordance with the protocols defined by policy #4.053.

VI. Treatment Plans:

A. Nevada Revised Statutes (NRS433.494) requires and individualized plan of services for each client. An individualized written plan of mental health services must be developed for each person receiving service at any mental health agency, including services for people that are cooperatively served by both mental health and developmental services agencies.

B. Service Plan development includes the development of a written comprehensive, individual service plan based upon the information collected through the assessment phase.

C. The service plan identifies the activities and assistance needed to accomplish the objectives developed between each person served and the Service Coordinator.
D. The plan must provide for the least restrictive treatment procedure that may reasonably be expected to benefit the individual.
E. The plan must be kept current and must be modified when indicated. The plan must be thoroughly reviewed at least once every 3 months.
F. The person in charge of implementing the plan of services must be designated in the plan.
G. The person served or guardian must consent to the plan.
H. Person served or guardian informed of risks, benefits and alternative treatments.
I. Service/Treatment plan must include at a minimum:
    1. Goals stated clearly and objectively;
    2. Specific objectives must be measurable;
    3. Objective measures to be used to access the effects of treatment or service;
    4. Time table must be established for each goal specified;
    5. Description of each objective for specific treatment procedure to attain goal;
    6. Identify each staff member responsible for each goal; and
    7. Time intervals at which treatment or service outcomes will be reviewed.

VII. Documentation:

A. Service Coordination cases must have an intake summary, assessments, treatment plans and progress notes pursuant to ACDD, JCAHO, CARF,CMS and Medicaid requirements.
B. Unless the state records retention schedule requires longer, maintain the case files for three (3) years after Service Coordination services are discontinued.
C. Any individual who makes an entry in the case file must write legibly, date it with the current date, sign their name, and enter their job title and/or professional capacity.
D. All files at a site must be organized in the same way.
E. Documents which must be in the record include:
    1. An assessment which shows that the individual meets the criteria for the target group;
    2. The identity and discipline of the person who determined the person meets the target group criteria;
    3. The Service Coordinator's qualifications as an eligible provider;
    4. The service as a legitimate Service Coordination activity;
    5. The actual time in quarter hour increments spent providing Service Coordination services;

6. An up-to-date treatment plan; and
7. Dated progress notes for each treatment encounter, type of service rendered and progress of the client.

F. The service log such as the example shown in Appendix B must include:

1. The actual dates and time spent providing Service Coordination service in quarter hour increments;
2. The name of the Service Coordinator providing services;
3. The nature and extent of Service Coordination services; and
4. The place service was provided.

VIII. Billing Procedures/Definitions:

There is to be no co-payment. The Medicaid payment will be considered payment in full for Medicaid eligible clients.

People whose Medicaid eligibility is pending will not be billed until the Medicaid eligibility determination is made. If the person is determined eligible, than Medicaid will be billed retroactively to the Medicaid eligible month. Submit a request to the Welfare Division for "prior med" based on prior service Coordination (case management) services. Each person served should be informed that if Medicaid eligibility is denied, a fee may be assessed based on ability to pay.

People whose Medicaid eligibility is Qualified Medicare Beneficiary (QMB) will be assessed on ability to pay.

A. Medicaid-eligible person:

Medicaid reimbursement must be sought for Medicaid-eligible seriously mentally ill (SMI) adults, for Medicaid-eligible severely emotionally disturbed (SED) children, and for Medicaid-eligible people with developmental delays and related conditions.

B. Non-Medicaid person;

Medicaid cannot be billed for people who do not meet the SMI, SED or MR target definition.

Non-Medicaid people who are living alone or with their families will be assessed for ability to pay per Division policy 3.006. Exceptions to fee amount based on ability to pay can be submitted to the division administrator if there are unusual circumstances.

C. Billable Service Coordinators:

Only services provided by the following can be billed to Medicaid:

1. An employee or contractor of the Department of Health and Human Services or one of its divisions; and

2. A psychiatrist licensed to practice medicine in Nevada and eligible for certification by the American Board of Psychiatry and Neurology;

3. A psychologist licensed to practice in Nevada;

4. A licensed clinical social worker (LCSW) licensed in Nevada (referred to by Medicaid as a Qualified Mental Health Professional (QMHP). QMHP is used only under the Medicaid Behavioral Health Redesign;

5. A Marriage and Family Therapist (MFT) licensed in Nevada (referred to by Medicaid as a Qualified Mental Health Professional (QMHP). QMHP is only used under the Medicaid Behavioral Health Redesign;

6. A psychiatric registered nurse (RN) licensed in Nevada to practice professional nursing (referred to by Medicaid as a Qualified Mental Health Professional (QMHP). QMHP is only used under the Medicaid Behavioral Health Redesign;

7. A service coordinator with a bachelor's degree in a health-related field (referred to by Medicaid as a Qualified Mental Health Associate (QMHA). QMHA is only used under the Medicaid Behavioral Health Redesign);

8. A mental health professional who works under the direct supervision of a person listed above;

9. A developmental disabilities professional with at least a bachelor's degree in human sciences; or

10. An RN, LPN, psychiatric caseworker, mental health technician III or IV, mental health counselor, child development specialist who works under the direct supervision of a person in B through L above.

D. Freedom of Choice:

Medicaid recipients must have freedom of choice of providers. This means people must be allowed to choose their Service Coordinator and must be informed of their right to change their Service Coordinator if multiple providers are available.

E. Financial Information:

If a current mental health financial form is not on file, one must be completed. Subsequently, re-determination must be done every 12 months or sooner when there is indication of change in the client's financial situation. In all instances, an original must be forwarded to billing staff and a copy placed in the client's file.

F. Billing Procedures:

Services are entered via to Clinical Work Station (CWS) with a Progress Note. A separate Medicaid bill is required for each person served each month. Other Medicaid services cannot be included on the billing for Service Coordination services. The bill must include:

Provider billing number (provider type is 54)

NNAMHS	54-16864
SNAMHS	54-02897
Rural Clinics	54-13001
SN Child & Adolescent Services	54-02800
NN Child & Adolescent Services (CBS)	54-16700
NN Child & Adolescent Services (ATC)	54-16705

Provider name and address
Client full name (as it appears on the Medicaid eligibility)
Client Medicaid number
Dates of service (may be first day of month)
Units of service in quarter hours
Procedure code for service rendered

Chronically mentally ill adults	T1017 (modifiers HI and HB)
Emotionally disturbed youth	T1017 (modifiers HA)
Developmentally delayed (non-waiver)	T1017 (modifiers HI)

and
Total due.

Private pay billings must be prepared using the statewide fee schedule. Third party payers (insurance) are to be billed full fee until such time as those payments are denied in writing for Service Coordination services for the specific policy then the services will be assessed for ability to pay.

G. Internal Review/Audit:

Each agency will designate one representative to serve on an audit team. The team also will include one representative of central office and one representative of Nevada Medicaid (when available). Audits will be conducted annually.

H. Hourly Rate:

The hourly rate will be negotiated with the Nevada Division of Health Care Financing and Policy and is based on actual cost of the service.

I. Fee Schedule:

The fee schedule is structured so that fees of amounts less than the cost of preparing a bill are not charged. The charges start at 10 percent of the cost of the service.

J. Non-duplication of Payments:

Bills for Service Coordination shall not be submitted to Medicaid for services for which another payer is liable or for services for which no payment liability is incurred. Bills for Service Coordination shall not be submitted to Medicaid for activities which are an integral and inseparable part of another Medicaid covered services, such as discharge planning from hospitals or nursing facilities, and outpatient services (therapies, medication management, etc.). Bills shall not be submitted to Medicaid if it duplicates payment made under other program authorities for this same period.

K. All CMS (formally HCFA) 1500 billing claims must be submitted to Medicaid's new MMIS fiscal agent (either on paper or electronically):

First Health Service Corporation/CMS 1500
P.O. Box 39931
Reno, NV 89501-2127

L. Staff Orientation:

All Service Coordinators must be thoroughly trained in the terms of this policy.

M. Each Division mental health agency shall develop specific written procedures to implement the provision of this policy or shall incorporate this policy into the agency policy manual.

Appendix A

MEDICAID BEHAVIORAL HEALTH INTENSITY OF NEEDS FOR ADULTS

Level	Service Criteria	Intensity of Service	Provided By:
LEVEL ONE Recovery Maintenance and Health Management	➢ DSM Axis I diagnosis, including v-codes, that does not meet SMI criteria (excludes dementia and mental retardation) ➢ LOCUS Level One or above	➢ Clinic case management (3 face-to-face sessions per calendar year) ➢ Assessment/Evaluation (twice per year) ➢ Individual, group or family therapy (6 sessions per calendar year) ➢ Medication Management (6 times per calendar year). ➢ Crisis Intervention (CI) ➢ 4 Hours Peer support services ➢ 4 Hours Family support services	➢ Any qualified BHCN. Provider qualifications are dependent on service requirements ➢ Independent Psychiatrists and Psychologists
LEVEL TWO Low Intensity Community Based Services	➢ DSM Axis I diagnosis, including v-codes, that does not meet SMI criteria (excludes dementia and mental retardation) ➢ LOCUS Level Two or above	➢ Clinic case management (4 face-to-face sessions per calendar year) ➢ Assessment/Evaluation (twice per year) ➢ Individual, group or family therapy (12 sessions per calendar year) ➢ Medication Management (8 times per calendar year)	➢ Any qualified BHCN. Provider qualifications are dependent onservice requirements ➢ Independent Psychiatrists and Psychologists ➢ Independent Mental Health Rehabilitative Providers
LEVEL THREE High Intensity Community Based Services	➢ DSM Axis I diagnosis (excludes v-codes, dementia, mental retardation or a primary diagnosis of a substance abuse disorder, unless they co-occur with another mental illness that meets DSM criteria) ➢ LOCUS Level Three or above ➢ SMI determination	All Level Two services plus: ➢ Targeted Case Management ➢ Individual, group and family therapy (12 sessions per calendar year) ➢ Medication Management (12 times per calendar year) ➢ Psychosocial Rehabilitation ➢ Crisis Intervention (CI) ➢ Basic Skills Training	➢ Any qualified BHCN. Provider qualifications are dependent on service requirements ➢ Independent Psychiatrists and Psychologists ➢ Targeted Case Management to be provided by the state agency or Mojave ➢ Independent Mental Health Rehabilitative Providers
LEVEL FOUR Medically Monitored Non-Residential Services	➢ DSM Axis I diagnosis (excludes v-codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless they co-occur with another mental illness that meets DSM criteria) ➢ LOCUS Level Four or higher ➢ SMI determination	All Level Three services plus: ➢ Individual, group and family therapy (16 sessions per calendar year) ➢ Medication Management (12 sessions per calendar year) ➢ Day Treatment ➢ Program for Assertive Community Training (PACT)	➢ Any qualified BHCN. Provider qualifications are dependent on service requirements ➢ Independent Psychiatrists and Psychologists ➢ Qualified Treatment Home Providers ➢ Targeted Case Management to be provided by the state agency or Mojave
LEVEL FIVE Medically Monitored Residential Services	➢ DSM Axis I diagnosis (excludes v-codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless they co-occur with another mental illness that meets DSM criteria) ➢ LOCUS Level Five or higher ➢ SMI determination	All Level Four services plus: ➢ Individual, group and family therapy (18 sessions per calendar year) ➢ Treatment Homes	➢ Any qualified BHCN. Provider qualifications are dependent on service requirements ➢ Independent Psychiatrists and Psychologists ➢ Qualified Treatment Home Providers ➢ Targeted Case Management to be provided by the state agency or Mojave
LEVEL SIX Medically Managed Residential Services	➢ DSM Axis I diagnosis (excludes v-codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless they co-occur with another mental illness that meets DSM criteria) ➢ LOCUS Level Six ➢ SMI determination	All Level Five services plus: ➢ Inpatient Hospitalization	➢ Inpatient hospitalmust be state licensed as a psychiatric hospital ➢ Medicare-certified and/or JCAHO accredited

ATTACHMENTS:

A. Medicaid Behavioral Health Intensity of Needs for Adults, Children and Adolescents

Administrator

Effective Date: 12/31/97
Date Revised: 11/12/03, 11/14/03,12/06/06

Division of Public and Behavioral Health
Clinical Services

Control # Revised
HR 2.5 5/20/11

Title: CONFLICT PREVENTION AND RESPONSE TRAINING (CPART) CERTIFICATION REQUIREMENTS

Effective Date: 11/2/01
Next Review Date:

POLICY: It is the policy of the Division that all Developmental Support Technicians (DSTs), Mental Health Technicians (MHTs), and Forensic Specialists become certified in Conflict Prevention and Response Training (CPART) within six months of hire and become re-certified every two years thereafter.

PURPOSE: CPART is an instructional course for staff working with persons served by Division agencies. CPART focuses on verbal de-escalation/intervention techniques and conflict resolution to reduce the potential for verbal or physical abuse and to decrease the likelihood of injuries to people served and/or others. Emphasis is placed upon positive behavioral techniques that modify the environment and emphasize verbal intervention, with application of specific defensive techniques and restraint techniques only as a least resort. Physical restrictive intervention techniques are used only when there is an imminent danger to the health and safety of the person serviced and/or others.

SCOPE: Division Wide

PROCEDURES:

I. Essential Functions - An analysis of duties for all DSTs, MHTs, and Forensic Specialists requires CPART certification as an essential function for these positions.

II. Work Performance Standards - Each Division agency shall include the requirement of CPART certification and the use of its techniques in the DSTs, MHTs, and Forensic Specialists Work Performance Standards in accordance with NAC 433.060.

III. Certification Requirement for Probationary Employees

Control # Revised
HR 2.5 5/20/11

Title: CONFLICT PREVENTION AND RESPONSE TRAINING (CPART) CERTIFICATION REQUIREMENTS

Effective Date: 11/2/01
Next Review Date:

A. Newly employed Division DST, MHT, and Forensic Specialists must become CPAR certified within six months of employment. A certificate of completion is provided to the employee upon successful completion of the training. Should the employee fail the certification test, the employee shall then be given individual instruction by the agency CPART instructor and an additional opportunity to pass the test within a 30-day period.

B. If a probationary employee is unable to become CPART certified within the 30-day period, the CPART instructor shall document the failure and notify the agency director. The agency director will then dismiss the employee from probation for inability to perform an essential function of the job.

IV. Temporary Waiver

A. If a permanent employee is unable to become CPART certified due to a physical limitation, the CPART instructor shall notify the agency director in writing of the specific CPART technique(s) the employee is unable to perform.

B. The agency director shall make a determination to grant or deny a temporary waiver for the technique(s) specified by the CPART instructor. The determination shall be in writing to the employee with a copy to the employee's supervisor and the agency's personnel office.

C. Should the temporary waiver be approved, the employee shall be required to perform all CPART techniques not covered by the temporary waiver.

D. The employee shall provide a note from his/her doctor describing physical limitation(s), treatment prescribed, and the anticipated date of medical recovery.

E. The employee shall be CPART trained and re-tested either upon a medical clearance or upon one year from the previous CPART testing.

V. Re-Certification

A. With the exception of a temporary waiver or failing the waiver provision, if a permanent employee is unable to become CPART re-certified after the re-test then the CPART instructor shall document the failure in writing and notify the agency director. If the agency director concurs, then the agency will:

1. With the assistance of the Division Administrator, attempt to locate a position within the Division or the Department of Health and Human Services in which CPART is not required;
2. Refer the employee to State Personnel for job development assistance; and/or

3. Refer the employee to the Bureau of Vocational Rehabilitation.

B. A CPART certified employee will be required to re-certify every two years by successful completion of either a Division sponsored CPART course or the course offered by the community college.

VI. Termination of Employment

A. If a permanent employee is unable to become CPART re-certified or accommodated within the state system in accordance with waiver standards due to a medical condition, the agency will follow the steps outlined in NAC 284.611. If these steps are unsuccessful, the employee may be medically separated as provided in NAC 284.611.

B. If a permanent employee is unable to become CPART re-certified for non-medical reasons, the agency may pursue disciplinary action up to and including termination of employment for failure to maintain a current occupational certification.

VII. Training

A. Each MHDS Agency shall have a minimum of two certified CPART Trainers whose responsibility is to provide training to new and existing staff as required and addressed in section III, A and B, and section V, A and B, of this Policy, for purposes of maintaining and sustaining all required CPART training.

B. To serve as in-house MHDS agency CPART trainers, a person shall meet the following criteria:

1. Have at least one years' experience as a Technician;
2. Be a Technician II or higher; and
3. Have successfully completed the CPART course at the community college level.

C. To serve as a MHDS Division "Train the Trainer" CPART

Trainer, a person shall meet the following criteria:

1. Be an in-house trainer for at least one year; and
2. Be recommended and appointed as a CPART "Train the Trainer" by the MHDS Statewide CPART Oversight Board.

D. To serve as a CPART Community College (College of Southern Nevada and Truckee Meadows Community College) instructor a person shall meet the following criteria:

1. Be approved by the directors of the Mental Health/Developmental Disabilities (MHDD) programs at the two colleges.

2. Be approved by the CPART Oversight Board.

3. Meet the employment application requirements at the two colleges.

VIII. Oversight Board

Control # Revised
HR 2.5 5/20/11

Title: CONFLICT PREVENTION AND RESPONSE TRAINING (CPART) CERTIFICATION REQUIREMENTS

Effective Date: 11/2/01
Next Review Date:

A. A CPART oversight board shall be established for the purpose of research and implementation of best practices in conflict prevention and response training. The Oversight Board shall consist of at least one member from each of MHDS' mental health and developmental services agencies appointed by their agency director and one member from MHDS' Central (Division) Office. Additionally, if necessary, a Physical or Occupational Therapist may be consulted at any time deemed necessary by the Oversight Board.

B. Certificates shall be provided by the CPART Oversight Board to all staff attending and completing the CPART Train the Trainer and Agency trainings. The Certificate must contain the name and signature of Chair of the Oversight Board and Agency Director.

C. Responsibilities include:

1. Monitoring of CPART classes;

2. Assuring agencies have sufficient training

opportunities for staff;

3. Certification of instructors including:

a. Setting criteria for instructor status;

b. Tracking of instructor's hours of instruction;
c. Consistency of training through monitoring and recertification; and

4. Ongoing research relative to techniques taught.

IX. Each Division agency shall develop specific written procedures to implement the provisions of this policy or shall incorporate this policy into their agency policies.

EFECTIVE DATE: 11/2/01

DATE REVIEWED/REVISED: 08/15/05; 10/12/07; 4/1/11, 5/20/11

SUPERCEDES: 2.015 – Conflict Prevention and Response Training Certification Requirements

APPROVED BY MHDS ADMINISTRATOR: 11/2/01, 5/20/11

APPROVED BY MHDS COMMISSION: 5/20/11

Division of Public and Behavioral Health
Clinical Services

Control #	Revised	Title	Effective Date: 09/2017
A 4.1	11/2019	Mail Room and Mail Safety	**Next Review Date:** 11/2021

1.0 POLICY:

To provide guidelines for safe screening and handling of all incoming packages and letters, whether delivered via the United States Postal Service (USPS), third party couriers (FedEx, UPS, DHL) special messengers, interoffice mail or guest and visitors.

2.0 PURPOSE:

To provide mail center managers, supervisors, staff and security personnel a framework for mitigating risk when handling mail and packages received. Mail security and screening protects employees, clients, facilities, business functions and guests.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 Personal Protective Equipment (PPE) protective clothing, helmets, goggles, masks (inclusive of N95) or other garments or equipment designed to protect the wearer's body from injury or infection. The hazards addressed by protective equipment may include physical, electrical, heat, chemicals, biohazards, and gaseous or airborne particulate matter.

4.2 CBRNE - Chemical, Biological, Radiological, Nuclear or Explosive Substances

4.2.1 **Chemical** – is a specialized weapon that uses **chemicals** formulated to inflict death or harm on humans. Examples of chemical threats include nerve agents, blood agents, pulmonary agents, blister agents, industrial chemicals and irritants. Chemical threats can be solid, liquid or gaseous/vapor.

4.2.2 **Biological** - also called bio-agent, biological threat agent, biological warfare agent, biological weapon, or bioweapon—is a bacterium, virus, protozoan, parasite, or fungus that can be used purposefully as a weapon in bioterrorism or biological warfare (BW).

4.2.3 **Radiological** - or radiological dispersion device (RDD) is any **weapon** that is designed to spread radioactive material with the intent to kill and cause disruption.

4.2.4 **Nuclear** - a bomb or missile that uses nuclear energy to cause an explosion.

4.2.5 **Explosive** - weapons that affect an area around the point of detonation, usually through the effects of blast and fragmentation.

4.3 Dangerous Items – items that can cut, shock or harm an individual when the letter or package is opened.

4.4 Illegal or Contraband Items – illegal drugs, guns, knives, swords or other potentially dangerous substances or weapons.

4.5 Hoax – a suspicious mail item that is designed to present the appearance of a dangerous substance or other threat but do not actually contain the actual substance necessary to cause harm.

4.6 White Powder Envelope or Package– Any white powdery substance that creates the appearance of anthrax, a dangerous biological substance or toxin.

4.7 Threats – suspicious mail may contain threatening language on the envelop or inside the envelope's contents. The threat intends to inflict pain, injury, damage or other hostile action on someone or something.

4.8 Mailroom – a point of receipt, sorting and distribution of mail and packages.

4.9 Types of Mail and Package Deliveries

4.9.1 U.S. Postal Service (USPS) agency responsible for general delivery of a full range of items.

4.9.1.2 U.S. Postal Service Accountable Mail Certified and Registered Mail. Includes the deliverer and recipient signature and is assigned a unique tracking number.

4.9.2 Express Couriers provide pickup and delivery of express mail and packages. Security features include end to end tracking and limited security screening. Terrorist have begun using global express couriers for delivery of explosive packages.

4.9.3 Interoffice Mail – Mail created and delivered entirely within a system, building, or campus environment. Interoffice mail cannot be assumed safe and must be considered a potential source of suspicious mail. Disgruntled employees, visitors and others can introduce suspicious mail directly into the internal mail sorting process.

5.0 REFERENCES:

5.0.1 Maintaining Mail Safety and Security on A Budget: White Paper, Pitney Bowes, 2009 (current version)

5.0.2 Handling Powdery Substances 2019, Secure Community Network

5.0.3 Best Practices for Mail Screening and Handling Processes: A Guide for the Public and Private Sectors, January 2015, US Department of

Homeland Security and the Interagency Security Committee.

6.0 PROCEDURE:

6.1 Basic Mail Security Procedures:

6.1.1 All mail including packages must be delivered through a central location in each agency; preferably a designated mail center or room.

6.1.2 Ensure that all mail delivery personnel from the postal service and other package delivery and supply vendors are clearly identified and log in.

6.1.3 Provide a designated parking area for delivery of mail, packages and supplies.

6.1.4 Staff handling and sorting mail should wear gloves and wash their hands or use hand sanitizer immediately after completion of the task.

6.1.5 Personal Protective Equipment (PPE) should be available in every mail center or room location.

6.1.6 Basic PPE – gloves, gowns and masks should be donned before handling suspicious mail.

6.1.6.1 Suspicious mail indicators include the following but must be considered within the context of the organization and its population:

6.1.6.1.1 Powdery substance on the outside of the package.

6.1.6.1.2 Is an unexpected delivery

6.1.6.1.3 Has excessive postage, is hand written or contains a poorly typed address, incorrect title, or just a title with no name or misspells of common words.

6.1.6.1.4 Is addressed to someone no longer with the organization or is otherwise outdated.

6.1.6.1.5 Has no return address or one that cannot be verified as legitimate.

6.1.6.1.6 Unusual weight for its size or is lopsided or oddly shaped.

6.1.6.1.7 Has an unusual amount of tape on it.

6.1.6.1.8 Is marked with restrictive endorsements.

6.1.6.1.9 Has strange odors, stains or protruding wires.

6.1.7 Close off the room including the ventilation system (if possible)

6.1.8 Call an Overhead Code as appropriate for your organization: example Code Bravo, Code 45, Code 77;
6.1.9 Call 911 and notify Capitol Police.
6.1.10 Report immediately through your chain of command to activate the emergency notification process (DPBH Policy A.4 DPBH Emergency Notification).
6.1.11 Notify other agencies in immediate proximity as appropriate.
6.1.12 Notify the DPBH Statewide and Regional Emergency Operations Managers.
6.1.13 Update HAvBED and put agency status on Internal Disaster.
6.1.14 Notify the U.S.P.S Post Master.
6.1.15 Don't open any parcel until it is verified as safe.
6.1.16 If you receive a suspicious letter or package: handle with care, do not shake, bump, open, smell, touch or taste it.
- 6.1.16.1 Isolate it immediately – treat it as suspect.
- 6.1.16.2 If possible isolate it in a separate room that can be closed off and is away from personnel and staff traffic. If possible isolate the air ducts to and from the room or area.
- 6.1.16.3 If it has powdery or other substances leaking from the package do not clean up and avoid further contact.
- 6.1.16.4 Calmly and immediately move away from the envelope or package and inform others in the area to leave.
- 6.1.16.5 Do not walk around and show others or invite others to come in and look.
- 6.1.16.6 If your clothes are contaminated, do not brush vigorously as this may disperse powder into the air. Remain in place and wait for directions from first responders.
- 6.1.16.7 Do not touch your eyes, nose, mouth, hair or any other part of your body.
- 6.1.16.8 If possible and without contaminating other areas, wash your hands with soap and water or hand sanitizing gel or wipe.
- 6.1.16.9 Make a list of all people who had contact with the powder or were in the area when the powder was released.

6.2 TRAINING

6.2.1 Suspicious Mail Training:
6.2.1 All staff will be trained on hire and annually
6.2.1.1 Training will include emergency response procedures.
6.2.2 Mail Center staff will be trained on hire and once (1) per year.

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY:
Each DPBH agency shall implement this policy and will develop specific written protocols and procedures as necessary to do so effectively.

EFFECTIVE DATE: 9/2017
DATE APPROVED BY DPBH ADMINISTRATOR: 9/2017
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 9/2017, 11/2019

Division of Public and Behavioral Health
Clinical Services

Control #	Revised	Title	Effective Date: 11/15/2019
A 1.3	New	Maintenance of Agency All Staff Reader's Group	Next Review Date: 11/21

1.0 POLICY:

Each Agency will maintain Policy Tech Reader's (Assignee) groups.

2.0 PURPOSE:

To allow for the distribution and tracking of DPBH Poicy and Agency Protocol to all Division staff.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 **Policy Tech**: Online policy and procedure management system used by the Division of Public and Behavioral Health to store track and manage agency policy, protocol and procedure.

4.2 **Active Directory (AD):** is a Microsoft directory service that stores information about Members (staff) of the domain, including devices and users, verifies their staff credentials and defines access rights to email and Policy Tech accounts.

4.3 **Reader's (Assignee) Group**: A group of staff that are assigned to read specific Documents.

4.4 **DPBH Reader's Group**: All staff assigned to DPBH.

4.5 **Agency All Staff Reader's Group**: Each Agency's "all staff" reader's group

4.6 **Program Specific Reader's Groups:** Reader's groups assigned by each agency to facilitate the agency's ability to provide directed information. Specific Reader's groups can be discipline, program or content specific as needed.

4.7 **DPBH Policy**: DPBH Clinical Service Branch guideline or principles upon which a program or course of action is based.

4.8 **Agency Protocol**: Individual agency guidance that supports and adds clarity at the agency level for the implementation of Division policy.

4.9 **Procedure:** a discipline or department specific procedure which defines the process and actions needed to implement a protocol.

5.0 REFERENCES:

5.1 DPBH Clinical Services Branch Policy Development and Review Process

5.2 Department Procedure Development and Review Process

6.0 PROCEDURE:

6.1 Active Directory will maintain the following reader's groups

6.1.1 DPBH All Staff
6.1.2 Agency All staff groups

6.2 All staff reader's groups both DPBH and Agency will populate through Active Directory.

6.3 Agency staff will maintain Program Specific groups.

6.4 The Personnel Roster Change form (PRCF) will be completed on all new hires, terminations and transfers;

6.4.1 PRCFs must be submitted on contract employees, students and residents as well as employee terminations.

6.4.2 The PRCF will be used to create or archive the employee email and Policy Tech account.

6.4.3 Contract employees are assigned a state email and Policy Tech account based on the submission of a PRCF.

6.4.3.1 Contract employees will be maintained in the DPBH and Agency All Staff Groups by AD.

6.4.3.2 Agency staff will add or delete contact employees to Program Specific groups as needed.

6.4.4 The Personnel Roster Change form will also be used when an employee transfers from one department or supervisor to another.

6.5 Program staff may not manually add or delete staff Policy Tech accounts.

6.5.1 Employee accounts must be created through AD.

6.5.2 Employee accounts created manually will be archived by AD when it does a routine nightly update.

6.5.3 If an account that should be in Policy Tech is missing, notify Office of Information Technology (OIT) so that the problem with Active Directory can be corrected.

6.4.4 If staff identify duplicate accounts, notify OIT.

6.6 Agency Managers will assign Policy Tech management staff who will have the responsibility for maintaining Program Specific Groups.

6.7 New employees, contract employees, students and residents may be added to Program Specific groups at the agency's discretion.

6.8 When employees, contractors, and students leave the agency, a PRCF must be submitted to remove them from the DPBH and Agency All Staff groups.

6.9 Each Agency's Policy Tech management staff must be included in notifications of hires, terms, contractor hires and terms and students rotating in and out or the agency.

Control #	Revised	Title	Effective Date: 11/15/2019
A 1.3	New	Maintenance of Agency All Staff Reader's Group	Next Review Date: 11/21

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY:
Each DPBH agency shall implement this policy and may develop specific written protocols and procedures as necessary to do so effectively.

Division of Public and Behavioral Health
Clinical Services

Control #	Revised	Title:	Effective Date: 09/2017
A 4.0	11/2019	Emergency Notification	**Next Review Date:** 11/2021

1.0 POLICY:

The Clinical Services Branch ensures proper communications during emergent events, while protecting and promoting the safety and confidentiality of those involved

2.0 PURPOSE:

This policy establishes guidelines for proper communications during emergent events to the Administrator of DPBH with the use of telecommunications, electronic communications and personal electronic devices.

This policy is not intended to replace existing policies related to significant/serious incident reports but rather to establish a quick reporting mechanism to key staff at the time the event is unfolding.

3.0 **SCOPE:** Clinical Services Branch

4.0 DEFINITIONS:

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

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

5.0 REFERENCES:

5.1 DPBH Policy CRR 1.4 Reporting of Serious Incidents
5.2 DPBH Policy A6.1 Psychological First Aid Counselor Response
5.3 DPBH Policy A6.3 Clinical Services Disaster Requirement Plan
5.4 DPBH Comprehensive Emergency Management Plan
5.5 DPBH CRR1.5 Management of Elopement Inpatient Services

6.0 PROCEDURE:

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

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

6.1.2 Notification of the incident will be made immediately to the operator and/or

Forensic Control Room staff by phone or in person.

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

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

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

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

6.1.6 Voice-to-voice notification will be made to the House Supervisor, Nursing Director, Administrator on call and/or Hospital Administrator, the Capitol Police, State-wide and/or agency Emergency Preparedness Coordinator (as appropriate) and immediate supervisor according to agency protocol.

6.1.6.1 The Emergency Preparedness Manager/Coordinators will be able to activate Crisis Counseling or Psychological First Aid Counselors as needed.

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

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

6.1.8.1 Notification should occur through multiple redundant communication mechanisms such as Everbridge Communicator, Email, Text messaging, Over Head Paging and Voice to voice to ensure rapid and inclusive awareness of the situation.

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

7.0 **ATTACHMENTS:** N/A

8.0 IMPLEMENTATION OF POLICY:

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

EFFECTIVE DATE: 09/2017
DATE APPROVED BY DPBH ADMINISTRATOR: 09/2017
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 09/2017, 11/2019

Nevada Department of Health and Human Services
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

Policy

SUBJECT: Requesting a Written Opinion from the Attorney General's Office

NUMBER: A 4.6

EFFECTIVE DATE: 11/2019

NEXT REVIEW DATE: 11/2021

SUPERCEDES: 8/1997

1.0 PROTOCOL:

It is the policy of the Division of Public and Behavioral Health (DPBH) that written opinions and/or investigations requested from the Attorney General's Office be requested through the Division Administrator.

2.0 PURPOSE:

This policy will identify the procedures required for soliciting written opinion and/or investigations from the Attorney General's Office.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS: N/A

5.0 REFERENCES: N/A

6.0 PROCEDURE:

6.1 Any request for an attorney general's written opinion and/or investigation requested must be generated by the Agency Director and forwarded through the Division Administrator or designee.

6.2 Once the Division Administrator or designee has approved the request, it is forwarded to the appropriate regional deputy attorney general.

6.3 The Attorney General's written response must be forwarded through the Division Administrator to the Agency Director.

6.4 Any informal non-written attorney general request must be generated by the Agency Director. The Agency Director must consult with the Division Administrator or designee prior to contacting the Attorney General's Office.

6.5 Any informal non-written attorney general request must be generated by the Agency Director.

6.5.1 The Agency Director must consult with the Division Administrator or designee prior to contacting the Attorney General's Office.

6.6 Once the Division Administrator approves the Agency Director's request for an investigation, the request is forwarded to the Director of the Department of Health and Human Services (DHHS).

6.6.1 If the DHHS Director approves the request, it will be sent directly to the Chief Investigator of the Attorney General's Office.

6.7 The Chief Investigator will notify the Director of DHHS whether the referral has been accepted for investigation.

6.8 It will be the responsibility of the Agency Director to cooperate and assist the investigation as requested by the Chief Investigator or designee.

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY:

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

Effective Date: 08/1997
Date Reviewed/Revised: 02/2007, 11/2019
Date Approved by DPBH Commission: 11/2019

Division of Public and Behavioral Health
Clinical Services

Control #	Revised	Title	Effective Date: 11/16/2018
A 5.1	11/2019	Division Level II Incident Report Management and Closure Process	Next Review Date: 11/01/2021

1.0 POLICY:
The 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 **DHHS Critical Incident** is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health safety or well-being of a DHHS client, employee or the public that must be reported to the Director's Office

4.2.1 Reportable Critical Incidents are defined as: Abuse; Death/Suicide; Lost/Missing Person; Run-Away/Elopement; Serious Injury; Threat of Hostage Situation; Public Health Emergency; Health Facility Emergency; Fire/National Disaster.

4.3 **Patient Safety Officer** (PSO) as used in this policy references NRS. 439.815 means a person who is designated pursuant to NRS 439.870.

4.4 **Division Incident Report Committee** is a Clinical Services Branch Committee consisting of membership of each agency's PSO or Quality Assurance Specialist (QAS).

4.5 **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 if filed as a closed chart.

4.6 **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.

Control #	Revised	Title	Effective Date: 11/16/2018
A 5.1	11/2019	Division Level II Incident Report Management and Closure Process	Next Review Date: 11/01/2021

5.0 REFERENCES:

5.1 NRS. 439.815
5.2 NRS 439.870
5.3 DPBH Clinical Services Branch CRR .014 Risk Management and Reporting Serious Incident

6.0 PROCEDURE:

6.1 Level II Division Incidents will be reviewed and managed at the agency level by staff assigned by the Agency Manager,

6.2 Level II Division Incidents must be entered Avatar by a QAS, a clinical staff person or a QAPI staff member, AAs do not enter Level II Incidents even with an SIR worksheet.

6.3 The PSO or QAS will review agency Level II incidents and report with recommendation for further review or closure of each of their assigned Level II Division incidents.

6.4 The PSO or QAS will have access to closed and locked medical records both electronic and paper/hard copy on request to allow them to do the necessary research to determine the status of an open Division Level II Incident. Results of this research will be recorded in the Incident Notes section of the Incident Report.

6.5 The Agency Manager or delegee will ensure that a final incident note be recorded in Avatar prior to closure of the indent.

6.6 When incidents remain open for more than six (6) months, the Agency Manager or delegee will work with the DPBH Deputy Administrator to resolve issues and facilitate closure.

6.7 The Agency Manager will focus on identifying trends that would point to opportunities for system improvements throughout the Division and make recommendations for further action or analysis.

7.0 ATTACHMENTS:

8.0 IMPLEMENTATION OF POLICY:

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

Effective Date: 11/16/2018
Date Reviewed/Revised: 11/2019
Date Approved by DPBH Commission: 11/2019

Division of Public and Behavioral Health
Clinical Services

Control # Revised
A 5.3 09/2019

Title: Quality Assurance and Performance

Improvement Effective Date: 10/16

Next Review Date: 09/2021

1.0 POLICY:

The Division of Public and Behavioral Health (DPBH) Clinical Services Branch shall maintain quality assurance and performance improvement (QAPI) program throughout all agencies.

2.0 PURPOSE:

Quality Assurance and Performance Improvement ensures an organizational focus on continuous performance improvement, patient safety and staff development in all functional areas to assist consumers with mental illness improve their quality of life

The quality assurance (QA) components of QAPI focus on assisting the agencies in meeting or exceeding regulatory standards as set forth by State CMS (HCQC), The Joint Commission (TJC), and the Centers for Medicare and Medicaid Services (CMS).

The performance improvement (PI) components of QAPI move beyond the expectations of external regulatory entities to promote continuous improvement in the efficiency, effectiveness and availability of resources aimed at meeting the needs of and protecting, promoting and improving the lives of consumers who seek our services. PI is a continuous, positive, process-oriented endeavor that provides educational and technical support to leadership and staff at Division, Agency and Program levels.

3.0 SCOPE:

All DPBH entities within the Clinical Services branch including (1) Southern Nevada Adult Mental Health Services-SNAMHS, (2) Northern Nevada Adult Mental Health Services-NNAMHS, (3) Rural Clinics (4) Forensic Facilities .

4.0 DEFINITIONS

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

Control # Revised
A 5.3 09/2019

Title: QualityAssuranc and Performance Improvement

Effective Date: 10/16

Next Review Date: 09/2021

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

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

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

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

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

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

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

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

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

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

Control # Revised
A 5.3 09/2019

Title: Quality Assurance and Performance Improvement

Effective Date: 10/16

Next Review Date: 09/2021

5.0 REFERENCES: N/A

6.0 PROCEDURES:

6.1. Agency QAPI staff will provide technical assistance, support and training to leadership and staff regarding QAPI processes, including the standards used by HCQC, TJC and CMS for site reviews, which may include, but not limited to:

6.1.1 Consumer surveys;
6.1.2 Staff surveys;
6.1.3 Administrative/fiscal review;
6.1.4 Environment of care review;
6.1.5 Contract service provider review;
6.1.6 Clinical record review;
6.1.7 Client centered evaluation;
6.1.8 Cultural competency.

6.2. QAPI activities are the responsibility of all staff at all levels of the Division. Coordination and implementation of the QAPI process at the Agency level (including contract providers) is the responsibility of the Agency Director.

6.3 QAPI Team member(s) located at the agencies shall assist and provide technical support to Agency Directors in order to implement and coordinate the QAPI process.

6.3.1 It is the responsibility of QAPI personnel to resist the tendency to assume full responsibility for implementing QAPI activities at the Agency and/or Program level and instead provide guidance, technical assistance, consultation and oversight.

6.4. Each Agency shall have a defined process for reviewing, analyzing and noting actions required on QAPI reports.

6.4.1 This process shall include the Agency Director, other management staff and QAPI personnel.

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

6.6. Each Agency shall develop and maintain a comprehensive and integrated QAPI process throughout all programs (clinical and administrative including the role of contract providers).

6.6.1 Each Department and/or Program within each Agency will submit a Performance Improvement Plan (PIP) on an annual basis.

6.6.2 Each PIP should be:

6.6.2.1 multi-tiered,

6.6.2.2 involve staff at all levels,

6.6.2.3 approved by the Agency QAPI Coordinator and the Agency Director.

6.7. QAPI will collaborate with staff training coordinators to enhance competencies related to performance improvement activities.

6.8. QAPI may be involved with, but is not limited to, the following initiatives at the Division and Agency levels:

6.8.1 Licensure, certification and accreditation of DPBH hospitals;

6.8.2 Developing and implementing the DPBH Annual Medicaid State Plan;

6.8.3 DPBH Strategic Planning;

6.8.4 Reviewing Serious Incident Reports;

6.8.5 Patient Safety;

6.8.6 Patient Satisfaction;

6.8.7 Patient Advocacy, Compliments

6.8.8 Complaints and Grievances;

6.8.9 Policy and Procedure Development and Management;

6.8.10 Disaster Management and Emergency Preparedness;

6.8.11 Corrective Action Plans and Measures of Success;

6.8.12 Root Cause Analyses;

6.8.13 Staff Development and Training.

Control # Revised
A 5.3 09/2019

Title: QualityAssuranc and Performance Improvement

Effective Date: 10/16

Next Review Date: 09/2021

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY:

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

Effective Date: 10/2016
Date Reviewed: 10/2018, 09/2019
Date Approved by Commission on Behavioral Health: 11/2019
Replaces: APM #79-3

Division of Public and Behavioral Health
Clinical Services

Control # Revised
BHO-006 11/2019

Title: Behavioral Health Outpatient Case Management

Effective Date: 07/2019
Next Review Date: 11/2021

1.0 POLICY:

The Division will ensure timely access to case management services under an established statewide service delivery model based on an integrated system of care that meets the individually assessed resource and supportive service needs of consumers served. The provision of services will be based on medical necessity and the emergent, urgent, and stabilization needs of each consumer. All care will be coordinated, and services will be provided in conjunction with policy BHO-003 Service Delivery.

Case Management services will be provided according to the most recent Nevada *Medicaid Services Manual* (MSM), Chapter 2500 Case Management. Consumers may receive case management services in conjunction with other services or independent of other services. Case management services are based on the assessed resource/service needs of the consumer served.

2.0 PURPOSE

DPBH will ensure effective and systematic compliance with Federal, State and Division policies through uniformity in the access, provision and documentation of all outpatient mental health services. The purpose of this policy is also to establish policy for compliance with Nevada Medicaid in the provision of Targeted Case Management (TCM) services.

3.0 SCOPE

This policy applies to all Division's behavioral health agencies and integrated care centers. This policy is to be implemented in conjunction with DPBH policies, SP 4.47 Utilization and Quality Review for Mental Health Agencies, and BHO-003 Service Delivery.

4.0 DEFINITIONS

4.1 **Case Management.** A service to assist eligible individuals in gaining access to needed medical, social, educational, and other support services including housing and transportation needs. These services do not include the direct delivery of medical, clinical or other direct services. It includes an assessment, development of

a person-centered care plan, referral and linkage to needed services, and monitoring and follow-up.

4.2 **Case Manager.** The clinician providing the case management services to the consumer.

4.3 **Lead Case Manager.** A case manager who is responsible for coordinating the additional case management services with case managers from other target groups when the recipient is included in more than one target group at a given time. The Lead Case Manager represents children and adolescents with a Severe Emotional Disturbance (SED) or adults with a Serious Mental Illness (SMI) regardless of whether they were the original or a subsequent case manager for the consumer.

4.4 **Target Groups for Case Management Services.** Case management is based on the assessed eligibility status for a target group. Eligibility status is determined by a clinician that meets the requirements of a Qualified Mental Health Professional (QMHP) as defined in Chapter 400 of the MSM. Case management for DPBH will be provided to consumers that meet the diagnostic and impairment criteria in one of the following target groups defined in Chapter 2500 of the MSM:

4.4.1 Adults (individuals 18 years of age or older, statewide) with a **Non-Serious Mental Illness (Non-SMI)**.

4.4.2 Adults (individuals 18 years of age or older, statewide) with a **Serious Mental Illness (SMI)**.

4.4.3 Children and adolescents (individuals under age 18 years of age, in rural areas) with a **Non-Severe Emotional Disturbance (Non-SED)**.

4.4.4 Children and adolescents (individuals under age 18 years of age, in rural areas) with a **Severe Emotional Disturbance (SED)**.

5.0 REFERENCES:

5.1 Code of Federal Regulations, Title 42, Chapter IV, Subchapter C, Part 440.169, Case Management Services (42 CFR 440.169).

5.2 Code of Federal Regulations, Title 42, Chapter IV, Subchapter C, Part 441.18, Case Management Services (42 CFR 441.18).

5.3 Nevada Revised Statutes, Title 39 Mental Health, Chapter 433 (NRS 433), 433A, 433B, 433C, and 435.
5.4 Nevada Administrative Code, Chapter 433 (NAC 433) and 436.
5.5 Nevada Medicaid Services Manual (MSM) Chapter 2500, Case Management
5.6 Nevada Medicaid State Plan, Supplement 1 to Attachment 3.1-A
5.7 Billing Manual for Nevada Medicaid and Nevada Check Up.
5.8 Nevada Medicaid Provider Type 54 Billing Guide.

6.0 PROCEDURE:

6.1 ELIGIBILITY

6.1.1 ADMISSION CRITERIA: DPBH strives to serve all people in Nevada with a mental/behavioral health disorder in need of services that are not available or accessible in the private sector. To be eligible for case management services, an individual must meet the diagnostic and impairment criteria in one of the target groups and require assistance in obtaining and coordinating needed resources and support services.

6.2 CONTINUING STAY CRITERIA

Consumers must meet all the following:

6.2.1 Continues to meet admission criteria.
6.2.2 Individualized care plan identifies all medical, social, educational and other support services currently being provided, as well as the unmet needs of the consumer.
6.2.3 Documentation supports progress towards specific case management goals identified in the case management care plan, with barriers identified and addressed.
6.2.4 Care plan and goals are established.

6.3 DISCHARGE/EXCLUSIONARY CRITERIA

Must meet at least one (1) of the following:

6.3.1 The consumer or their legal representative chooses not to participate in the program.
6.3.2 The consumer has died, moved out of the area, or has not responded to three (3) documented attempts to contact him/her and/or see them face-to-face within 90 days.

6.3.3 No longer meets the diagnostic and impairment criteria in one (1) of the target groups.

6.3.4 No longer meets the admission and continuing stay criteria.

6.3.5 Has been incarcerated, or admitted into a Psychiatric Hospital, Institution for Mental Disease (IMD), or nursing facility, for more than 60 consecutive days.

6.3.6 Has a support system sufficient to sustain stability, thus not requiring unnecessary or frequent acute treatment.

6.3.7 The consumer's independent actions or lack thereof creates a situation that does not allow the agency to assure the consumer's health and safety.

6.4 SERVICES

All reimbursable case management services must:

6.4.1 Be provided on a one-to-one (telephone or face-to-face) basis.

6.4.2 Be medically necessary (pursuant to MSM Chapter 100).

6.4.3 Be provided by a qualified individual.

6.5 SERVICES INCLUDE THE FOLLOWING FUNCTIONS:

6.5.1 Case Management Assessment. Assessment of the consumer's case management needs in areas of medical, educational, social, or other services.

6.5.2 The assessment must be completed at the time of admission to case management services and reassessed at least annually thereafter. Assessment includes the following activities:

6.5.2.1 Taking/updating or reviewing the consumer's history.

6.5.2.2 Identifying the needs of the consumer and completing related documentation.

6.5.2.3 Gathering additional information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible consumer.

6.5.3 Case Management Care Plan.

A person-centered care plan based on the assessed case management needs of the consumer.

6.5.3.1 The plan outlines the need for any medical, educational, social, or

other services that are medically necessary for the consumer to regain societal integration and functioning, and the specific goals and actions needed to attain these goals.

6.5.3.1.1 The initial care plan is developed jointly with the consumer (or their legal representative) at the time of admission to services and at the conclusion of the Case Management Assessment.

6.5.3.1.2 A new updated/revised plan is jointly developed with the consumer (or their legal representative) at least annually thereafter, or sooner whenever there is a substantial change in the consumer's functioning/situation. The care plan includes:

6.5.3.1.3 The consumer-stated (or guardian-stated) personal outcomes desired (i.e. goals) and actions required to address the medical, social, educational, and other resource/service needs of the consumer.

6.5.3.2 Activities such as ensuring the active participation of the consumer and working with the consumer and others to reach the identified goals.

6.5.3.3 The course of action (objectives) to respond to the assessed needs of the consumer.

6.5.4 Case Management Referral and Linkage.

Activities to help the consumer obtain the identified resource/support services. Referral and related activities help link the consumer with medical, social, or educational providers; or with other programs and services to provide the needed service(s) specified in the care plan.

6.5.5 Case Management Monitoring and Follow-Up.

Activities and contacts that are necessary to ensure that the case management care plan is effectively implemented and is adequate to meet the assessed needs of the consumer.

6.5.5.1 These activities and contacts may be with the consumer, family members, service provider or other entities or individuals.

6.5.5.2 The monitoring is to be conducted as frequently as necessary, and at least annually, to determine whether the services are

being provided according to the consumer's care plan, whether the services are adequate, and whether there are any changes in the resource/service needs or status of the consumer.

6.5.5.3 Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers to respond to outcomes, barriers to progress, or other changes in the consumer's status or needs.

6.6 **SERVICE LIMITATIONS.**
Nevada Medicaid requires a Prior Authorization Request (PAR) be submitted and approved whenever the service limits stipulated in Chapter 2500 of the MSM will be exceeded.

6.7 Consumers under 21 years of age and part of the SED target group that are residing at a psychiatric facility or hospital may receive transitional targeted case management services 14 days prior to discharge.

6.8 Transitional case management activities must be coordinated with and not a duplication of institutional discharge planning services.

6.9 DOCUMENTATION

6.9.1 Services are to be documented in accordance with DPBH policy BHO-007 Tracking Services and Activities.

6.9.2 Documentation in the consumer's case record must meet the requirements DPBH policy SP 4.47 Utilization and Quality Review for Mental Health Agencies, and also needs to include the following:

6.9.2.1 The type of actual case management service received.

6.9.2.2 Whether the goals specified in the care plan have been achieved.

6.9.2.3 If the consumer declined any services listed in the care plan, the declination must be documented within the care plan.

6.9.3 Timelines for providing services and reassessment.

6.9.4 The need for and occurrences of coordination with case managers of other programs.

6.10 **DISCHARGING FROM CASE MANAGEMENT SERVICES** and transitioning to a different level of care,

6.10.1 No more than 30 days prior to the proposed discharge, the Case Manager or interdisciplinary team shall meet with the consumer, and assess and document the following in a Discharge Summary Progress Note:

6.10.1.1 The date of the last case management contact with the consumer;
6.10.1.2 The reason for discharge from services;
6.10.1.3 A summary statement that describes the effectiveness of the services provided, progress or lack of progress towards the case management care plan goals and objectives, and the apparent stability of the consumers current status;
6.10.1.4 The corresponding ICD diagnosis at both admission and termination of services;
6.10.1.5 The current (within 30 days of the date of discharge) Intensity of Needs level (i.e. LOCUS or CASII score, level of care, date of rating, rater's name and credentials); and
6.10.1.6 Recommendations for further services.

6.10.2 Within seven (7) days of the discharge date, the Case Manager will ensure the consumer's case management case records, documentation, and any other Division and/or Agency required discharge paperwork is up-to-date and completed; and then submit the consumer's chart to the approved entity for closure.

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY

Each Division agency within the scope of this policy shall implement this policy and

Will develop specific written procedures as necessary to do so effectively.

NEXT REVIIEW: 07/01/2021
EFFECTIVE DATE: 07/01/2019
SUPERSEDES: 3.002 Service Coordination Services, 4.035 Mental Health Service Coordination Closing Criteria

Control #	Revised
BHO-006	11/2019

Title: Behavioral Health Outpatient Case Management

Effective Date: 07/2019
Next Review Date: 11/2021

APPROVED BY DPBH COMMISSION: Click or tap to enter a date.

Division of Public and Behavioral Health
Clinical Services

Control # Revised
CRR-1.1 11/19

Title: Consumer Rights

Effective Date: 03/2017
Next Review Date: 11/2021

1.0 POLICY:

The Division of Public and Behavioral Health (DPBH) provides a process that supports and protects all of the rights granted to people receiving services from Division agencies through Nevada Revised Statutes chapters, 433.003, 433.456 - 433.536, 433A

2.0 PURPOSE:

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

3.0 SCOPE: Clinical Services Branch including services by contract providers

4.0 DEFINITIONS: N/A

5.0 REFERENCES:

4.1 Nevada Revised Statutes (NRS): 433.003, 433.5493, 433.456-433.536, 433A.270, 433A.290, 435.350

4.2 DPBH Policy #2.014 Labor of Persons Receiving Services

4.3 DPBH – Clinical Services Branch HIPAA Manual 2016

6.0 PROCEDURE:

6.1 Staff Education Regarding Consumer Rights

6.1.1 Each DPBH agency employee or contract service provider staff will be apprised of this policy in orientation and educated in its implications prior to working independently with consumers.

6.1.1.1 Through this education, each staff member or provider staff will be knowledgeable about the consumer rights as defined.

6.1.1.2 Documentation of this training will be maintained within the agency

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

6.2 Consumer Education Regarding Consumer Rights

6.2.1 Each consumer will be given a list, during the admission process, of the rights granted to them and a copy of the agency's policies regarding when these rights can be suspended (NRS 433.531).

6.2.2 The Division and/or provider agency staff member will review these rights with the consumer and/or legal representative or guardian, as appropriate, within a reasonable time following admission.

6.2.3 This will be documented by having the consumer sign a statement that they have reviewed these rights, and being countersigned by the admitting staff (NRS 433.533).

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

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

6.4 Consumer Rights:

6.4.1 Dispose of property
6.4.2 Marry
6.4.3 Execute instruments
6.4.4 Make Purchases
6.4.5 Enter into contractual relationships
6.4.6 Vote
6.4.7 Hold a driver's license
6.4.8 Freedom of religion

6.4.9 Free association

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

6.6 Right to habeas corpus unimpaired (NRS 433.464).

6.7 Rights concerning admission and discharge (NRS 433.471).

6.7.1 Right not to be admitted to the agency under false pretenses.

6.7.2 The right to receive a copy, upon request, of the criteria upon which the agency makes admission and discharge decisions.

6.8 Rights concerning involuntary commitment (NRS433.472):

6.8.1 Right to request and receive a second evaluation by a psychiatrist or psychologist who does not have a financial interest in the agency.

6.8.2 Right to receive a copy of the procedure of the agency regarding involuntary commitment and treatment.

6.8.3 Right to receive a list of consumer rights concerning involuntary commitment or treatment.

6.9 Personal Rights (NRS 433.482):

6.9.1 Right to wear his/her own clothing, to keep personal possessions (unless they may be used to endanger his/her or another's life), and to keep and spend a reasonable sum of his/her own money.

6.9.2 Right to have access to individual space for storage for his/her private use.

6.9.3 Right to privacy regarding the consumer's program.

6.9.4 Right to see visitors daily.

6.9.5 Right to have reasonable access to a phone to make and receive confidential calls.

6.9.6 Right to ready access to materials for writing letters, including stamps.

6.9.7 Right to send and receive unopened correspondence (not packages). Correspondence containing checks payable to the consumer may be subject to safekeeping by the Agency Director or designee, as specified in the service plan.

6.9.8 Right to reasonable access to an interpreter if the consumer does not speak English or is hearing impaired.

6.9.9 Right to have information presented in a manner that meets their specific needs.
6.9.10 Right to designate a person to be kept informed of the consumer's condition by the agency.
6.9.11 Right to deny access to the medical records to any person other than a member of the staff of the agency or related medical personnel, as appropriate, persons with a waiver from the consumer, and persons with a court order.

6.10 Rights concerning care, treatment and training (NRS 433.484):
6.10.1 Right to medical, psychosocial and rehabilitative care, and treatment and training, including prompt and appropriate medical treatment and care.
6.10.2 Before instituting a plan of care, express and informed consent must be obtained in writing from the consumer, the parent or legal guardian of a minor consumer, or the legal guardian of a consumer adjudicated incompetent.
6.10.3 Right to be free from abuse, neglect, and aversive interventions.
6.10.4 Right to consent to transfer from one agency to another.
6.10.5 Right to be respected for cultural and personal values, beliefs, and preferences.
6.10.6 Right to an individualized written plan of care that provides for the least restrictive treatment that may reasonable be expected to benefit the consumer;
6.10.7 The plan must be current and modified when indicated by the consumer's change of circumstances, and thoroughly reviewed at least every three (3) months.
6.10.8 The plan must be developed with the input and participation of the consumer to the extent that they are able to participate.
6.10.9 The plan must designate the individual that is in charge of implementing the plan (NRS 433.494).
6.10.10 Right to participate in decisions about his/her care.

6.11 Right to information (433.504):
6.11.1 A consumer must be permitted to inspect his/her records.

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

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

6.12 Medication (NRS 433.514):

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

6.13 Labor by consumers (NRS 433.524):

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

6.13.2 Consumers must voluntarily agree to perform labor.

6.14 Right to counsel (NRS 433A.270):

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

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

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

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: 04/30/98
REVIEWED/REVISED: 12/21/2007, 7/30/2010, 3/15/2013
SUPERSEDES: Policy 2.001 Consumer Rights

Control # Revised
CRR-1.1 11/19

Title: Consumer Rights

Effective Date: 03/2017
Next Review Date: 11/2021

DATE APPROVED BY MHDS ADMINISTRATOR: 08/06/10, 3/15/2013
DATE APPROVED BY MHDS COMMISSION: 09/17/2010
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 9/2019

Division of Public and Behavioral Health
Clinical Services

Control # Revised
CRR 1.3 5/2017

Title: Seclusion/Restraint of Consumers

Effective Date: 05/2017
Next Review Date: 05/2019

1.0 POLICY:

The Division of Public and Behavioral Health (DPBH) treats and manages all clients in the least restrictive manner consistent with their clinical status and needs and that seclusion or restraint be used only in an emergency to insure safety of the client and others and when less restrictive interventions have been determined to be ineffective to protect the client or others from harm.

2.0 PURPOSE:

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

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 **Direct Care staff:** Personnel that provide face to face services to clients.

4.1.1 This includes but is not limited to allied therapy, medical staff including residents and interns, nurses, MHT, Forensic Technicians psychiatric case workers, psychologists and social workers.

4.2 **Medical Staff:** 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 within their scope of practice.

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

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

4.2.2 Mechanical restraint: Pursuant to NRS 433.547 and NRS 449.772, mechanical restraint means the use of devices to limit a client's movement or hold a client immobile. This means the use of devices, including, without limitation, mittens, straps and restraint chairs to limit a client's movement or

hold a client immobile. All devices utilized as mechanical restraints must be ordered and re-ordered by medical staff in accordance with regulation.

Note: Mechanical restraint may include the use of the spit hood.

4.2.3 **Chemical restraint**: Pursuant to NRS 433.5456 and NRS 449.767, chemical restraint means the administration of drugs for the specific and exclusive purpose of controlling an acute or episodic aggressive behavior when alternative intervention techniques have failed to limit or control the behavior. The term does not include the administration of drugs on an ongoing basis as prescribed by medical staff to treat the symptoms of mental, physical, emotional or behavioral disorders or for assisting a client in gaining self-control over their impulses.

4.2.3.1 CMS CoP 42 CFR 482.13 defines chemical restraint as a medication when it is used as a restriction to manage the client's behavior or restrict the client's freedom of movement and is not a standard treatment or dosage for the client's condition.

4.2.3.2 Drugs that are used as part of a client's standard medical or psychiatric treatment and are administered within the standard dosage for the client's condition is not considered a chemical restraint.

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

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

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

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

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

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

4.2.6 Seclusion: Seclusion is the involuntary confinement of a client in a locked room (or unlocked with employee used to prevent exit) or a specific area from which the client is physically prevented from leaving.

4.2.6.1 Seclusion does not include confinement on a locked unit or ward, where the client is with others.

4.2.6.2 Seclusion is not just confining a client to an area, but separating him or her from others.

4.2.6.3 Seclusion may only be used for the management of violent behaviors towards others.

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

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

4.2.8.1 Physical Guidance/Contact: Utilizing physical touch and prompting to assist in completing a task or response if there is no, or minimal, resistance (appropriately labeled physical guidance, not restraint, and therefore not requiring the completion of paperwork related to restraint use.)

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

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

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

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

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

5.0 REFERENCES:

5.1 NRS.289.240
5.2 NRS 433.5466
5.3 NRS 449.770
5.4 CMS CoP 42 CFR 482.13
5.5 NRS 433.5456
5.6 NRS 449.767

6.0 PROCEDURE:

6.1. Standards for Seclusion and Restraint:

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

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

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

6.2 In the event that the use of seclusion or restraint becomes necessary, the following standards will apply to each episode:

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

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

6.1.2.3 Medical Staff who order these interventions shall be specially trained and qualified to assess and monitor the client's safety and the medical and behavioral risk inherent in the interventions;

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

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

6.1.2.6 Clients placed in seclusion or restraint will be appropriately communicated with verbally and monitored a minimum of required intervals established by agency protocol;

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

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

6.2.1.1 Notification: Upon admission, the service recipient and, with the service recipient's consent, their family/legal guardian shall be informed of the policies and procedures regarding the use of seclusion and restraint.

6.2.1.2 With the service recipient's consent, as documented in the medical record, designated family members / legal guardians shall be informed of their opportunity to be notified of each occurrence of seclusion or restraint within the timeframe agreed to by the family and to participate in the client's debriefing as appropriate.

6.2.1.2.1.1 When no family member/legal guardian are available, upon consent of the client, the Nevada Disability Advocacy & Law Center (NDALC) may be used.

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

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

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

6.3.3 Positioning a client in a manner that avoids placing physical or mechanical restraint or excessive pressure on the chest or back of the client or inhibits or impedes the client's ability to breathe.

6.3.3.1 The client's face will always be in view of staff for immediate identification of physical distress such as pain or breathing difficulties.

6.3.4 Restraint of clients in a manner to minimize medical complications.

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

6.3.6 The client shall be continually monitored by staff, face to face. Such monitoring will be documented no less than every 15 minutes.

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

6.3.8 Any concerns will be referred to medical staff by the registered nurse.

6.3.9 Staff will offer fluids, toileting and comfort measures every fifteen (15) minutes. Meals and snacks will be offered at regular times. Staff will assist the client with hand washing after toileting and before meals.

6.3.9.1 Any exception to the above procedures must be clinically justified and noted in the medical record.

6.3.10 Range of motion and movement of limbs will be provided for at least ten (10) minutes at least every two (2) hours. Relief from mechanical restraint will occur as long as it is deemed to be safe.

6.3.10.1 If client has not regained sufficient control to be considered safe, this must be documented in the progress note.

6.3.10.2 During relief periods, the staff shall insure proper positioning of the client and provide movement of limbs as necessary.

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

6.4.1 If the client is falling asleep or falls asleep, an immediate assessment of the client and the release criteria will be made.

6.4.2 Clients who are sleeping in seclusion and/or restraint must be evaluated and removed from seclusion and/or restraint if they meet release criteria. A sleeping client continues to require face to face monitoring while in seclusion or restraint.

6.5 In an emergency requiring evacuation (including drills), the client will be removed from seclusion and/or restraint, and staff will stay with the client on a 1:1 basis.

6.5.1 Precautions shall be taken to assure the protection of the client in restraints from being mistreated or harmed.

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

6.6.1 A registered nurse must be notified immediately if a client exhibits threatening or harmful behavior.

6.6.2 The emergency use of seclusion and/or restraints requires an RN assessment.

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

6.6.2.1.1 Client's verbalization of feelings;
6.6.2.1.2 Verbal reassurance/redirection given to client;
6.6.2.1.3 1:1 interaction for the client with staff;
6.6.2.1.4 Reduction in stimuli;
6.6.2.1.5 Environmental changes for the client;
6.6.2.1.6 Limit setting;
6.6.2.1.7 Time Out offered to the client;
6.6.2.1.8 Medication offered to the client;
6.6.2.1.9 Antecedent behaviors or events which triggered the Escalation
6.6.2.10 Determining the point of conflict and deciding why

the client cannot "win" or get their way.

6.6.3 Upon determination by a registered nurse that seclusion or restraint is necessary, a medical staff order is obtained.

6.6.3.1 The RN notifies medical staff of the client's behavior and assessment,

6.6.4 Order to seclude and/or restrain:

6.6.4.1 Orders will be written on the Seclusion and Restraint Order Form no more than fifteen minutes after seclusion or restraint.

6.6.4.2 Verbal orders to a staff RN are acceptable.

6.6.4.3 The RN shall record the event on the Seclusion and Restraint Order Form and place the form in the order section of the client's medical record.

6.6.4.4 No application of seclusion or restraint shall occur without a medical staff order, stating the reason for use.

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

6.6.4.6 Seclusion or restraint orders shall not be written as PRN.

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

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

6.6.5 Chemical restraints are only given during an emergency when the client's behavior poses a danger to themselves or others and where other interventions were unsuccessful in maintaining the client's or others' safety.

6.6.5.5 All uses of drugs as a restraint can only be implemented following a written order.

6.6.5.6 An order for the use of medication as a restraint must specify that the medication is to be used as a restraint.

6.6.5.7 Medical Staff must identify the duration of time for which the patient must be monitored once the medication has been given.

6.6.5.8 Monitoring and observation must include post medication administration assessment by an RN and include the same monitoring requirements as mechanical or manual restraint.

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

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

6.6.7 The Nursing Supervisor, or charge nurse on duty, must be notified immediately of all applications and removals of restraints and/or seclusions.

6.6.8 The Nursing Supervisor must come to that unit to assist/observe and provide senior clinical assistance.

6.7 Documentation: The RN must document the clinical rationale for the use of seclusion and/or restraint.

6.7.1 This documentation shall include, but not be limited to:

6.7.1.1 An assessment of the client's behavior including any relevant behavioral history.

6.7.1.2 History of violent assaultive behavior is a significant consideration and therefore, shall be included in the assessment, with examples.

6.7.1.3 Clinical justification necessitating the use of seclusion and/or restraint.

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

6.7.1.4 The de-escalation techniques attempted prior to using seclusion and/or restraint (e.g., administration of medication, counseling, quiet time).

6.7.1.5 Criteria for termination of seclusion and/or restraint shall be

explained to the client; including the behavior that will determine their readiness for release from seclusion and/or restraint.

6.7.1.6 A description of interventions implemented to assist the client attaining the release criteria.

6.7.1.7 A summary of the client's current physical assessment, including vital signs.

6.8 Continuation of seclusion/restraint is determined by need:

6.8.1 The client must be continuously assessed monitored and re-evaluated as to the need for seclusion and/or restraint.

6.8.2 The review and assessment will occur and be documented within one (1) hour following the initiation of seclusion and/or restraint and follow every two (2) hours, as well as any time there is a change in the client's physical status and at shift change by the RN coming on duty.

6.8.2.1 Vital Signs will be monitored ever 30 minutes the first hour and then
hourly while the client is in restraint.

6.8.3 Each agency policy, protocol and procedures shall include the necessary factors to assess.

6.9 Release conditions for seclusion or restraint: Release criteria includes that the client must be able to demonstrate calm behavior(s) and/or be able to state that they are calm.

6.10 Other actions as documented by medical staff and nursing staff are considered interventions to assist the client in accomplishing the emergency behavioral plan.

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

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

6.13 Client and Staff Debriefing:

6.13.1 An initial staff debriefing shall occur immediately after the seclusion or restraint and prior to any shift change. The debriefing shall be done by a licensed mental health professional.

6.13.2 The purpose of the debriefing will be to elicit feedback information from the client about the intervention.

6.13.3 Findings from the staff debriefing and proposed administrative changes or strategies to prevent reoccurrence shall also be documented in the electronic medical record on the seclusion and restraint tab.

6.13.4 The debriefing information shall be available to the treatment team prior to its next meeting with the client.

6.13.5 If the client refuses to participate in the debriefing, a licensed mental health professional shall meet separately with the client following release from seclusion or restraint to review the reason or purpose of the restraint.

6.13.5.1 This must be done prior to any shift change, and no later than eight (8) hours post restraint/seclusion.

6.15 Staff Training:

6.15.1 All staff will be certified in procedures leading to the de-escalation and physical management of clients on hire with a refresher annually and recertification every three (3) years.

6.16 Immediate notification and submission of incident report required to the on-call executive for the following:

6.16.1 For incidents of seclusion or restraint that exceed eight (8) hours, or a client that experiences more than two (2) separate episodes of restraint and/or seclusion within a 24-hour period, Agency Administration and clinical leadership shall be notified within one (1) hour.

6.16.2 For episodes more than twelve (12) hours, daily administrative review and clinical rationale to continue seclusion and/or restraint shall be provided by a non-treating psychiatrist or designee of the Medical Director.

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

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

6.16.5 The Agency Director/designee will forward copies of the orders to the DPBH Administrator for review.

6.16.6 Seclusion or restraint events that exceed 12 hours, or more than two (2) separate episodes of restraint and/or seclusion within a 24-hour period will be forwarded to DPBH Administration by close of business on the next working day.

6.16.7 Originals of all documents are maintained in the medical record.

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

6.16.9 Seclusion and Restraint data will be systematically aggregated and analyzed on an ongoing basis by Leadership staff at each agency.

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

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

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

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

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

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

6.17.2 Staff must document in the client's medical record the date and time that

the death was reported to CMS. {42 CFR §482.13(g)}

7.0 ATTACHMENTS: N/A

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

EFFECTIVE DATE: 4/98
DATE REVIEWED/REVISED: 12/98, 2/99, 2/00, 1/02, 3/03, 8/04 06/05
DATE APPROVED BY THE MHDS COMMISION: 1/98
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 2/17

Division of Public and Behavioral Health
Clinical Services

Control # CRR 1.5
Revised: 9/2019
Title: Management of Civil Inpatient Elopement Episodes
Effective Date: 08/2017
Next Review Date: 09/2021

1.0 POLICY:
DPBH Clinical Services Brach will have uniform prevention, reporting, investigation, review and response to each episode of inpatient elopement.

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

3.0 SCOPE: Clinical Services Branch

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

5.0 PROCEDURE:

5.1 HOSPITALS:

5.1.1 Prevention of Elopement Episodes:

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

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

5.1.1.2 Each hospital will develop a procedure identifying elopement prevention training for staff. The following must be addressed:

5.1.2 Reporting of Elopement Episodes:

5.1.2.1 All division agencies will develop procedures for the reporting of elopement incidents, which will include:

5.1.2.1.1 Reporting of elopement incidents using the SIR format and reporting time frames as given in Division Policy CRR .014;

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5.1.2.1.2 Notifying the local law enforcement agency immediately;
5.1.2.1.3 Notifying legal guardians and family of record; and
5.1.2.1.4 Notifying any person in the community toward whom the consumer had been known to make a threat verbal or otherwise.

5.1.3 Investigation of elopement Episodes:
5.1.3.1 All staff immediately involved in the elopement incident will provide statements regarding the elopement prior to the end of their work shift.
5.1.3.2 Environmental risk assessment will be completed immediately and in no case more than one (1) day following an elopement episode.
5.1.3.3 All staff involved in an elopement episode will undergo debriefing within one (1) working day which will be documented.
5.1.3.4 All elopement episodes from hospitals will undergo formal Root Cause analysis per CRR1.14 Root Cause Analysis.

5.1.4 Reporting of Elopement Episodes:
5.1.4.1 All elopement will be reported to division using a SIR and reporting time frames as given in Division Policy CRR-1.4, within (1) one business day of discovery.
5.1.4.2 Elopements will be reported to law enforcement as missing persons.
5.1.4.3 Elopements will be reported to the Sentinel Event Registry if there is a serious injury or death related to the elopement.

6.0 REFERENCES:

6.1 Division Policy CRR .014 Risk Management and Reporting of Serious Incidents
6.2 Division Policy #4.048 DPBH Investigations Manual
6.3 Division Policy CRR 1.13 Sentinel Events
6.4 Nevada State Health Division: Sentinel Event Reporting Guidelines 2012

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY:

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

Division of Public and Behavioral Health
Clinical Services

Control # CRR 1.5
Revised: 9/2019
Title: Management of Civil Inpatient Elopement Episodes
Effective Date: 08/2017
Next Review Date: 09/2021

EFFECTIVE DATE: 09/2017
DATE APPROVED BY DPBH ADMINISTRATOR: 09/2017
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 09/2017

Division of Public and Behavioral Health
Clinical Services

Control # HR 3.5
Revised: 11/2019
Title: Presentations to Organizations/Conferences
Effective Date: 12/1997
Next Review Date: 11/2021

1.0 POLICY:

It is the policy of DPBH those employees who provide presentations to organizations/ conferences regarding Division programs or data be approved by the administration before being presented.

2.0 PURPOSE:

The purpose of this policy is to establish the approval process for DPBH employees who provide presentations at conferences workshops or trainings.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS: N/A

5.0 REFERERNCES:

5.1 Policies:

5.1.1 A-1.3 DIVISION TRAVEL
5.1.2 2.009 RESEARCH PROJECTS INVOLVING INDIVIDUALS
5.1.3 6.012 –PHI PROTECTED HEALTH INFORMATION: DE-IDENTIFIED DATA POLICY

6.0 PROCEDURE:

6.1 DPBH employees who wish to present information derived from Division or agency programs at conferences, workshops or trainings, must obtain approval of the information to be presented from the Clinical Service Branch Deputy Administrator PRIOR to accepting the invitation. A memo requesting such approval shall include:

Control # HR 3.5
Revised: 11/2019
Title: Presentations to Organizations/Conferences
Effective Date: 12/1997
Next Review Date: 11/2021

6.1.1 A complete description of the information to be presented.
6.1.2 The anticipated benefit to the Division, Department and State of Nevada.
6.1.3 The expected cost to the State including reimbursement for travel expenses and any other associated expenses

6.2 The prior approval by the Deputy Administrator is required regardless of whether the:
6.2.1 Presentation is being provided in or out-of-state and
6.2.2 Presenter is requesting reimbursement for the travel associated with the presentation.
6.2.3 The leave status of the employee at the time of the presentation.

6.3 Employees on travel status, paid release time or administrative leave are representing DPBH and its agencies, no stipend or honoraria can be received by the employee for the presentation.

6.4 Employees are responsible to complete required in-state or out-of-state Anticipated Travel Request forms associated with the request. See A-1.3 Division Travel Policy.

6.5 Employees are responsible to ensure that their supervisor has approved the request to present and any associated leave request.

6.6 Presentations must comply with the requirements of privacy, confidentiality, and data de-identified policies. See 6.012 –PHI Protected Health Information: De-Identified Data Policy.

Control # HR 3.5
Revised: 11/2019
Title: Presentations to Organizations/Conferences
Effective Date: 12/1997
Next Review Date: 11/2021

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY:

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

EFFECTIVE DATE: 12/31/97
REVISED / REVIEWED DATE: 02/13/07, 08/23/11, 11/2019
SUPERSEDES: # 4.023 PRESENTATION TO NATIONAL ORGANIZATIONS/CONFERENCES
APPROVED BY DPBH COMMISSION: 09/16/11, 11/2019

Division of Public and Behavioral Health
Clinical Services

Control # IMRT 3.0
Revised: New
Title: Collection of Reporting of Veteran Health Information
Effective Date: 11/2019
Next Review Date: 11/2021

1.0 POLICY:
The Division of Public and Behavioral Health (DBPH or the Division) will collect military service and health information from people who, when admitted into services, have indicated serving in the military and may have a military-related disability**.**

2.0 PURPOSE:
The purpose of this policy is to outline the process that DPBH agencies will use to obtain service, combat, disability, and benefits information from people who are admitted into a DPBH clinical program.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS: N/A

5.0 REFERENCES:
5.1 Nevada Revised Statutes (NRS), Title 37, Chapter 417: Veterans Services and Honorary Recognition Releated to Military Service

6.0 PROCEDURE:
6.1 Division agencies will ensure that admission forms collect the following service information on veterans:
- 6.1.1 In what branch of the military the person served, including:
  - 6.1.1.1 Armed Forces of the United States: Air Force, Army, Marines, or Navy
  - 6.1.1.2 National Guard or a reserve component of the Armed Forces of the United States
  - 6.1.1.3 Commissionerd Corps of the United States Public Health Services or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States
- 6.1.2 Date entered and discharged from service
- 6.1.3 Discharge status, which includes:
  - 6.1.3.1 General
  - 6.1.3.2 Honorable
  - 6.1.3.3 Other than honorable
  - 6.1.3.4 Bad conduct
  - 6.1.3.5 Dishonorable

6.1.4 If they are enrolled in and/or receiving military benefits
6.1.5 Participated in conflict and, if so, the location
6.1.6 If they have a service-connected disability
6.1.6.1 Indicate the type of disability

6.2 For persons who are not a veteran, but had a family member serve, are they receiving survivor benefits due to the family member's service-connected disability
6.2.1 Family members to be referred to the Department of Veteran's Affairs

6.3 Agencies will verify that referral information has been provided to the person at admission, including:
6.3.1 American Heart Association
6.3.2 American Lung Association
6.3.3 Leukemia and Lymphoma Society
6.3.4 Other referrals for health, welfare, human and social services

6.4 This information will be used to complete applicable Veteran Status information in Avatar – which is under Other Client Data in the Admission tab

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.

Division of Public and Behavioral Health
Clinical Services

Control # SP 2.13
Revised: 11/2007
Title: Civil Rights Grievance Procedures
Effective Date: 03/2000
Next Review Date:

1.0 POLICY:

It is the policy of the Division of Public and Behavioral Health to not discriminate in provision of services, or hiring and employment practices, on the basis of race, age, color, creed, sex, sexual orientation, religion, disability (including HIV and related conditions), or national origin. DPBH has an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. These policies state, in part, that no person will, solely by reason of his/her race, age, color, creed, sex, sexual orientation, religion, disability (including HIV and related conditions), or national origin be excluded from participating in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial participation.

2.0 PURPOSE:

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

3.0 SCOPE: Clinical Service Branch

4.0 DEFINITIONS:

5.0 REFERENCES:

6.0 PROCEDURE:

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

Control # SP 2.13
Revised: 11/2007
Title: Civil Rights Grievance Procedures
Effective Date: 03/2000
Next Review Date:

6.2 Grievances must be submitted to Central Office Personnel Officer, Civil Rights Coordinator (at DPBH 4126 Technology Way, Suite 201, Carson City, NV 89706, 775/684-5943) within thirty (30) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.

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

6.4 The Civil Rights Coordinator, or designee, will conduct an investigation of the complaint to determine its validity. The investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Civil Rights Coordinator will maintain the files and records for DPBH relating to such grievances.

6.5 The Civil Rights Coordinator will issue a written decision on the grievance no later than 30-days after its filing.

6.6 DPBH Administrator will issue a written decision in response to the appeal no later than 30-days after its filing.

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

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

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: 03/01/00

Revised/Review Date: 11/06/07

Approved by Commission:

Division of Public and Behavioral Health
Clinical Services

Control # SP 2.14
Revised: 11/2019
Title: Labor of Persons Receiving Services
Effective Date: 7/7/2000
Next Review Date: 11/2021

1.0 POLICY:

All Labor performed by clients receiving services for which the Division would otherwise employ someone to perform, will be in the best interest of the person receiving services and in accordance with NRS 433.524.

2.0 PURPOSE:

A client performing labor for the agency in which the client is receiving services, must be properly compensated and beneficial to the client.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS: N/A

5.0 REFERENCES: N/A
ICF-MR 4.83.420

6.0 PROCEDURE:

6.1 A client receiving services may perform labor which contributes to the operation of the facility and for which the facility would otherwise employ someone only if:

6.1.1 The client voluntarily agrees to perform labor and the agreement for volunteer services is documented in the client record.

6.1.2 Engaging in labor is not inconsistent with and does not interfere with the client's plan of care as documented in the treatment plan.

6.1.3 The staff responsible for the client's treatment plan agrees to the labor, and

6.1.4 The amount of time or effort needed to perform the labor is not excessive.

6.2 The Client is not required or expected to do chores or work for the facility other than appropriate care of one's own personal space or shared responsibility of common areas.

6.3 In no event may discharge or privileges be conditioned on the performance of labor.

6.4 A client receiving services, who performs labor which contributes to the operation and maintenance of a Division facility for which the facility would otherwise employ someone else, will be compensated.

6.4.1 The compensation will be in accordance with applicable state and

federal labor laws.

6.4.2 One-half (1/2) of any compensation paid to a person receiving services pursuant to the above condition is exempt for collection or retention as payment of services rendered by the Division or any of its facilities, and from levy, execution, attachment , garnishment or any other remedies by law for collect ion of debts.

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: 7/7/00
Date Revised: 8/16/07
Date Reviewed: 3/10/05
Approved by the MHDS Commission: 11/17/00
Approved by the Commission on Behavioral Health: 11/2019

Division of Public and Behavioral Health
Clinical Services

Control # SP 4.08
Revised:
Title: Reporting AWOL Clients to Law Enforcement Agencies
Effective Date:
Next Review Date:

1.0 POLICY:

It is the policy of the division to cooperate with law enforcement agencies by reporting AWOL clients.

2.0 PURPOSE:

3.0 SCOPE: Clincal Services Branch

4.0 DEFINITIONS:

5.0 REFERENCES:

6.0 PROCEDURE:

6.1 A client on a status listed below who goes absent without leave from a division facility or outpatient program shall be reported immediately to the police, the committing judge, the district attorney, and public defenders office by the agency administrator or designee. Said report shall contain a physical description of the client, client's name, mental status, potential for acting out, and last point of contact.

6.1.1 Involuntary civil commitment, including emergency commitments.

6.1.2 Convalescent leave status if it is evident that client is potential danger to self or others.

6.1.3 Voluntary status if it is evident that client is potential danger to self or others and the facility intends to petition the court for an involuntary commitment.

6.1.4 Criminal commitment pursuant to NRS 178.

6.1.5 Outpatient commitment order.

6.1.6 Commitment pursuant to NRS 435.

Control # SP 4.08
Revised:
Title: Reporting AWOL Clients to Law Enforcement Agencies
Effective Date:
Next Review Date:

6.2 If the AWOL client has a history of violence, assaultiveness, or is potentially a danger to self or others, the appropriate family members and the district attorney's office will be notified, in addition to law enforcement.

6.3 Within three (3) working days of notifying law enforcement, family members, judge, public defender and/or the district attorney of an AWOL client, the agency administrator or designee will file a denial of right form describing the circumstances of the event and will make an entry in the client's medical record regarding the event. The denial of right form will be submitted to the division administrator, who will forward it to the Commission of Mental Health and Developmental Services.

6.4 The agency administrator will conduct an internal investigation within 3 days and submit the report to the division administrator.

6.5 Each division agency shall formulate policies and procedures to implement the provisions of this policy or shall incorporate this policy into its policy and procedures manual.

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: 11/30/97
Date Revised:
Date Reviewed: 2/27/98, 3/10/05
Date Approved by MHDS Commission:
Replaces: APM #79-3

Nevada Department of Health and Human Services
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

Policy

SUBJECT: Licensure of Community Placement Facilities

NUMBER: SP 4.13

EFFECTIVE DATE: 11/2019

NEXT REVIEW DATE: 11/2021

SUPERCEDES: 3/2005

1.0 PROTOCOL:

The clinical services branch will ensure that community residential facilities that have more than two (2) beds and are used as referral sources by division agencies shall meet licensing standards established by State Division of Welfare, Health or other appropriate state licensure agencies.

2.0 PURPOSE:

To ensure that clients are placed in community residential facilities that meet licensure standards.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS: N/A

5.0 **REFERENCES:** N/A

6.0 PROCEDURE:

6.1 No client under the jurisdiction of the division shall be placed in a community living facility of more than two (2) beds unless that facility is appropriately licensed.

6.2 The division will not pay for a placement unless the facility is appropriately licensed.

6.3 Supervision of clients in licensed homes is the responsibility of the referring agency administrator unless otherwise specified by the division administrator.

6.4 Each division agency shall develop specific written procedures to implement the provision of this policy or shall incorporate this policy into the agency policy manual.

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: 12/31/1997
DATE REVIEWED BY THE MHDS COMMISSION: 3/10/2005
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 11/2019
SUPERCEDES: APM #85-5 and MHDS 4.013

Control # SP 4.15
Revised: 11/2019
Title: Obtaining, Use, and Documentation of Formulary Approved Medication including Clozapine (Clozaril)
Effective Date: 07/2007
Next Review Date: 11/2021

1.0 POLICY:

Department of Public and Behavioral Health (DPBH) formulary approved medications may be prescribed by all DPBH physicians who have been privileged to do so. Within the framework of professionally accepted standards of medical practice the choice of medication(s) prescribed is conditioned by certain parameters: the clinical condition of the patient, cost effectiveness, risk/benefits and desired outcomes. In questions relating to the parameters, review by Division medical director will be final.

Note: In all cases, the patient, guardian, patient advocate, or responsible physician may initiate an appeal process regarding medication(s).

2.0 PURPOSE:

The purpose is to establish procedures for use and documentation of medications as prescribed components of the patient's multidisciplinary treatment.

3.0 SCOPE: Division of Public and Behavioral Health

4.0 DEFINITIONS:

4.1 Risk Evaluation and Medication Strategies (REMS) – A risk management plan required by the FDA for certain prescription drugs that uses tools beyond routine professional labeling to ensure that the benefits of the drug outweigh its risk.

5.0 REFERENCES:

5.1 The Food and Drug Administration Amendments Act of 2007.
5.2 FDA Clozapine REMS protocol

~~5.0~~6.0 PROCEDURE:

~~5.1~~6.1 Clozapine is an atypical antipsychotic medication indicated for the treatment of

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resistant schizophrenia and schizophrenia associated suicide prevention.

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~~5.2~~6.2 Clozapine may be prescribed in accordance with the FDA REMS protocol.

~~5.3~~6.3 All Prescribers must be enrolled in the FDA REMS program.

6.4 Only prescribers or their designated representatives can enroll patients in the Clozapine REMS Program.

~~5.4~~6.5 All pharmacies dispensing clozapine products must certify in the Cloazapine REMS Program.

~~5.5~~6.6 Clozapine is contraindicated in patients with myeloproliferative disorders, a history of Clozapine induced agranulocytosis, severe granulocytopenia, or patients receiving other marrow suppressing medication, particularly Carbamazepine, or severe central nervous system depression.

~~**6.0 REFERENCES:**~~

~~6.1 The Food and Drug Administration Amendments Act of 2007.~~

~~9.0~~7.0 ATTACHMENTS: N/A

~~10.0~~8.0IMPLEMENTATION 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: 6/8/98
Date Revised: 2/28/03; 7/02/07; 09/01/17
Date approved by DPBH Administrator: 09/2017
Date approved by the Commision on Behavioral Health: 09/2017, 11/2019

Division of Public and Behavioral Health
Clinical Services

Control # Revised

SP 7.1 New

Title: SP 7.1 Seasonal Influenza Vaccine Program

Effective Date: 9/17

Next Review Date: 9/19

1.0 POLICY:

It is the policy of the Department of Public and Behavioral Health (DPBH) Clinical Services Branch to have an annual influenza vaccination program for the prevention and control of seasonal influenza.

2.0 PURPOSE:

To maintain a safe and healthy environment for employees, patients, visitors, and the general public by using vaccination as a potential means to minimize the spread of influenza.

3.0 SCOPE: DPBH Clinical Service Branch

4.0 DEFINITIONS:

4.1 Influenza: ("flu") is a mild to severe contagious disease caused by a virus that causes an average of 36,000 deaths each year in the U.S., mostly among the elderly. Influenza spreads from an infected person to the nose and throat of others and can cause fever, sore throat, cough, chills, headache and muscle aches. Influenza can lead to pneumonia and can be dangerous for people with heart or breathing conditions.

4.2 Influenza Season: The time period (generally between October and March) when influenza is most prevalent in the United States.

4.3 Influenza Vaccine: A preparation of Influenza viruses (live or inactivated virus), which stimulate the production of specific antibodies when introduced into the body.

4.4 Influenza Vaccine High Dose: Fluzone High-Dose is three-component (trivalent) inactivated flu vaccine, Fluzone High-Dose is licensed specifically for people 65 years and older. Fluzone High-Dose contains four times the antigen (the part of the vaccine that helps your body build up protection against flu viruses) of standard-dose inactivated influenza vaccines. The higher dose of antigen in the

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vaccine is intended to give older people a better immune response, and therefore, better protection against flu. Fluzone High-Dose is licensed only for persons aged 65 years and older.

4.5 Personnel: All DPBH Clinical Services Branch employees and contracted staff, students, residents, trainees, and volunteers.

4.6 Personnel with Client Contact: All personnel who routinely (Medical Staff, Nurses, CNs, MHTs) perform work tasks or intermittently (Maintenance, Food Service Staff, AT staff) within six (6) feet of patients or who have contact with their environment in the performance of their duties.

5.0 REFERENCES:

5.1 CDC (Centers for Disease Control and Prevention – https://www.cdc.gov/flu/prevent/qa_fluzone

5.2 Centers for Disease Control "Immunization Recommendations for Health Care Workers"

5.3 New York State Department of Education: NYC Department of Health and Mental Health

5.4 CDC, FDA Fact Sheet for Vaccine Information Statements, current year

5.5 Link http://injectsafebandages.com/ Quick reference

6.0 PROCEDURE:

6.1 Annually, t~~T~~he State Health Officer prescribes a standing order and protocol for the administration of an annual influenza vaccination for DPBH C~~c~~linical Service Branch staff.

6.1.1 Vaccine will be offered free of charge at various times and locations, as soon as the vaccine becomes available. Vaccines will be offered throughout the flu season or our allotment of vaccines has been depleted (whichever occurs first).

6.2 All individuals covered by this protocol must be immunized within six (6) weeks after the vaccine becomes available to employees.

6.2.1 If individuals covered by this protocol are immunized through services other than Employee Health Services (i.e. private physician office, public clinics, or other employers) they must provide proof of immunization to Employee Health Services.

6.2.2 Proof of immunization must be provided within six (6) weeks after the vaccine becomes available to employees.

6.2.3 Proof of immunization must include:

6.2.3.1 Name of the individual immunized

~~7.0~~ 6.2.3.2 Date of the immunization

~~8.0~~ 6.2.3.3 Immunization type

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~~8.1~~6.3 Every year, a log will be maintained documenting how many people (staff, volunteers, and independent licensed contractors) receive the vaccine, as well as the numbers who refused and the reason for declination. These data will be shared with the infection prevention committee and the executive committee during monthly meetings.

~~8.2~~6.4 All staff shall be provided with information explaining the influenza vaccine, its risks, and the risks versus benefits of vaccination.

~~8.2.1~~6.4.1 Documentation must show that specific education was provided, that the staff either received influenza vaccine or did not receive the vaccine, and whether a refusal was due to medical contraindications.

~~8.2.2~~6.4.2 The Infection Control Practitioner or designated Registered Nurses employed by DPBH Clinical Services Branch are authorized to administer influenza vaccine and anaphylaxis treatment agents, including epinephrine for the emergency of treatment of anaphylaxis as set forth below to all agency employees.

~~8.2.3~~6.4.3 DPBH nurses are authorized to administer the influenza and anaphylaxis treatment agents only in the course of their employment.

~~8.2.4~~6.4.4 Any Personnel who decline (regardless of reason) to be vaccinated must complete a declination form.

~~8.2.5~~6.4.5 Personnel who decline or are unable to have the flu immunization and who have patient contact are required to wear a surgical mask when

within six (6) feet of a client or when they enter a client area such as a unit, waiting room, exam room, treatment area, reception area or an outpatient clinic area.

~~8.2.5.1~~6.4.5.1 The surgical mask must be changed every four (4) hours with a fresh new surgical mask.

~~6~~5.5 The exact dates for the requirement to wear respiratory protection will be determined annually when influenza is identified in the community.

~~2.1~~ 6.6 These dates will be communicated DPBH staff via email and/or other rapid means of communications.

~~2.2~~ 6.7 If a non-immunized DPBH employees, contracted staff, students, residents, trainees, and volunteers who have submitted a declination fails to comply with the requirement to wear a mask, they will be subject to progressive corrective action, up to and including termination.

~~2.3~~ 6.8 Criteria for Influenza Vaccine for DPBH Clinical Services Branch Employees:

6.8.1 All healthcare workers who qualify for vaccination based on CDC recommendations.

~~2.3.1~~ 6.7.1.1 All healthcare workers over the age of 65 will be offered the high dose flu vaccine.

~~2.3.2~~6.8.2 All persons will be screened for contraindications to influenza vaccine which can include:

~~2.3.2.1~~6.8.2.1 Serious allergic reaction to chicken, feathers, eggs or egg products;

~~2.3.2.2~~6.8.2.2 Allergies to dry rubber, rubber products or latex;

~~2.3.2.3~~6.8.2.3 Allergies to thimerosal (a preservative) or gelatin;

~~2.3.2.4~~6.8.2.4 History of anaphylactic reactions to the influenza vaccination or

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any vaccination;

~~2.3.2.5~~6.8.2.5 History of Guillian-Barre Syndrome within six (6) weeks of any influenza vaccination

~~2.3.2.6~~6.8.2.6 Illness at the time of inoculation, including acute respiratory infection, other active infection, or serious febrile illness;

~~2.3.2.7~~6.8.2.7 Acute evolving neurological disorder;

~~2.3.2.8~~6.8.2.8 Bleeding disorders such as hemophilia or thrombocytopenia;

~~2.3.2.9~~6.8.2.9 Anticoagulant therapy (e.g. Warfarin); and

~~2.3.2.10~~6.8.2.10 Use of Theophylline, and Phenytoin

~~2.4~~6.9 The Infection Preventionist and/or designated Registered Medical Nurse Shall:

~~2.4.1~~6.9.1 Ensure that all recipients of the vaccine is provided with the current seasons Vaccine Information Sheet (VIS) from the CDC.

~~2.4.2~~6.9.2 Ensure that the potential recipient is assessed for contraindications to immunization.

~~2.4.3~~6.9.3 Confirm each recipient of the vaccination has received a copy of the appropriate Vaccine Information Statement and has been informed of the potential side effects and adverse reactions, orally and in writing, before administering the immunization.

~~2.4.4~~6.9.4 Confirm that each recipient as completed the Influenza Consent/Declination form prior to the administration of the vaccine.

~~2.4.5~~6.9.5 The Infection Preventionist will be responsible for the record of all persons immunized including the recipient's name, date, address of immunization, administering nurse, immunization agent, manufacturer, lot number, expiration date, recommendations

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for future immunization and standing order and protocol is maintained and reviewed/revised annually.

~~2.4.5.1~~6.9.5.1 These records will be kept for up to 30 years as part of the employees health records.

~~2.4.6~~6.9.6 The Infection Preventionist will be responsible to maintain a record of all personnel declining the influenza vaccination. These records will be kept for 2 years.

6.10 Any designated RNs involved in the administration of immunizing agents in accordance with standing order and protocol must be currently certified in CPR by the American Red Cross, American Heart Association or an equivalent organization.

~~2.5~~

~~3.0~~ 6.10 Administration of Influenza Vaccine (Multidose Vial):

~~3.1~~ A separate sterile syringe and needle will be used for each injection to prevent possible transmission of infectious agents from one person to another.

~~3.1.1~~6.10.1 The expiration date of the vaccine will be noted on the vial using an auxiliary label. The expiration date will be 28 days from the date the vial was first opened and used. Any expired vaccine will *not* be used.

~~3.1.2~~6.10.2 Shake the container vigorously each time before withdrawing vaccine.

~~3.1.3~~6.10.3 Never remove the stopper from the container. Moisten the stopper with a sterile alcohol wipe, allowing the antiseptic to act for a few moments.

~~3.1.4~~6.10.4 Draw into the syringe 0.5 ml of air.

~~3.1.5~~6.10.5 Shake the vaccine container vigorously then pierce the center of the stopper with the sterile needle attached to the syringe. Turn the vial upside down and inject the air from the syringe.

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Keeping the point of the needle immersed in the vaccine, withdraw immediately into the syringe 0.5 ml vaccine.

~~3.1.6~~6.10.6 Primarily: Disinfect the skin at the site of injection (deltoid muscle) with a suitable antiseptic wipe. Inject 0.5 ml of vaccine intramuscular (never IV), aspirating to ensure that the needle has not entered a blood vessel before injection.

~~3.1.7~~6.10.7 Secondary: Disinfect the skin at the site of the injection (deltoid muscle) with a suitable antiseptic wipe. Remove bandage from package and apply safe barrier bandage to skin. Make injection through center of bandage and remove. Inject 0.5 ml of vaccine intramuscular (never IV), aspirating to ensure that the needle has not entered a blood vessel before injection. Suggest that this should read aspirating BEFORE injecting.

~~3.1.8~~6.10.8 Dispose of safety syringe in appropriate sharps container.

~~3.1.9~~6.10.9 All vaccinated persons should be observed for about fifteen (15) minutes after vaccinations.

~~3.2~~6.11 Alternate Administration Prefilled Syringe:

~~i.~~ 6.10.1 Use of prefilled syringes to deliver a single dose.

6.10.2 Each prefilled syringe will be used once, and then discarded into a

~~ii.~~ puncture resistant container.

~~3.3~~6.12 Anaphylaxis Reactions

~~3.3.1~~6.12.1 All addresses, clinic areas and units where immunizations are administered will be supplied with anaphylaxis treatment agents and will be equipped with appropriate syringes, needles and supplies for treatment administration.

~~3.3.2~~**6.12.2** In the event that a person who received an influenza vaccine develops signs and symptoms consistent with anaphylaxis, (e.g. but not limited to; difficulty in breathing, hives, swelling of face, throat or airway and loss of consciousness), the nurse is to administer one (1) adult dose of EPI-PEN IM or epinephrine 0.3

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mg [USP 1:1000, 0.3 ML] subcutaneous and **CALL 911 IMMEDIATELY.**

~~3.3.3~~6.12.3 The RN shall ensure that a record of all persons to whom they administered an anaphylaxis treatment agent, including the recipient's name, date, address of administration, administering nurse, anaphylaxis treatment agent, manufacturer, and lot number is kept in the medical record in the person's medical file.

~~3.3.4~~6.12.4 The RN shall report to the local emergency medical system or other provider equivalent follow-up care information regarding the administration of the anaphylaxis treatment agent, including when it was administered, the dosage, strength, and route of administration.

~~3.3.5~~6.12.5 The nurse shall also report information to the person's primary care provider if one exists, unless the patient is unable to communicate the identity of his or her primary care provider.

~~3.3.6~~6.12.6 The Infection Preventionist is responsible to report adverse reactions of immunizations to Vaccine Adverse Event Reporting System, (VARES).

~~4.0~~ 6.12 Data and Tracking:

~~4.1~~6.13 The Infection Preventionist/Employee Health program will be responsible for tracking seasonal influenza rates.

~~4.2~~6.14 Rates will be calculated as a percentage (%).

~~4.2.1~~6.14.1 Numerator will be all staff receiving vaccinations.

~~4.2.2~~6.14.2 Denominator will be all staff within the agency between the start of the flu season and the end of the flu season.

7.2.3 Declinations will recorded for all staff declining the vaccine/all staff within the agency between the start of the flu season and the end of the flu season.

7.2.3.1 Declinations will be further calculated based on reason for declination.

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7.2.4 Data will be presented to the Agency Infection Control Committee and Executive Leadership Committee annually at the end of each flu season.

7.2.4 The Agency Infection Preventionist/Employee Health coordinator will be responsible for entering the vaccine information into the State of Nevada's vaccination tracking system, WebIZ.

~~8 REFERENCES:~~

~~8.2~~7.3

~~9~~8 ATTACHMENTS:

~~10~~9 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: 9/01/2017
DATE APPROVED BY DPBH ADMINISTRATOR: 9/01/2017
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 9/2017