Control #	Rev.	Title	Effective Date: 09/2017
A 4.0	~~New~~	**Emergency Notification**	**Next Review Date: 09/2019**

1.0 POLICY:

The Department of Public and Behavioral Health (DPBH) 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 Director of DPBH and Director of DHHS, with the use of telecommunications, electronic communications, and personal electronic devices. Each agency will incorporate this policy into their agency protocol. 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 Service Branch ~~Division Wide~~

4.0 DEFINITIONS:

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

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

~~4.1.1~~

5.0 ~~REFERENCES :~~REFERENCES:

5.1 DPBH Policy CRR ~~1.4 Reporting~~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

5.6 HPP – 0020 Criminal Activity and Damage or Theft of Property

5.7 DHHS Critical Incident Reporting Form

~~5.0~~6.0 PROCEDURE:

6~~5~~.1 Response to one of the above critical incidents requires action by staff in the immediate area, as well as an organization-wide response. The following steps will be taken:

~~5.1.1~~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.

~~5.1.2~~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.

~~5.1.3~~6.1.3 Notification to~~of~~ security with pertinent information of the incident will be made by phone or in person.

~~5.1.4~~6.1.4 Immediate search of the unit, agency, and/or surroundings area(s) in which the incident took place.

~~5.1.5~~6.1.5 Immediate search of the hospital, facility, and/or grounds will be made by security/appropriate personnel.

~~5.1.6~~6.1.6 Notification of 911, providing pertinent information about the incident and necessary response.

~~5.1.7~~6.1.7 Voice-to-voice notification will be made to the House Supervisor, Nursing Director, Administrator on call and/or Hospital Administrator, the Capitol Police, State-wide and/or agency Emergency Preparedness Coordinator (as appropriate) and immediate supervisor according to agency protocol.

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

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

6.1.9 The DPBH Administrator will notify the Director of DHHS preferably by voice, text or email as appropriate.

6.1.9.1 The DHHS – Director's Office Critical Incident Report form will ~~5.1.8~~ be completed and submitted.

~~5.1.9~~6.1.10 Notification of Partner Agency Managers within the geographic area. Once the incident has been cleared, notification will be made to all ~~all~~ agencies included in initial notification.

~~5.1.9.1~~6.1.10.1 Notification should occur through multiple redundant communication mechanisms such as Everbridge, Email, Text messaging, ~~over head~~overhead paging and voice to voice to ensure rapid and inclusive awareness of the situation.

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

6.1.10 Notification of Criminal Activity and Damage or Theft of Property

6.1.10 DPBH Personnel shall report Suspicious or criminal activity to the Capitol Police

6.1.10.1 DPBH Personnel who come across criminal activity around DPBH buildings and offices should immediately call Capitol Police at the below numbers depending on locations. **Note: If there is still active criminal activity or threat of serious bodily harm call 911.**

5.1.10.1.1 Carson City- Capitol Police –

5.1.10.1.1 Emergency – (775) 687-5700

5.1.10.1.2 Administrative - (775) 687-5030

5.1.10.2 Las Vegas – Capitol Police – (702) 486-2935

5.1.10.3 Outside Carson City and Las Vegas contact your local sheriff or police department to obtain the necessary police report.

5.1.11 An online reporting system allows staff to file pertinent information quickly.

5.1.11.2 Using this online law enforcement report system allows you to submit a report immediately and the ability to print a copy of the police report, http://eblast.nv.gov/CapitolPolice/start-report.html.

~~5.1.9.2~~

~~**6.05 REFERENCES :**~~

~~6.15.1 DPBH Policy CRR 1.4 Reporting of Serious Incidents~~

~~6.25.1 DPBH Policy A6.1 Psychological First Aid Counselor Response~~

~~6.35.1 DPBH Policy A6.3 Clinical Services Disaster Requirement Plan~~

~~6.45.1 DPBH Comprehensive Emergency Management Plan~~

~~6.5 DPBH CRR1.5 Management of Elopement Inpatient Services~~

~~7.0~~6 ATTACHMENTS:

7.1 DHHS – Director's Office ~~Criticial~~Critical Incident Report – Attachment A

~~8.0~~7 IMPLEMENTATION OF POLICY:

Each Division agency shall implement this policy and may develop specific written 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

Control #	Rev.	Title	Effective Date: 09/2017
A 4.0	~~New~~	**Emergency Notification**	**Next Review Date: 09/2019**

DHHS – Director's Office
Critical Incident Report (CIR)

***Note: Internal use only. This form does not replace any Division's serious incident reporting forms. ***

Notification must be provided to: Richard Whitley; Chrystal Main; Julia Peek, Deborah Hassett; Stacey Johnson; Tawny Chapman

Please list all other personnel notified of incident:

Date of Incident: MM/DD/YYYY **Time of Incident:** HH:MM AM/PM

Office/Facility/Location of incident:

Type of Event: **(select one)**

- ☐**Abuse**
- ☐**Death/Suicide**
- ☐**Lost/Missing Person**
- ☐**Run-Away/Elopement**
- ☐**Serious Injury**
- ☐**Threat or Hostage Situation**
- ☐**Public Health Emergency**
- ☐**Health Facility Emergency**
- ☐**Fire/Natural Disaster**
- ☐**Other:**

Brief Synopsis of Event (including client(s) and/or staff involved):

Crime and/or reason for violation, and length of stay at facility as applicable:

Senior DHHS staff member(s) serving as "in charge" of incident (list name(s)/contact number(s)):

First/Last Name	Title/Organization	Contact Number	Email

Other entities that have been notified **(e.g. Law enforcement, Child or Adult Protective Services, fire department, ambulance services, coroner, etc.…):**

What action(s) have or are being taken by division in response to the incident:

What action(s) are being requested of Director's Office to assist with the incident, if applicable:

Other Comments/Concerns:

CIR reported by: Printed Name Title/Position

Date Reported: MM/DD/YYYY **Time Reported:** HH:MM AM/PM

Revised 01/15/2019– Supersedes 06/11/2018

Control #	Rev. Date:	Title:	Effective Date: 8/1998
A 4.7	8/2011	MEDIA CONTACTS/EVENTS	Next Review Date:

1.0 POLICY:

It is the policy of the Division that all media contacts/events shall be reported immediately to the Division of Public and Behavioral Health Administrator or designee and through that individual to the Director of the Department of Health and Human Services (DHHS). This includes both contacts initiated by a division agency and by the media.

2.0 PURPOSE:

The purpose of this policy is to ensure information is properly disseminated to the public and is of high quality, consistency and accuracy.

3.0 SCOPE:

Division Wide

4.0 DEFINITIONS

N/A

5.0 PROCEDURE:

5.1 Each Division Agency Administrator shall report to the Division Administrator, or designee, any potential media initiated contacts before providing a response. Planned agency media contacts shall receive prior approval by the Division Administrator or designee.

5.2 Notice of a media contact through the completion of the "Media Contact Report" (online form) shall be forwarded to the DPBH Administrative Office the same day. If the media contact occurs after hours or on a weekend or holiday, the Division Administrator or designee should be called on their cell phone or home phone.

5.3 The agency's notice to the DPBH Administrative Office should answer the following questions:

5.3.1 Who (agency staff and media personnel involved)?

5.3.2 What information was requested and provided? If you issued a press release or other written statement, please include a copy.

5.3.3 How and when do you expect the media to use this information, if known?

5.3.4 Any additional comments that may be useful to DPBH Central Office and DHHS in responding to questions we may receive about the media contact.

5.4 It shall be the Division Administrator or designee's responsibility to notify the DHHS Director or Deputy Director of the media contact by:

5.4.1 A. Forwarding the completed "Media Contact Report" (online form) to the DHHS' Public Information Officer; and/or

5.4.2 B. Providing a verbal report if the media contact is of high visibility.

5.5 This media procedure is intended to assist DPBH agency administrators/staff in providing high quality, consistent, and accurate information to the public and the media. It is not the intent of this procedure to in any way restrict the media's access to DPBH employees or interfere with an employee's ability to discuss issues and policies for which the employee is responsible.

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

6.0 ATTACHMENTS:

6.1 Media Contact Report (online form)

7.0 IMPLEMENTATION OF POLICY:

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

Control #	Rev. Date:	Title:	Effective Date: 8/1998
A 4.7	8/2011	MEDIA CONTACTS/EVENTS	Next Review Date:

EFFECTIVE DATE: 8/10/98

REVISED / REVIEWED DATE: 02/13/07, 08/23/11

SUPERSEDES: # # 4.034 MEDIA CONTACTS/EVENTS

APPROVED BY DPBH ADMINISTRATOR: 08/25/11

APPROVED BY DPBH COMMISSION: 02/13/07, 09/16/11

DHHS
MEDIA CONTACT REPORT

Employee: **Date:**
Program:

Reporter:

☐ TV ☐ RADIO ☐ NEWSPAPER ☐ MAGAZINE

Purpose of Contact/Action Taken:

Single Overriding Communications Objective (SOCO) Fact Sheet
(Use guide below to form your response to the initial contact)

RETURN OR FAX COMPLETED FORM TO ADMINISTRATION ON <u>DAY OF CONTACT</u>

Control #	Rev.	Title	Effective Date	Page
BHO: 001	2	Benefits for Payment: Healthcare Coverage	10-01-2016	1 of 5

1.0 POLICY

It is the policy of the Division that clients applying for services will apply for all benefits for reimbursement for services received in order to be assessed for payment on the Division's sliding fee scale. The Division will assist individuals who may be eligible for Affordable Care Act (ACA), Medicaid and/or other federally based benefits (e.g., SSI/SSDI) in the applying for these benefits. The clients' other personal resources must be used.

2.0 PURPOSE

This policy is to ensure compliance with State laws and regulations and maximize health benefits available to individuals through the expanded ACA, Medicaid programs, and other federally based benefits. In addition, this policy is to ensure that all opportunities for reimbursement are appropriately pursued and claimed.

3.0 SCOPE: DPBH Clinical Services Branch

4.0 DEFINITIONS:

4.1 Certified Application Counselor (CAC) – CAC's provide free information to consumers about the full range of Qualified Health Plans (QHP) options and insurance affordability programs (e.g., Medicaid, Nevada Check Up) for which they are eligible. Navigator-IPA-Program-CAC-Plan

5.0 REFERENCES:

5.1 Medicaid Services Manual (MSM), Chapter 100 – Medicaid Program
5.2 MSM, Chapter 400 – Mental Health and Alcohol/Substance Abuse Services
5.3 MSM 600 – Physician Services
5.4 MSM, Chapter 2500 – Case Management
5.5 Silver State Health Insurance Exchange - Getting Insured Through Nevada Health Link

6.0 PROCEDURE

6.1 All staff will be provided training in their required role in the pursuit of all reimbursement opportunities for services provided. The agency directors will ensure all staff are trained in and implement this policy. All staff will be ready to encourage, assist or refer all individuals who may be eligible for any benefits.

6.1.1 Each agency will have identified staff trained as Certified Application Counselors (CAC) as designated by the agency director or designee. These staff may include Financial Services staff, Service Coordinators, or others as deemed appropriate by the agency director or designee.

6.1.1.1 CAC's will be made available across agencies to assist individuals and Consumer Assistance Program (CAP) Staff/ Consumer Services Assistants/Peer Supporters as necessary.

6.1.1.2 Each site will have staff trained or access to staff trained by a CAC to assist individuals with benefit applications. This staff will ensure all applications are completed and submitted or provided to DWSS, as appropriate.

6.1.1.3 Staff will refer individuals with eligibility for Nevada Health Insurance plans to a designated CAC for assistance, if necessary.

6.2 CAC or other staff will be assigned to the Division hospitals to assist individuals in applying for benefits.

6.3 Effective on the date of this policy and upon request for services or admission to any DPBH program, all individuals will be screened for eligibility for ACA enrollment and Medicaid.

6.3.1 All agencies will assist individuals with applying for benefits or provide the following information to individuals seeking services:

6.3.1.1 Where and how to apply.

6.3.1.2 The need to apply within 30 days of seeking services.

6.3.1.3 Notification that failure to apply may result in the individual being financially responsible for services.

6.4 Eligibility for ACA enrollment and Medicaid for all individuals currently served by a DPBH program will be assessed. Individuals who may be eligible for ACA

enrollment and Medicaid benefits will be identified using the following current Avatar information: insurance (if any), income and family size information.

6.4.1 All sites will make every effort to contact these individuals during the enrollment period. Individuals will be assisted in completing and applying for benefits. For those individuals who decline application:

6.4.1.1 The declination will be documented in the financial section of Avatar and clinical staff will be alerted for the purpose of providing a full verbal and written explanation (to the individual of their role and responsibilities and to ensure the individual understands. A CAC or designee must also be available to answer any specific ACA or Medicaid questions the individual may have.

6.4.1.2 If the individual continues to decline application, the information will be referred to the clinic director (or designee) to further clarify the individual's role and responsibilities and encourage application.

6.4.1.3 If the individual continues to decline application, the clinic director (or designee) will provide written notice to the individual, when applicable; they will no longer be able to be billed on a sliding fee scale. The clinic director may also make a determination of the agency's ability to continue to provide services.

6.5 Each site and all Division's Drop-In Centers will provide an opportunity for individuals to access information and assistance with applications for benefits.

6.5.1 Paper applications will be available at the DPBH site. Where available, Internet access will be offered at specified sites and all Division's Drop-In Centers for individuals who are able to access the Nevada Health Link https://www.nevadahealthlink.com/ on their own. Assistance by staff will be provided upon request.

6.6 Division Service Coordinators/Case Managers will ensure that individuals on their caseload have applied for appropriate federal benefits. Documentation of this

application assistance and referral effort will be included in the progress notes using appropriate coding.

6.7 Division Service Coordinators/Case Managers (or their designees) will not deny services to an individual for lack of insurance. Individuals that qualify for Medicaid Managed Care Organizations (MCO) will be referred to their respective MCO covered providers, as applicable for care.

6.8 ACA Compliance

6.8.1 Each agency director will monitor the percentage of uninsured individuals opened to services on a monthly basis.

6.9 The 270/271 transaction will be used to track the progress of individuals aided in applying for benefits towards successful enrollment for benefits.

6.9.1 This mechanism will be used to track the paper applications delivered to DWSS.

6.10 Individuals' Role and Responsibility

6.10.1 It is the responsibility of all individual's served to pursue and apply for all eligible benefits for reimbursement to the Division for services provided for the individual to be eligible for the sliding fee scale.

6.11 Urgent or emergent services will not be delayed or denied as a result of failure to apply for benefits.

7.0 ATTACHMENTS:

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.

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Control #	Rev.	Title	Effective Date:
BHO-004	09/2018	**Medication Clinic Services**	04/2014
			Next Review Date 09/2020

1.0 POLICY:

The Division of Public and Behavioral Health (DPBH) ensures timely access to medication clinic services under an established statewide service delivery model, designed to meet the individually assessed biopsychosocial needs of individuals served. The provision of services is based on medical necessity and the emergent, urgent, and stabilization needs of each individual in conjunction with their goals and choices. Individuals will be offered entry into any service needed, regardless of the point of contact. All care will be coordinated and services will be provided under this policy and BHO-003: Service Delivery.

2.0 PURPOSE:

The purpose of this policy is also to establish policy for compliance with applicable accreditation agencies (e.g. Centers for Medicare and Medicaid Services also known as CMS). DPBH ensures effective and systematic compliance with Federal, State and Division policies through uniformity in the access, provision and documentation of all outpatient behavioral health services.

3.0 SCOPE:

Clinical Services Branch

4.0 DEFINITIONS:

4.1 Examination: the physical aspect of a psychiatric or nursing assessment.

4.2 Health Questionnaire: a tool completed by an individual and used by Registered Nurses RN's) to assist in the evaluation of the physical health concerns as reported by the individual. Reported health issues become integral as a focus in coordination of care and is the basis for development of the nursing care plan.

4.3 Medication Clinic (MC) Assessment: the assessed biopsychosocial needs of an individual which determines the medication clinic plan of care and the nursing care plan. Information is obtained from direct examination, clinical interview and can also be obtained through an AVATAR clinical record review, and/or from outside medical providers.

4.4 **Medication Clinic (MC) Plan of Care:** a plan of medication treatment services to be provided to an individual. This plan is documented on the medical staff progress note each time an individual is provided a billable treatment service by a medical staff. The MC Plan of Care is reviewed, updated and documented in the plan section of each progress note at each clinical visit.

4.5 **Nursing Care Plan:** a plan for nursing services which are based on the assessed nursing care needs of the individual and in support of medical staff services. The Plan is reviewed, updated and documented in the plan section of each nursing progress note at each clinical visit.

4.6 **Pain Assessment:** the assessed level of self-reported pain of an individual that contributes to reduced functioning and/or coping, or exacerbates a behavioral health disorder, and is addressed in the nursing care plan.

5.0 REFERENCES:

5.1 NRS 433, 433A, 433B, 435 and 436

5.2 NAC 433 and 436

5.3 Medicaid Services Manual Chapters 100, 600, 3400 and 3600 and the MSM Addendum.

Note: this policy is based on the most recent editions of the MSM chapters as of the date approval and includes chapter references.

6.0 PROCEDURE:

6.1 Medication Clinic services will be provided according to the most recent Medicaid Services Manual, Chapter 600, Physician Services: https://dhcfp.nv.gov/MSM/CH0600/MSM%20Ch%20600%20FINAL%209-12-13.pdf .

6.1.1 Individuals may receive medication in conjunction with or independent of other services.

6.1.2 Services are based on an on-going review of psychiatric symptoms, treatment history and in coordination with an individuals' primary care provider, when appropriate.

6.1.3 If an individual does not have a primary care provider, every effort will be made to encourage and link the individual to available resources.

6.2 Eligibility

6.2.1 Admission criteria - Eligibility for Medication Clinic Services is based on the medical necessity for medication clinic services and meeting criteria in one of the following categories:

6.2.1.1 Non-Seriously Mental Ill (Non-SMI) Adults
6.2.1.2 Non-Severely Emotionally Disturbed (Non-SED) Children
6.2.1.3 Seriously Mental Ill (SMI) Adults
6.2.1.4 Severely Emotionally Disturbed (SED) Children

6.2.2 Continuing stay criteria: Must meet all of the following:

6.2.2.1 Continues to meet admission criteria.
6.2.2.2 Services are not available, accessible, or appropriate in the community or private sector.
6.2.2.3 MC Plan of Care and goals are established.

6.3 Discharge/Exclusionary criteria: Must meet at least one (1) of the following:

6.3.1 No longer meets the admission and continuing stay criteria.
6.3.2 The individual or their legal representative chooses not to participate in the program or is non-compliant with agreed upon treatment.
6.3.3 The individual has been linked/referred to an available community resource and the transfer of care has been confirmed.

6.4 Services: Based on medical necessity and individually assessed needs of the client.

6.4.1 Services are provided as prescribed in a MC Plan of Care by a medical staff prescriber and as documented in the nursing care plan.

6.4.2 All services provided and the coordination of care must be documented in individual's electronic medical record.

6.4.3 Services include:

6.4.3.1 Behavioral Health Screen – A screen to determine eligibility for services.

6.4.3.1.1 All individuals presenting to the medication clinic who are identified being at risk of harm to themselves or others and/or present with any other type of verbal or non-verbal response (e.g., excessive tearfulness, agitation, pacing) that might suggest the need for an immediate assessment, will receive a behavioral health screen by an RN or clinician as soon as possible and no longer than 15 minutes.

6.4.3.1.2 If the individual is in crisis consistent with the requirements of a legal hold, a legal hold will be initiated following Division policies and procedures.

6.5 Evaluation and Management (E/M) Services: a medical service provided by a medical staff prescriber to assess the psychiatric needs of an individual.

6.5.1 E/M services include a determination of the level of complexity of the assessed needs.

6.6 Injection: under medical staff supervision a "therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular."

6.7 Medication Training and Support: provided by an RN to monitor compliance, side effects, to provide education and support, and to coordinate requests to a DPBH medical staff prescriber for changes in medication(s).

6.8 Pharmacy Support Services: assist individuals to improve their understanding of their prescriptive medications prescribed by a DPBH medical staff prescriber. The intent is to broaden the individual's understanding of the importance of

medication self-administration thereby improving self-sufficiency and promoting greater medication adherence.

6.9 Psychiatric Evaluation: an evaluation to determine psychiatric diagnosis(es).

6.9.1 New individuals requesting medication clinic services will receive a psychiatric evaluation. If an existing psychiatric evaluation is available, less than a year old, then a review and/or an update of their recent psychiatric evaluation is done.

6.9.2 Adults who have not received an evaluation within two (2) years and children/adolescents who have not received an evaluation within one (1) year prior to receipt of services will receive a new evaluation.

6.9.2.1 Prescribers will utilize any current evaluation available including those submitted by an outside provider (in the case of a client transfer), in order to complete, review and/or update a Psychiatric Evaluation/Update.

6.9.2.2 Consumers with uninterrupted care can have a reviewed/updated evaluation combined with a psychiatric symptoms checklist, completed in the progress note section of AVATAR.

6.9.2.3 Previous consumers with a break in service less than one (1) year, can also have an updated psych evaluation completed in the progress note as an extended visit.

6.9.2.4 Consumer's new to the clinic from other programs or clinics with a current psych evaluation under two (2) years can also be updated in the progress notes.

6.9.2.5 The medical staff may determine at any time based on acuity, new consumer status, or other changes to schedule a new psychiatric evaluation.

6.9.2.6 All medical staff psychiatric evaluation updates completed in the progress notes must also update the diagnosis section in AVATAR.

6.10 Nursing Assessment: Individuals receiving medication services will receive a nursing assessment or review and/or update of their current AVATAR assessment.

6.10.1 All nursing services are provided under medical supervision and are based on the assessed needs of the individual served.

6.10.2 All nursing staff will utilize any current assessments available including those submitted by an outside provider (in the case of a client transfer), in order to complete, review and/or update a Nursing Assessment.

6.10.3 A reviewed/updated nursing assessment combined with medical necessity and clinical judgment will be the basis for all nursing services.

6.10.4 Nursing assessments may be provided on the same day, prior to an evaluation and management medical staff visit, or independent of that visit.

6.10.5 Completed nursing assessments will include a nursing care plan based on identified client biopsychosocial needs.

6.11 LOCUS/CASI Assessments: Completed at the time of Behavioral Health Screening and every ninety (90) days thereafter by clinician, or RN if open to medication clinic only. (Per Medicaid Regulations)

~~**6.11**~~ ~~6.11.1 Clients~~6.11.1 Clients entering Outpatient Services will receive a LOCUS/CASI ~~–~~on admission to service.

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: 04/2014
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 09/2018

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

Control #	Rev.	Title	Effective Date: 9/2017
CRR .014	11/2018	**Risk Management and Reporting Serious Incidents**	**Next Review Date: 11/2020**

1.0 POLICY

It is the policy of the Division of Public and Behavioral Health (DPBH) that serious incidents be reported to the Agency Director and Division Administrator or Designee and responded to appropriately, utilizing risk management techniques.

2.0 PURPOSE

In the interest of ensuring the safety and rights of the people receiving services, DPBH agencies have established a system for reporting incidents that may represent high risk situations. The purpose of this reporting is to ensure that appropriate safeguards are implemented, and all reportable serious incidents are handled and addressed appropriately.

3.0 SCOPE

DPBH Clinical Services Branch

4.0 REFERENCES

4.13.1 DPBH Policy A 5.2 Review of Clients Death for Mental Health Agencies. Refer to this policy for reporting and follow-up procedures

4.13.2 DPBH Policy CRR 1.13 Sentinel Events. Refer to this policy for reporting, follow- up procedures

4.13.3 DPBH Policy A 51. Division Level II Incident Reports

4.13.4 Nevada Revised Statue (NRS) 618.378.

4.13.5 NRS 439.835

5.0 DEFINITIONS:

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

5.2 Incident means an action, practice or situation that appears to be inconsistent with a

federal or state statute, rule or regulation of the Division or the Centers for Medicare and Medicaid Services or conditions and standards of or requirement for participation in Medicare or Medicaid. NRS 449.0046b

5.2.1 Agency Level I incident is an incident that represents risk at the agency level. These incidents are reported to the Agency Administrator to ensure that appropriate safeguards are implement within the agency/facility.

5.2.2 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. Any client death and/or incident that meets the criteria of Sentinel event as defined by The Joint commission are Level II incidents. 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.

5.2.3 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. Reportable Critical Incident Define 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; and Other.

6.0 PROCEDURE

6.1 A serious incident is an event 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 the Division to ensure that appropriate safeguards are implemented and all serious incidents, whether at the Agency or Division level, are evaluated and addressed appropriately.

6.2 A serious incident report (SIR) does not substitute for the normal documentation of events in a person's (both consumer and employee) service records.

6.2.1 Documentation of the details of the incident must be included in the progress notes. Progress notes must not include reference to the submission of a Serious Incident Report.

6.2.2 All documentation in the record must also be completed to include all follow-up activities identified and implemented.

6.3 Level I Agency Incident Reports may be entered in the AVATAR Incident

Tracking module from a written worksheet by staff at the Agency Manager's discretion.

6.4 Level II Division Incident reports must be entered in 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.

6.5 In addition to the SIR process, other reporting may be necessary depending on the type of incident. For example, abuse or neglect may require reports to protective services or law enforcement.

6.3.1 The SIR does not substitute for required reports to law enforcement, protective services, Human Resources, Fleet Services or Risk management etc.

6.6 The Deputy Attorney General will be notified of Level II Division Level Serious Incident Reports by Division Central Office.

6.7 In the event of a serious incident involving one or more Division consumers or staff, an agency of the Division or one of its contract service providers will follow the reporting procedure set forth below.

6.8 Process for reporting Serious Incident events will be by using the AVATAR Incident Tracking Module (AITM).

6.8.1 All Serious Incident events will be reported by using AITM to include the designated reporting category. A detailed description of the event, including the names of witnesses, will be entered into AITM no later than the end of the first working day after the incident occurs.

6.8.2 All follow-up notations, addendums and requests for closure will be completed in AITM.

6.8.3 Any plan of correction, written statements, photographs or other documents related to the incident that cannot be documented in the follow-up notes will be scanned and submitted electronically to SIR Investigations email account.

6.8.4 All Serious Incident Events that are non-patient related (involving employees and/or non-patient person(s) (i.e. visitors, venders)) will be addressed by following proper risk management protocol and reported to direct supervisors or onsite program managers as soon as possible

6.9 All DPBH Community Providers (SLAs, group homes, etc.) will be required to report incidents within one (1) hour of their discovery to their state contracting agency.

6.10 DPBH agencies will ensure that agency protocol and employee training for reporting SIRs are aligned.

6.11 DPBH agencies will train all staff on the reporting and completion of SIR protocols.

6.12 SAPTA's community treatment providers will be made aware of the policy for reporting serious incidents. SAPTA will be responsible for ensuring reporting and data collection compliance by their community providers.

6.13 Follow up reports of serious incidents are due within ten (10) days of the initial report using AITM

6.14 Incidents are categorized as either Agency or Division. The determination regarding aa incident is made by the Agency Director or their designee using the criteria provided in Attachment A.

6.15 Attachment

6.15.1 all work-related fatalities, and all work-related inpatient hospitalizations, all amputations and all losses of an eye within 24 hours, per "Employer Responsibilities" Occupational Safety and Health Administration. United States Department of Labor

6.16 In the event of a non-patient, non-fatal employee injury or accident employees and supervisor (or his/her designee in in event of an absence) are to follow protocols set-fourth by the Department of Administration Risk Management. Supervisors will also contact and work with human resource management representative A "Risk Management Criteria for Determination of Incident Level" outlines criteria for establishing whether an event rises to a Level I (Agency incident) or Level II (Division Incident).

6.17 Procedures regarding types of incidents:

6.17.1 Death of a person receiving services in a 24-hour care setting (i.e., hospitals), deaths within seven (7) days of seclusion or restraints, and death within 72 hours of discharge is considered a Sentinel Even and handled in accordance with CRR 1.13Sentinel Events. Refer to this policy for reporting, follow-up procedures and additional reportable sentinel events. Refer to policy #A 5.2 Review of Client Death for Mental Health Agencies.

6.17.2 Death of a person currently open to community-based services or discharged within the last 30 days will be reported to Division Administration as an SIR.

6.17.3 Reports of deaths also require the completion of additional questions regarding a death. Follow-up information is due within 30 days of the initial SIR report. Refer to policy #A 5.2 Review of Clients Death for Mental Health Agencies.

6.17.4 In the event of an employee death or any accident or motor vehicle crash occurring during employment which is fatal to one or more employees or which results in the hospitalization of three or more employees must be reported by the employer orally to the nearest office Division within eight

(8) hours after the time that the accident or crash is reported to any agent or employee of the employer, per Nevada Revised Statuses (NRS) 618.378. The appropriate Agency Director or their designee will notify OSHA within eight (8) hours of.

6.17.5 In the event of an automobile accident involving a state car employee(s) and supervisor (or his/her designee in in event of an absence) are to follow protocols set-fourth by the Department of Administration Fleet Services Division.

6.17.6 Agency Directors or designees will verbally notify the Division Administrator or Designee within thirty (30) minutes of becoming aware of any serious incident that may be considered high profile or of media interest. Outside of regular work hours (8AM-5PM), the Agency Director or designee will call the Division Administrator or Designee at home or on their cell phone.

6.17.7 The Division Administrator or Designee will notify the Director of DHHS of a serious incident that may be considered high profile or of media interest. Outside of regular work hours, the Division Administrator or Designee will attempt to contact the Director or Deputy Director of DHHS. If the Director or Deputy Director of DHHS is unavailable, the assistant to the Governor will be contacted.

6.17.8 In the event of theft of State property, law enforcement must be notified immediately. If confidential information, such as a consumer's name, is disclosed to law enforcement agencies, a formal denial of rights must be filed at the time such notification occurs. The DPBH HIPAA and Agency HIPAA Privacy officers must be notified.

6.18 Timeframes for Notification to Division of Level II Required Documentation

6.18.1 Verbal Notification - Deaths (including suicide and homicide) occurring in a Division facility or Division-contracted 24-hour care setting must be verbally reported within one (1) hour to the Division Administrator, State Medical Director and the Division's Deputy Administrator of Clinical Services

6.18.2 Avatar Inputting – Any patient serious incidents will be entered in Avatar within one (1) working day of the discovery of the serious incident.

6.18.3 If the incident has been determined to meet the Sentinel Event Criteria as defined by NRS 439.835 and 439.805 staff shall follow mandatory reporting requirements of sentinel events as defined by NRS 439.835.

6.18.4 An event is also considered sentinel if it is one of the following:

6.16.4.1 Suicide of any patient receiving care, treatment, services in an around-the-clock care setting or within 72 hours of discharge.

6.16.4.2 Abduction of any patient receiving care, treatment, and services

6.16.4.3 Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting, leading to death, permanent harm, or severe temporary harm to the patient.

6.16.4.4 Rape or sexual assault (leading to the death, permanent harm, or severe temporary harm).

6.16.4.4.1 Sexual abuse/assault, including rape as a sentinel event is defined as nonconsensual sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated on the premises of the hospital which includes oral, vaginal, anal penetration or fondling of the patient's sex organ(s) by another individual's hand, sex organ or object.

6.16.4.4.2 One or more of the following must be met: Any staff witnessed sexual contact as described above, admission by the perpetrator that sexual contact, as described above occurred on the premises or sufficient clinical evidence obtained by the hospital to support allegations of sexual contact.

6.16.4.4.3 Homicide of any patient receiving care, treatment, and services while on site at the hospital.

6.16.4.4.4 Rape, assault of any patient (leading to death, permanent harm, or severe temporary harm).

6.16.4.5 Homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital.

6.17 Data Collection

6.17.1 In addition to responding to serious incidents at their agency or Division level to assure they are responded to appropriately, serious incidents also provide a performance improvement opportunity for DPBH agencies with their overall services to their consumers.

6.17.2 Data on incidents, both at the agency (Level I) and Division (level II) shall be collected, and analyzed for trends to determine opportunities for continuous performance improvement activities at each agency.

6.19 Each Agency of the Division may develop and implement their own written protocol, to implement the provision of this policy.

7.0 ATTACHMENTS:

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

EFFECTIVE DATE: 09/2017
DATE APPROVED BY DPBH ADMINISTRATOR: 9/2017, 11/18
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 9/2017, 11/18

Control #	Rev.	Title	Effective Date:	Page
CRR: 014	1	Risk Management and Reporting Serious Incidents Attachment A	09/2017 Revision Date: 09/2019	1 of 7

Incident	Definition	Level I (Agency)	Level II (Division)	Reporting method	Data Collection Points
Consumer Death	Death of a Person Receiving Services in a 24-hour care setting Death of a person receiving services from a community based care program Death of a person closed from community based care within 30 days.		✓Suicide ✓Homicide ✓Accident with injury ✓Death in a 24-hour care setting ✓Death within 72 hours of discharge from 24-hour care setting ✓Death occurring within seven (7) days of seclusion or restraint	✓AVATAR Incident Tracking Module (AITM). ✓ DHHS- Director's Office Critical Incident Report (CIR)	✓Deaths that qualify as a sentinel event.

Abuse/ Neglect	Abuse: Willful infliction of pain or injury upon a person receiving services by anyone else – includes physical, sexual, mental, verbal abuse and exploitation Neglect: Any omission to act that causes injury to a consumer or that places a consumer at risk of injury, including, but not limited to the failure to follow: 1) an appropriate plan of treatment to which the consumer has consented, 2) the policies of the facility for the care and treatment of consumer and 3) standards of practice by professionals engaged in healthcare	✓ Allegation of abuse or neglect of a client by DPBH staff, or contract staff.	✓An allegation of abuse, neglect or exploitation against DPBH staff or contract staff, *with substantiated evidence.* ✓The incident poses a significant danger to the community	✓ AVATAR Incident Tracking Module (AITM). ✓DHHS- Director's Office Critical Incident Report (CIR)	✓ Abuse/Neglect/Exploitation by Levels I and II ✓Abuse allegations ✓Outcomes of inquiries resulting from allegations ✓Neglect allegations ✓ Outcomes of inquiries resulting from allegations *Abuse/neglect allegations that require reporting to authorities (e.g., CPS, EPS) must be documented in the consumer's medical record*

Incident	Definition	Level I (Agency)	Level II (Division)	Reporting method	Data Collection Points
Consumer Injury	Injury due to: Accident Aggressive Behavior Self-Harm Trip or Fall Medication Error Restraint Auto Accident in State car or on state business Other Unknown Cause	✓ Any injury that requires First Aid only ✓ An accident that occurred on the ground of an DPBH facility ✓ Defective equipment ✓ An injury that resulted from DPBH staff error or negligence	✓An injury as a result of DPBH staff or contract staff negligence that results in permanent physical or psychological impairment (or severe exacerbation of an existing psychological impairment. ✓Any injury resulting from the use of restraint	AVATAR Incident Tracking Module (AITM). DHHS- Director's Office Critical Incident Report (CIR)	Consumer Illness/Injury by: ✓Levels I and II ✓Accident ✓Aggressive behavior ✓Self-Harm ✓Trip or Fall ✓Defective Equipment ✓Medication Errors ✓Injury or illness resulting from staff negligence
Consumer Behavior	Suicidal Behavior (includes suicide attempts or completed suicides)	✓ Suicidal threats and/or ideations with a plan and/or intent	✓Suicidal behavior that results in permanent physical or psychological impairment. ✓ Completed suicide	✓AVATAR Incident Tracking Module (AITM). ✓DHHS-Director's Office Critical Incident Report (CIR)	✓ Suicides

Incident	Definition	Level I (Agency)	Level II (Division)	Reporting method	Data Collection Points
Consumer Behavior	Sexual Behavior exhibited by the Consumer in the 24-hour care setting Alleged Sexual abuse or assault	✓ Sexual behavior that is not a threat to others and does not involve a report to law enforcement or to an oversight agency in a DPBH facility (inpatient only) Examples: consensual sex, masturbation, rape allegation without supporting evidence. Sexual behavior that involves the threat to the safety of others or involves a report to law enforcement or to an oversight agency. Example – unwanted sexual advances/harassment	Rape or sexual assault, sexual coercion in a DPBH facility.	✓AVATAR Incident Tracking Module (AITM).	✓ Incidents of rape, consensual sex, masturbation, unwanted sexual advances, sexual assault and coercion.

Consumer Behavior	Acts or Threats of Violence made by or to a consumer, or other illegal behavior	✓ Aggressive or destructive act that does not involve a report to law enforcement or an oversight agency (not resulting in injury) ✓ Targeting other consumers or employees Examples – pushing or hitting, throwing furniture	✓ An aggressive or destructive act or illegal behavior that involves a report to law enforcement or a complaint to an oversight agency (results in injury) ✓ A consumer act that results in death, permanent physical or psychological impairment ✓ Any injury (consumer or staff) resulting from assault by peer that requires hospitalization and/or medical attention beyond standard first aid ✓ Incident poses a significant danger to the community Example – destroying property ($500.00 or more), shooting someone, stealing drugs	✓AVATAR Incident Tracking Module (AITM).	✓ Assaults against consumers ✓Assaults against employees ✓Destroying property ✓Weapons use
Incident	**Definition**	**Level I (Agency)**	**Level II (Division)**	**Reporting method**	**Data Collection Points**
Consumer Behavior	Consumer Absence or Elopement from a 24 hour care setting	✓ An absence from a provider group home less than 24 hours where law enforcement is not required	✓ An absence from a provider group home greater than 24 hours, or an absence that requires contact with law enforcement to file a missing person ✓ An absence or elopement from a 24-hour inpatient facility	✓AVATAR Incident Tracking Module (AITM). ✓DHHS-Director's Office Critical Incident Report (CIR)	✓ Consumer absence or elopement from an inpatient facility ✓Consumers missing from residential setting and reported as missing person

Employee Incidents	Auto accident in state car or on State business in personal car.	✓ Auto accident that does not result in injury ✓ Automobile accidents that results in injury requiring the employee to seek/received outpatient medical care.	✓ Automobile accident that results in injury requiring the employee to seek/receive inpatient hospital medical care Note: An auto accident resulting in an employee and/or consumer injury or death, will be reported as injury or death.	✓State Car – Fleet Services ✓Personal car- Risk Management	✓ Auto accidents resulting in injury ✓Auto accidents that do not result in an injury
Employee Incidents	Internet and/or email misuse	✓Internet and email use not involving pornography	✓ Internet use involving pornography ✓Internet use involving illegal activity	✓Administration and Human Resources	✓ Internet use not involving pornography ✓ Internet use involving pornography
Employee Incident	Confidentiality Breach	✓ Any breach of a consumer's confidentiality	✓ A serious breach of confidentiality reportable to the Office of Civil Rights (OCR)	✓HIPPIA officers and Administration	✓ Breach of consumer responsibility ✓Co confidentiality that is reported to OCR.
Property Damage	Property Damage	✓ Minimal property damage– under $1000 Including human resource cost for repairs.	✓Major Property Damage- $1000 or more. Including human resource cost for repairs.	✓Administration ✓Capitol Police per DPBH Policy HPP 0020	✓Property damage under $1000 ✓Property damage $1000 or more
Criminal Activity on DPBH Properties	Suspicious or Criminal Activity	✓	✓Any suspicious or criminal activity on or around DPBH buildings and property	✓ AVATAR Incident Tracking Module (AITM). ✓DHHS-Director's Office Critical Incident Report (CIR)	✓ Suspicious criminal activity in or around DPBH facilities ✓

			✓ Active criminal activity or threat of serious bodily harm	✓ Capitol Police ✓ Call 911 as appropriate	

Control #	Rev. Date:	Title:	Effective Date: 7/1998
CRR 1.2	3/2017	PROHIBITION OF ABUSE OR NEGLECT OF CONSUMERS AND REPORTING REQUIREMENTS	Next Review Date: 3/2019

1.0 POLICY:

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

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

2.0 PURPOSE:

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

~~3.0~~ 3.0 SCOPE: Clinical Services Branch, including contract providers and their staff

~~Division wide, including contract providers and their staff~~

~~4.0~~ 4.0 DEFINITIONS:

~~4.1~~2.1 Abuse: is any willful and unjustified infliction of pain, injury or mental anguish upon a person served by a DPBH or contract staff. Abuse includes, but is not limited to:

~~4.1.1~~2.1.1 Sexual abuse: Examples of sexual abuse include but are not limited to: rape, sexual assault, sexual exploitation, sexually degrading language or gestures, sexual molestation, attempts to engage a person in sexual conduct, intimate touching or fondling, encouraging a person to sexually touch a staff member, other consumer, or himself, exposing one's sexual parts to a person, encouraging a person to expose his sexual parts to others, encouraging a social or romantic attachment or relationship outside

of boundaries, encouraging the consumer to solicit for or engage in prostitution, or encouraging or allowing the viewing or production of pornographic material by minors.

~~4.1.2~~2.1.2 Physical abuse: Examples of physical abuse include but are not limited to: any act that causes physical pain or injury to the consumer, hitting, slapping, bruising, kicking, hair pulling, shoving, pinching, cutting, burning, or the use of arm bars or other holds to inflict pain. An allegation of physical abuse may be substantiated without an observable injury.

~~4.1.3~~2.1.3 Verbal abuse: Examples of verbal abuse include but are not limited to: verbal intimidation or coercion of a person without a redeeming purpose, name-calling, cursing, mocking, swearing, ridiculing, yelling, or using words or gestures that frighten, humiliate, intimidate, threaten or insult the person.

~~4.1.4~~2.1.4 Emotional/Psychological Abuse: Examples include but are not limited to: actions or utterances that cause mental distress such as making obscene gestures to the person, or using other non-verbal gestures that frighten, humiliate, intimidate, threaten or insult the person, harassment, threats of punishment or deprivation, including threats to deny or withdraw services, sexual coercion, intimidation whereby a person would suffer psychological harm or trauma, and social isolation of an individual from family and friends or from normal activities.

~~4.1.5~~2.1.5 Excessive Force: The use of excessive force when placing a consumer in physical restraints or in seclusion.

~~4.1.6~~2.1.6 Restraint: The use of physical, chemical or mechanical restraints or use of seclusion in violation of state and/or federal law.

~~4.1.7~~2.1.7 Exploitation: Exploitation is any illegal or improper use of a consumer's funds, property, or assets resulting in monetary, personal, or

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

~~4.2~~2.2 Neglect: is any act or omission to act that causes injury or mental anguish to a consumer or that places the consumer at risk of injury whether due to indifference, carelessness or intention. Neglect includes but is not limited to:

~~4.2.1~~2.2.1 Failure to establish or carry out an appropriate plan of treatment for which the person has consented, failure to follow the agency policies and procedures, failure to provide for basic needs (adequate nutrition, clothing, personal hygiene, shelter, supervision, education, or appropriate and timely health care including treatment and medication), failure to provide a safe environment, failure to respond to aggression between consumers served or to consumers engaging in self abusive behavior, and failure to act to stop abuse as defined above.

~~4.3~~2.3 Staff: is any Division of DPBH or contract service provider staff, employee, or volunteer, unless stated otherwise.

2.4 Supervisor: is any Division of DPBH or contract service provider supervisor, unless stated otherwise.

5.0 REFERERNCES

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

Control #	Rev. Date:	Title:	Effective Date: 7/1998
CRR 1.2	3/2017	PROHIBITION OF ABUSE OR NEGLECT OF CONSUMERS AND REPORTING REQUIREMENTS	Next Review Date: 3/2019

~~4.4~~

~~5.0~~6.0 PROCEDURE:

~~5.1~~6.1 The Division of DPBH strictly prohibits abuse and neglect.

Any act of abuse or neglect of a consumer by a DPBH or contract provider staff shall result in disciplinary action up to and including termination.

Should the investigation indicate that abuse, as defined in NRS 433.554 has occurred, the agency director shall recommend termination of the employee and shall review all pertinent agency policies, treatment procedures, and staff orientation practices to determine if they need to be revised to reduce the likelihood of recurrence of similar incidents.

~~5.2~~6.2 DPBH and contract staff shall receive training about abuse and neglect of consumers

~~5.2.1~~6.2.1 Each DPBH agency director shall ensure that training is provided to all staff on abuse and neglect prevention, identification, and reporting requirements in accordance with agency policies.

~~5.2.2~~6.2.2 Training shall be provided for new staff prior to their working independently with consumers receiving services.

~~5.2.3~~6.2.3 Training will be required a minimum of biannually for all staff.

~~5.2.4~~6.2.4 DPBH and contract agencies will document training for each staff member and will provide additional training as needed.

~~5.3~~6.3 All allegations of abuse and/or neglect shall be reported by following the requirements below, which will be repeated in Policy CRR-1.4, Reporting Serious Incidents and Denials of Rights:

~~5.3.1~~6.3.1 Any staff, upon observing, hearing of, or suspecting abuse and/or neglect of a person served by the Division will:

~~5.3.2~~6.3.2 Make a verbal report to his supervisor immediately and in all instances within a maximum of one (1) hour from becoming aware of the suspected abuse and/or neglect. The report must be made through

person-to-person contact; voice messages do not meet the reporting requirements;

~~5.3.3~~6.3.3 Complete an Incident Report to their supervisor, or designee, detailing the information as soon as possible following the verbal report, and in all instances by the end of the staff's workday, or if off duty within 16 hours;

~~5.3.3.1~~6.3.3.1 Make all verbal and written reports to the supervisor's supervisor if the direct supervisor is suspected of abuse or neglect;

~~5.3.3.2~~6.3.3.2 Notify other applicable entities as appropriate or required (i.e. Child Protective Services, Aging Protective Services, law enforcement) within 24 hours, or discuss with their supervisor if the notification(s) is to be made by the supervisor; and

~~5.3.3.3~~6.3.3.3 The DPBH or contract agency will ensure the immediate notification by agency staff of the person's parents (if a minor) or guardian (if legally appointed).

~~5.3.4~~6.3.4 The supervisor on receiving a report will:

~~5.3.4.1~~6.3.4.1 Take immediate action to ensure the victim has received appropriate medical treatment and follow-up as applicable, and take prompt action to provide for the person's welfare and safety;

~~5.3.4.2~~6.3.4.2 Make a verbal report to the DPBH agency director, or designee, immediately, and in all instances within a maximum of one (1) hour from becoming aware of the suspected abuse and/or neglect.; and

~~5.3.4.3~~6.3.4.3 Within twenty-four (24) hours of being apprised of suspected abuse and/or neglect, ensure that the written Serious Incident Report is submitted to the DPBH agency director or designee.

~~5.3.5~~6.3.5 The DPBH agency director, or designee, on receiving a report of alleged abuse and/or neglect will:

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

~~5.3.5.1~~6.3.5.2 Ensure submission of a DHHS- Director's Office Critical Incident Report (CIR).

~~5.3.5.2~~6.3.5.3 Provide protection of the person, when determined necessary, by restricting access to the person by the alleged perpetrator;

~~5.3.5.3~~6.3.5.4 If the alleged perpetrator is a staff of a contractor, the DPBH agency director, or designee, will ensure the

contractor has taken prompt action to restrict access to the person by the alleged perpetrator.

~~5.4~~6.4 Reporting abuse and/or neglect is absolutely required.

~~5.4.1~~6.4.1 A staff that fails to report abuse or neglect shall be subject to disciplinary action, up to and including termination.

~~5.4.2~~6.4.2 A staff that reports suspected abuse or neglect shall not be disciplined or receive any retaliation for making such a report, per NRS 433.536.

~~6.0~~7.0 ATTACHMENTS:

~~N/A~~ 7.1 A 4.0 DPBH Emergency Communication DHHS Director's Office Critical Incident Report Form Attachment A

~~7.05.0 REFERERNCES~~

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

8.0 IMPLEMENTATION OF POLICY:

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

EFFECTIVE DATE: 07/17/98
REVIEWED / REVISED DATE: 2/04/99; 07/18/01; 03/10/05; 05/09/07; 09/08/10
SUPERSEDES: Policy #2.003 Abuse or Neglect of Clients
APPROVED BY DPBH ADMINISTRATOR: 08/06/10
APPROVED BY DPBH COMMISSION: 09/17/10; 3/17/2017

DHHS – Director's Office
Critical Incident Report (CIR)

***Note: Internal use only. This form does not replace any Division's serious incident reporting forms. ***

Notification must be provided to: Richard Whitley; Chrystal Main; Julia Peek, Deborah Hassett; Stacey Johnson; Tawny Chapman

Please list all other personnel notified of incident:

Date of Incident: MM/DD/YYYY **Time of Incident:** HH:MM AM/PM

Office/Facility/Location of incident:

Type of Event: **(select one)**

- ☐**Abuse**
- ☐**Death/Suicide**
- ☐**Lost/Missing Person**
- ☐**Run-Away/Elopement**
- ☐**Serious Injury**
- ☐**Threat or Hostage Situation**
- ☐**Public Health Emergency**
- ☐**Health Facility Emergency**
- ☐**Fire/Natural Disaster**
- ☐**Other:**

Brief Synopsis of Event (including client(s) and/or staff involved):

Crime and/or reason for violation, and length of stay at facility as applicable:

Senior DHHS staff member(s) serving as "in charge" of incident (list name(s)/contact number(s)):

First/Last Name	Title/Organization	Contact Number	Email

Other entities that have been notified **(e.g. Law enforcement, Child or Adult Protective Services, fire department, ambulance services, coroner, etc.…):**

What action(s) have or are being taken by division in response to the incident:

What action(s) are being requested of Director's Office to assist with the incident, if applicable:

Other Comments/Concerns:

CIR reported by: Printed Name Title/Position

Date Reported: MM/DD/YYYY **Time Reported:** HH:MM AM/PM

Revised 01/15/2019– Supersedes 06/11/2018

Control #	Rev.	Title	Effective Date:
		Nevada Disability Advocacy Law	Review Date:
CRR 2.0	New	Center (NDALC) Visitation in Civil Facilities	

1.0 POLICY:

DPBH Civil facilities establish reasonable guidelines for allowing the Nevada Disability Advocacy Law Center (NDALC) to interact and access medical records with clients placed in inpatient and residential facilities.

2.0 PURPOSE

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

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS

4.1 NDALC – Nevada Disability Advocacy Law Center

5.0 REFERENCES: N/A

6.0 PROCEDURE

6.1 NDALC access to clients and agency facilities:

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

6.1.1.1 Dini Townsend Hospital: 9:00 to 11:00 am, 6:00 to 8:00 pm Monday through Sunday.

6.1.1.2 Rawson Neal Hospital: 9:00 to 11:00 am, 6:00 to 8:00 pm Monday through Sunday.

6.1.1.3 Exceptions to the hours shall be made only for emergency situations and require notice to the agency administrator or designee by NDALC staff.

6.1.1.3.1 Emergency situations include the investigation of abuse and neglect as defined by Nevada Statutes and any situation that involves the imminent danger to the health and welfare of a client.

6.1.2 When visiting the facility or conversing with clients via mail or telephone, NDALC staff members will not interfere with ongoing therapeutic activities and will refrain from giving therapeutic advice regarding prescribed medications or cooperating with treatment.

6.1.3 Notification of Presence on the Unit:

6.1.3.1 Prior to entering a unit, NDALC staff shall notify the agency administrator or his/her designee.

6.1.4 NDALC access to buildings and other areas:

6.1.4.1 Under no circumstances will agency staff give NDALC staff keys to agency buildings.

6.1.5 NDALC staff will gain access to the unit by being admitted by agency staff.

6.1.6 NDALC staff are not allowed in the nurse's stations.

6.1.7 Access to Records:

6.1.7.1 Health Information Management

6.1.7.1.1 All requests for copies of client records must be made to the agency Health Information Department.

6.1.7.1.2 All records shall be reviewed in the presence of Health Information staff and respective Treatment Team Leaders or their clinical designee.

6.1.7.1.3 A release of information that follows the Division policy for releases shall be presented to the Agency Director executed by director of NDALC certifying that there is probable cause to believe and setting out the basis for his/her belief, that the individual subject to NDALC's services has been the victim of abuse or neglect as defined by NRS 433.554.

6.1.8 Records other than medical:

6.1.8.1 Requests for any documentation, other than medical, by NDALC staff will be handled by the Deputy Attorney General.

6.1.8.2 If any agency staff receives a request for such information, it shall be referred to the Deputy Attorney General.

6.1.8.3 Reports prepared for purposes of performance improvement (i.e., root cause analysis, corrective action plans, denial of rights, and incident reports will be available to NDALC staff upon receipt by the Deputy Attorney General of a request by NDALC for such records accompanied by a consumer name.

6.1.9 Client Access to NDALC:

6.1.9.1 The agency shall not impede any of its clients from having regular and frequent access on their units to NDALC staff for obtaining information on legal rights and self-advocacy during the hours noted in Section 6.1 of this policy.

6.1.9.2 All residents shall have access to a telephone to call NDALC by making a local, toll-free or collect call without monitoring by, or permission from agency staff.

6.1.10 Agency shall post NDALC's rights poster with the telephone numbers in a conspicuous place in its facility.

6.1.11 NDALC Investigations

6.1.11.1 Agencies shall cooperate with any investigations of abuse and neglect by NDALC staff.

6.1.11.2 When investigating abuse or neglect of a client, NDALC staff shall be allowed to interview witnesses, inspect the premises and review individual records pertinent to the investigations.

6.1.12 Protection and Retaliation:

6.1.12.1 There shall be no retaliation against any individual for having filed a complaint with or provided information to NDALC or an NDALC representative.

6.1.13 Comments and Concerns:

6.1.13.1 NDALC staff shall refrain from commenting to any agency staff other than the Agency Director or designee on such matters that pertain to medical treatment, staffing levels, and the conduct of agency staff.

6.1.14 Agency staff shall bring any concerns they may have about the conduct of NDALC staff and/or violations of this policy to the attention of their own supervisors, who will transmit the information through the agency chain of command to the appropriate Agency Director or designee.

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY:

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

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

Control #	Rev. Date:	Title:	Effective Date: 04/2003
CRR 6.05	05/2007	Treating Personal Representative as the Individual	Next Review Date: 05/2007

1.0 POLICY:

If under applicable law a person has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, the Division will treat such person as a personal representative with respect to protected health information relevant to such personal representation.

With respect to unemancipated minors and ~~,~~ deceased individuals, ~~and others~~ the Division will follow these procedures in determining whether to treat a person as a personal representative of an individual.

2.0 PURPOSE:

The Division must treat a personal representative of an individual as the individual if the law so requires and if the person has authority under the law to act on behalf of the individual. This policy provides guidance when dealing with a personal representative.

3.0 SCOPE: DPBH Clinical Services Branch

4.0 DEFINITIONS:

Emancipated ~~Minor per~~Minor per NRS 129.080 means any minor who is at least 16 years of age, who is married or living apart from his or her parents or legal guardian, and who is a resident of the county, may petition the juvenile court of that county for a decree of emancipation.

NRS 129.030 Consent for examination and treatment.

1. Except as otherwise provided in NRS 450B.525, a minor may give consent for the services provided in subsection 2 for himself or herself or for his or her child, if the minor is:

(a) Living apart from his or her parents or legal guardian, with or without the consent of the parent, parents or legal guardian, and has so lived for a period of at least 4 months;

(b) Married or has been married;

(c) A mother, or has borne a child; or

~~4.0~~ (d) In a physician's judgment, in danger of suffering a serious health hazard if health care services are not provided.

~~Emancipated Minor~~

5.0 REFERERNCES:

5.1 NRS 129.080

5.2 NRS 129.030 ~~N/A~~

Control #	Rev. Date:	Title:	Effective Date: 04/2003
CRR 6.05	05/2007	Treating Personal Representative as the Individual	Next Review Date: 05/2007

~~5.0~~ 6.0 **PROCEDURE:**

~~5.1~~ 6.1 The Division will treat a person as a personal representative of an individual with respect to disclosure of protected health information if under applicable law:

~~5.1.1~~ 6.1.1 A parent, guardian, or other person acting in loco parentis (in place of a parent) has authority to act on behalf of an individual who is an unemancipated minor in making decisions related to health care, or

~~5.1.2~~ 6.1.2 An executor, administrator, or other person has authority to act on behalf of a deceased individual or the individual's estate.

~~5.2~~ 6.2 In the following circumstances, the Division will not treat a person as a personal representative of an unemancipated minor; when the minor has authority to act with respect to their protected health information pertaining to a health care service if:

~~5.2.1~~ The minor consent to such health care service, applicable law requires no other consent, and the minor has not requested that another person be treated as the personal representative.

~~5.2.2~~5.2.1 Applicable law permits the minor to obtain such health care service without the consent of a parent, guardian, or other person acting in loco parentis, and the minor, a court, or another person authorized by law consent to such health care services, or

~~5.2.3~~5.2.2 A parent, guardian, or other person acting in loco parentis assents to an agreement of confidentiality between a covered health care provider and the minor with respect to such health care service.

~~5.3~~ 6.3 The Division shall not treat a person as the personal representative of an individual if:

~~5.3.1~~5.2.3 There is a reasonable belief that the individual has been or may be subjected to domestic violence, abuse, or neglect by such person; or treating such person as the personal representative could endanger the individual, and

~~5.3.2~~5.2.4 In the exercise of professional judgment, the Division decides it is not in the best interest of the individual to treat the person as the individual's personal representative.

~~5.4~~5.3 The Division will follow the requirements and/or permissions of applicable state and other law in determining whether to provide or deny access to a minor's protected health information to a parent, guardian, or other person acting in loco parentis.

6.0 ATTACHMENTS: N/A

7.0 ~~REFERERNCES: 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: 04/15/03
Revised/Review Date: 04/15/03, 05/31/07
Approved by DPBH Administrator:
Approved by Commission:

Control #	Rev.	Title	Effective Date: 09/17
FS~~CRR~~ 2.6	NEW	Prevention, Management and Reporting Escapes from Forensic Units	Next Review Date: 09/19

1.0 POLICY:

~~It is the policy of the Department of Public and Behavioral Health (DPBH) that a~~All available efforts within the forensic facilities will be used to prevent escapes. Should there be a successful escape, notification to law enforcement, DPBH Administrator, and the committing criminal court will occur immediately.

~~1.0~~ 2.0 PURPOSE:

To ensure that forensic clients remain safely in secure units while in the custody of a DPBH facility and to ensure proper notification when an escape occurs.

3.0 SCOPE: DPBH Forensic Facilities and Units

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 A 4.0 DPBH Emergency Communication

5.2 DPBH CRR 1.5 Management of Elopement Inpatient Services

~~2.0~~

Control #	Rev.	Title	Effective Date: 09/17
FS~~CRR~~ 2.6	NEW	Prevention, Management and Reporting Escapes from Forensic Units	**Next Review Date:** 09/19

~~3.0~~ 6.0 PROCEDURE:

~~3.1~~5.2 Upon admission to the Forensic Unit, clients will be assessed for escape risk by the intake clinician.

~~3.2~~5.3 If a client is thought to be at risk of escape, they will be placed on Constant Escape Watch or an increased observation level and the risk documented.

~~3.3~~5.4 Clients determined to be at high risk for escape are to be issued an orange jumpsuit and a denial of rights to wear their own clothes form will be completed.

~~3.4~~5.5 Treatment teams will review the client's watch/observation level and risk of escape during every treatment team meeting.

~~3.5~~5.6 All Forensic Units are required to have at least two secure doors between the secure area of the facility and non-secure areas.

~~3.6~~5.7 Clients are not allowed to be near the exit doors without staff presence.

~~3.7~~5.8 Exit doors are always monitored by camera from the Control Room.

~~3.7.1~~5.8.1 Control Room staff will visually identify staff prior to opening a secure door.

~~3.8~~5.9 Staff will not open door if a client is near an exit door unless escorting the client to a non-secure area.

~~3.9~~5.10 Doors to courtyards require two forensic staff members to be present prior to opening.

~~3.10~~5.11 In the event of a successful escape from a forensic facility, the shift supervisor will immediately:

~~3.10.1~~5.11.1 Notify the nearest Police Department and State Capitol Police and provide the client's name, physical description, and last point of escapee contact.

~~3.10.2~~5.11.2 Notify the Officer of the Day, Correctional Sergeant or designee and the Agency Director.

~~3.10.3~~ Confirm all doors are secure and complete a count of remaining clients.

~~3.11~~5.12 Upon notification of an escape, the Agency Director or Designee will:

~~3.11.1~~5.12.1 Notify the Administrator and Deputy Administrator immediately.

~~3.11.2~~5.12.2 Notify the Committing Criminal Court.

~~3.11.3~~5.12.3 Notify the alleged victims, if applicable, as identified on the Arrest Report.

~~3.11.4~~ Complete a Critical Incident Report and a Serious Incident report.

~~3.12~~5.13 If a client attempts escape, they will immediately be placed on a constant escape watch or higher observation level watch and provided an orange jumpsuit.

~~3.13~~5.14 If transporting a Forensic Client, staff are to follow the agency protocol for transporting clients.

4.13.1 If a client attempts to elope, staff will make every effort to retain custody using approved methods.

4.13.2 If transporting staff are unable to regain custody, local law enforcement, Agency Director and Correctional Lt. /Sgt. will be notified immediately or as soon as practical.

4.13.3 Staff will not pursue the client but provide all details such as description, direction of escape and any other pertinent details to responding law enforcement officers.

4.13.4 A Serious Incident Report (SIR) must be completed.

4.14 If a client is on Conditional Release escapes from their program, the same notification procedures described above are to be followed.

4.15 If a client escapes or elopes from their placement notification protocols will be followed.

~~5.0~~ 7.0 ATTACHMENTS:

7.1 A 4.0 Emergency Communication DHHS Director's Office Critical Incident Report ~~N/A~~

~~6.0~~5.0 IMPLEMENTATION OF POLICY:

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

Control #	Rev.	Title	Effective Date: 09/17
FS~~CRR~~ 2.6	NEW	Prevention, Management and Reporting Escapes from Forensic Units	Next Review Date: 09/19

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

DHHS – Director's Office
Critical Incident Report (CIR)

***Note: Internal use only. This form does not replace any Division's serious incident reporting forms. ***

Notification must be provided to: Richard Whitley; Chrystal Main; Julia Peek, Deborah Hassett; Stacey Johnson; Tawny Chapman

Please list all other personnel notified of incident:

Date of Incident: MM/DD/YYYY **Time of Incident:** HH:MM AM/PM

Office/Facility/Location of incident:

Type of Event: **(select one)**

- ☐**Abuse**
- ☐**Death/Suicide**
- ☐**Lost/Missing Person**
- ☐**Run-Away/Elopement**
- ☐**Serious Injury**
- ☐**Threat or Hostage Situation**
- ☐**Public Health Emergency**
- ☐**Health Facility Emergency**
- ☐**Fire/Natural Disaster**
- ☐**Other:**

Brief Synopsis of Event (including client(s) and/or staff involved):

Crime and/or reason for violation, and length of stay at facility as applicable:

Senior DHHS staff member(s) serving as "in charge" of incident (list name(s)/contact number(s)):

First/Last Name	Title/Organization	Contact Number	Email

Other entities that have been notified **(e.g. Law enforcement, Child or Adult Protective Services, fire department, ambulance services, coroner, etc.…):**

What action(s) have or are being taken by division in response to the incident:

What action(s) are being requested of Director's Office to assist with the incident, if applicable:

Other Comments/Concerns:

CIR reported by: Printed Name Title/Position

Date Reported: MM/DD/YYYY **Time Reported:** HH:MM AM/PM

Revised 01/15/2019– Supersedes 06/11/2018

Control #	Rev. Date:	Title:	Effective Date: 12/2013
HR 5.031		BULLYING PREVENTION	Next Review Date:

~~Still needs a training compent.~~

1.0 POLICY:

The Division of Public and Behavioral Health (DPBH) is committed to working with its employees to provide and maintain a workplace environment free of verbal abuse, threats, sabotage, and bullying of any kind and where each staff member is valued and treated with respect and dignity. DBPH will not tolerate bullying behavior. Employees found in violation of this policy will be disciplined, up to, and, including termination.

2.0 PURPOSE:

The purpose of this policy is to ensure optimally safe work and service delivery environments, and appropriate response to workplace violence, including bullying.

3.0 SCOPE: Clinical Services Branch

~~Division Wide~~

4.0 DEFINITIONS:

4.1 **Workplace bullying**: is persistent, offensive, abusive, intimidating or insulting behavior, abuse of power, in which the employee is threatened, humiliated or vulnerable, which undermines their ~~self-confidence~~self-confidence, and which may cause them to suffer stress.

4.1.1 **Workplace bullying** often involves an abuse or misuse of power. ~~Bullying includes~~Bullying includes behavior that intimidates, degrades, offends, or humiliates a worker, often in front of others. Bullying behavior creates feelings of defenselessness in the target and undermines an individual's right to dignity at work.

4.1.2 **Workplace bullying** is in the majority of cases perpetrated by someone in authority over the target. ~~However,~~

4.1.2.1 B~~b~~ullies can also be peers,

~~Still needs a training compent.~~

4.1.2.2 ~~and on occasion~~ C~~c~~an be subordinates.

4.1.2.3 Bullying can be covert or overt.

4.2 The workplace includes any location where an employee performs work-related duties including, but not limited to the buildings and the surrounding perimeters and parking lots, field locations and through the work email or messaging systems.~~.~~

5.0 REFERENCES:

5.1 DPBH Policy HR 1.9 Workplace Violence Prevention

5.2 Department of Health and Human Services Prohibitions and Penalties

5.3 Nevada Administrative Code

~~1.0~~6.0 PROCEDURE:

~~1.1~~6.1 General Provisions:

Workplace bullying is any behavior that is meant to intimidate, humiliate or degrade another individual that occurs either with a manager(s)/supervisor(s) or with another co-worker(s). ~~The workplace includes any location where an employee performs work-related duties including, but not limited to the buildings and the surrounding perimeters and parking lots, field locations and through the work email system.~~

~~1.2~~6.2 Employee Responsibilities:

Each employee shall consistently be treated with courtesy and respect at all times and treat other employees and all other persons contacted in the course of performing their job duties with dignity and respect.

6.2.1 If you observe or experience an act of workplace bullying, it is your responsibility to immediately report the incident to your supervisor or manager or the DPBH Human Resources Office (See Attachment B – Bullying Incident Report Form).

6.2.2 The reporting of the incident should occur within 30 days of the ~~last~~ incident ~~.~~ All reports of incidents must be taken seriously and an "immediate intervention" must be initiated by the appropriate supervisor or manager~~.~~

~~Still needs a training compent.~~

~~4.2~~6.3 Supervisor Responsibilities:

Any conduct that can be interpreted as bullying will not be tolerated.

6.3.1 Individuals who commit acts of bullying will be subject to disciplinary action by their immediate supervisor.

6.3.2 All supervisors and managers shall promptly and thoroughly investigate all reports of workplace bullying.

6.3.3 -Supervisors are responsible for notifying the appropriate agency head and DPBH Human Resources Office when a report is received.

6.3.4 It is the responsibility of all supervisors/managers/agency representatives to ensure their employees are properly trained and oriented to the mission and prevention of workplace bullying in the workplace.

~~1.3~~6.4 Agency Responsibilities:

6.4.1 Supervisors/managers/Human Resources representatives who receive reports of workplace bullying must initiate appropriate action in response to the ~~report, and~~report and ensure that the complaint is forwarded to his/her supervisor.

6.4.2

Depending on the situation, the supervisor, manager, Agency Director, or Human Resources Office will continue to pursue resolution, or investigate further on behalf of the employee who has been identified as being bullied.

~~4.3~~6.5 Incident Reporting and Investigation:

6.5.1 If an employee feels he/she is being bullied or has witnessed someone being bullied, he/she should report the incident to their immediate supervisor.

6.5.2 If the employee or witness does not feel comfortable reporting the incident ~~to their~~to their direct supervisor, they may contact DPBH Human Resources.

~~1.3.1 .~~ Confidentiality throughout the investigative process is mandatory for both the victim and alleged employee identified as the bully.

~~1.3.2~~ In the case a complaint is not filed with the direct supervisor, DPBH Human Resources or a designated agency staff member will meet with the employee confidentially to gather information regarding the complaint.

~~Still needs a training compent.~~

6.5.5 Once a complaint has been confirmed, supervisors/managers/Human Resource~~s~~ staff can offer the employee additional training and education to assist them in coping with workplace bullies that may include coping and stress management strategies, developing skills and strategies for working with or around the bullies or confronting the bully in an appropriate manner.

6.5.6 Supervisors/managers/agency representatives may refer the employee identified as a workplace bully to an employee assistance program, or other appropriate source.

6.5.7 Once a complaint has been investigated by the supervisor/manager/agency representative, the investigation findings will be submitted to the Agency Director for further review.

6.5.8 Disciplinary action may range from a letter of instruction to dismissal in proportion to the seriousness of the offense and in accordance with the Department of Health and Human Services Prohibitions and Penalties and Nevada Administrative Code.

6.6 Training:

~~**5.0 REFERENCES:**~~

~~5.029 Workplace Violence Prevention~~

6.6

~~Still needs a training compent.~~

~~2.0~~ 7.0 ATTACHMENTS:

~~2.1~~6.7 Attachment A: Bullying Incident Report Form

~~3.0~~ 8.0 IMPLEMENTATION OF POLICY:

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

~~ADMINISTRATOR~~

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

Bullying Incident Report Form

Division/agency:_____ Today's date:_____

Address/location where incident occurred:

_____

Office Street Address City/State/Zip

Name/title/phone no. of person who reported the incident to you:

_____

Name Title Telephone No.

Date and time of incident: _____ _____A.M. or P.M.
Date & Day of Week Time

Person(s) who engaged in act of workplace bullying:

_____

Name(s) Title(s)

Person(s) the bullying was directed towards:

_____

Name(s) Title(s)

Describe the incident (Detail what happened, actions, words that were used, etc.):

What precipitated the incident?

How did incident conclude? (incident defused, etc.)

Other person(s) who witnessed the incident:

Name(s) Title(s)

Other pertinent information:

Recommendations of how similar incidents could possibly be avoided in the future:

Name/title/phone no. of person completing the report form:

Name	Title	Telephone No.

Signature Date

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

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

Stand4Change

{ The Fight Against Bullying

What Bullying Is

- When one or more people single out another person for unreasonable, embarrassing, or intimidating treatment.
- Purposeful attempts to control another person through verbal abuse (which can be in tone of voice or in content such as teasing or threats), exclusion, or physical bullying or violence.

What Bullying Can Look Like

- Shouting or swearing at someone or otherwise verbally abusing him or her
- One person being singled out for unjustified criticism or blame
- One person being excluded from activities or having his or her work or contributions purposefully ignored
- Language or actions that embarrass or humiliate someone
- Practical jokes, especially if they occur repeatedly to the same person
- **Size, Intent, and Context Matter**

What Bullying Isn't

- Not all bad things in a workplace are bullying
  - Criticism
  - Raised Voices
  - Disagreement
- Poor management and poor social skills are not necessarily bullying, but that also does not make them acceptable behaviors

Why do Bullies Bully?

- Usually the person is in a position of power and feels threatened by the victim or a change the victim represents
- Sometimes the person has been in a conflict and the hostility lingers

Why do Bullies Bully?

- Culture that supports and rewards acts of dominance
- Lack of high standards on how people should treat each other
- Family/Personal issues
- Having power
- Provocative victims

Where Does it Happen?

- Schools
- Workplaces
- Homes
- Playgrounds/Public Areas
- Nursing Homes/Hospitals/Institutions

Prevalence

- 1 out of every 4 kids at some point in their adolescence
- 1/3 of all workers
- Rates are higher among people with disabilities, women, and minorities
- Considered to be the most common type of violence in the U.S.

Negative Effects (Individual)

- Stress
- Absenteeism and low productivity
- Lowered self-esteem and depression
- Anxiety
- Digestive upsets
- High blood pressure
- Insomnia
- Trouble with relationships
- Post traumatic stress disorder

https://www.youtube.com/watch?v=ltun92DfnPY

Shane Koyzcan: To This Day

Negative Effects (Organization)

- Higher Turnover
- Loss of Innovation and Adaptability
- Difficulty in Hiring

What Can We Do?

- Don’t be a bystander
- Recognize it
- Report it
- Seek help
- Change the Culture

May 4th Stand4Change

- May the 4th be with you!
- Wear a Stand4Change Sticker inviting people to have the conversation
- Wear a Star Wars T-shirt or a T-shirt that means something special to you

Control #	Rev.	Title	Effective Date: 02/1992
IMRT 2.1	01/2019	**Basic Documentation Guidelines for Clinical Medical Records**	**Next Review Date:** 01/2022

1.0 POLICY:

The Division of Public and Behavioral Health will establish and maintain consistent clinical record documentation procedures in accordance with regulating entities.

2.0 PURPOSE:

To establish and maintain basic documentation guidelines for the Division of Public and Behavioral Health, healthcare facilities.

3.0 SCOPE: DPBH- Clinical Services Branch

4.0 DEFINITIONS:

4.1 Clinical Records, aka Medical Records/Health Records/Medical Chart/Medical File:
- 4.1.1 A clinical medical record is defined as a legal document within which is a recorded detail of an individual patient's course of illness, treatment rendered, outcome of treatment, and continuum of care plan.
- 4.1.2 Clinical Documentation (CD) is the creation of a record detailing a medical treatment, medical trial or clinical test.

4.2 HIS is defined as Health Information Services (aka Department of Medical Records)

4.3 EMR/EHR is the electronic medical record, aka electronic health record

5.0 REFERENCES:

5.1 CMS 482.24 Standard: Content of Record
5.2 CMS - Complying with Medical Record Documentation Requirement
5.3 The Joint Commission - Record of Care
5.4 http://library.ahima.org

6.0 PROCEDURE:

6.1 Clinical records shall be kept for each client in the care of DPBH clinical facilities.

6.2 Entries in the patients' medical record shall be:

6.2.1 Accurate – Document the facts as observed or reported; accurate and authenticated entries to promote uniform documentation standards Whenever possible identify the source of the information.

6.2.2 Timely – Record significant information at the time of the event. Avoid delays that can impact the course of patient care. All documentation should be completed in a timely manner. Entries not completed on date of service will be considered late entries.

6.2.3 Objective – Record the facts and avoid conclusions. Professional opinion must be based on documented findings and within the scope of practice for that profession. Written description of any event or any unusual event that leads to the transfer to a hospital or other facility or prior level of care should all be documented.

6.2.4 Specific, concise and descriptive – The medical record is a clinical communication tool and record entries should contain all pertinent findings and be organized according to the agency and professional standards.

6.2.5 Consistent – Entries should be consistent. When contradictory findings are observed, the record must provide explanation for inconsistent data.

6.2.6 Comprehensive – Record significant information relative to a patient's condition and course of treatment.

6.2.3.1 Documentation should reflect pertinent findings, services rendered, changes in the condition and the response to treatment.

6.2.3.2 Information should include all medication administration information, to include:

6.2.3.2.1 Physician's Orders

6.2.3.2.2 Indications

6.2.3.2.2.1 Instructions for administration and holding parameters

6.2.3.2.3 Dose

6.2.3.2.4 Frequency

6.2.3.2.5 Route of Administration

6.2.3.2.6 Patient Response

6.2.7 Legible – All entries should be neat and readable by other persons.

6.2.4.1 Only Authorized individuals through prior authorization of the

the HIS Director as reelected on the staff signature log.

6.3 Within 24-hours of inpatient admission each patient shall have a complete medical evaluation and physical examination performed unless a comprehensive examination has been performed within the prior thirty days and the written report is included in the agency medical record.

6.3.1 If written a report is used from previous examinations, an update must be done and documented within 24 hours of admission.

6.3.2 The medical staff shall report the presenting problem, personal and family medical history, social history, review of systems, and a physical examination, which includes a comprehensive neurological assessment of mental status, cranial nerves, muscle strength and tone, sensation, deep tendon reflexes, coordination, and presence or absence of tics, tremors or tardive dyskinesia.

6.3.2.1 This report shall be entered into the patient's medical record.

6.3.3 All pertinent medical problems will be communicated to all appropriate Medical Staff and incorporated into the treatment plan.

6.3.4 Within twenty-four hours of admission to an inpatient unit, each patient shall have a psychiatric evaluation which must include the presenting circumstances, prior psychiatric services, current psychiatric symptoms, pertinent medical problems, and complete mental status examination clearly stating the current level of orientation, memory ability, function of knowledge, approximate intellect, and the presence or absence of homicidal or suicidal ideation.

6.4 There shall be a statement describing the client's identified strengths in descriptive terms, admission psychiatric diagnoses using the DSM-5 in compliance with the agency Medical Staff procedures, and an initial treatment plan in the psychiatric evaluation.

6.5 Laboratory results, radiological reports, EKG's and all other diagnostic reports must be reviewed and initialed by the medical Staff.

6.6 Patients' drug and food allergies shall be documented in the following locations:

6.6.1 On the hard copy medical record.

6.6.2 In the electronic medical record (Avatar) in the Allergy assessment section of the Clinical Work Station (CWS).

6.6.3 In the electronic Pharmacy record (WORx) for the patient profile.

6.6.4 Nursing Services shall be responsible to enter all of the official updated patient allergy information onto the designated allergy sticker in red ink, which is then affixed onto the outside front cover of the chart(s).

6.6.5 Nursing Services shall be responsible for entering the patient allergy information on the Medication Administration Record (MAR).

6.6.6 Pharmacy Services shall enter the allergy information onto the electronic pharmacy record (WORx) and update as needed.

6.6.6.1 Pharmacy Services shall ensure the "footprint" of all patient allergies are maintained.

6.6.7 Contradictory entries must be reviewed by the treating Med Staff to resolve inconsistent findings.

6.7 Patient health record entries must include both the date and time of the entry and be authenticated by the individual making the entry.

6.7.1 All evaluations/examinations must include the date and time the service was rendered.

6.7.2 When information is transcribed, the date dictated and date transcribed is included along with the initials of the author and transcriptionist.

6.7.3 Reports that compile the results of multiple assessments, the entry must state the dates if each assessment and the date of the final report.

6.8 Each page in the hard copy medical record must have the client's name and medical record number on a label or written in the designated space.

6.8.1 If both sides of a page are used for documentation, the client's name and medical record number must be on a label or written on both sides.

6.8.2 All items on pre-printed forms must be addressed; no items may be left blank.

6.8.3 If the client was not seen or refuses to cooperate, a diagonal line may be drawn through the page and a statement made as to why the form could not be completed. This statement must be signed, dated and timed.

6.9 All entries will be made using the Electronic Health Record (EHR); unless the function is not available for entry, e.g. labs.

6.10 Remarks that are critical of treatment carried out by others that may indicate bias or that are unprofessional should not appear in the medical record.

6.11 Progress notes will follow a uniform format and will be documented in the medical record as outlined in the Medical Record Documentation Timeline Attachment D.

6.12 A summary of the patient's care will be written in a transfer note whenever a patient is transferred from one unit to another with a change of physician.

6.13 On discharge, when transitioning clients from Inpatient to Outpatient services, the medical staff must review the hospital discharge summary in Avatar, including discharge medications, the reason for admission (admission diagnoses, course of treatment, outcome of treatment, discharge plans and disposition and discontinued diagnoses.

6.14 On discharge, when transitioning clients from Inpatient to Outpatient services, outpatient Medical Staff must review the hospital discharge summary in Avatar and call the inpatient Medical Staff with any questions.

6.15 A summary of the patient's care will be written in a transfer note whenever the attending psychiatrist goes on leave.

6.14.1 This note documents current condition, barriers to discharge, risk assessment for suicide and violent behavior (harm to others).

6.16 Only authorized individuals are permitted to enter, delete, change, sign, or authenticate material in the medical record with prior authorization of the agency HIS Director through the staff signature authentication log.

6.17 Co-Signatures and Review

6.17.1 Discharge summaries, psychiatric evaluations and progress notes completed by residents or students, must be co-signed by the attending medical staff.

6.17.2 Physical examinations completed by residents or students must be reviewed and signed by the attending medical staff.

6.17.3 All progress notes made by medical students and residents must be co-signed by the attending medical staff.

6.17.4 All entries by pharmacy interns must be co-signed by a licensed pharmacist.

6.17.5 In the EMR inpatient chart only, all entries by practitioners in training, including students and interns, must be co-signed by a licensed staff of that discipline.

6.17.6 Entries by Marriage and Family Therapy (students/interns) must be signed by a clinical sponsor.

6.17.7 Residents may co-sign for medical students only and may not sign for another resident or in lieu of the attending medical staff.

6.17.8 Entries by social work interns must be co-signed by a licensed LCSW

6.17.9 Nursing Students – Nursing students do not document at SNAMHS

6.17.10 Entries by psychology interns must be cosigned by a licensed psychologist.

6.17.11 Documentation shall be developed and maintained considering:

6.17.11.1 Continuity of care,

6.17.11.2 Evidence in support of insurance and reimbursement claims,
6.17.11.3 Proof of illness,
6.17.11.4 To provide a basis for performance improvement and education review of care rendered by an individual practitioner and the professional treatment team, and proof of care rendered,
6.17.12 Use to advance the knowledge and practice of effective patient care interventions,
6.17.13 To communicate facts, figures, observations, etc., to other members of the treatment team,
6.17.14 For future use which may become legal evidence in the event of litigation,
6.17.14 To ensure both quality and timely documentation,
6.17.15 To provide important information for continuity of care to client.
6.17.16 Compliance with all Joint Commission, CMS, and NRS standards.

6.18 Medical record entries will be maintained in chronological sequence.

6.19 Electronic progress notes will be maintained unless the EHR is not available.
6.19.1 During down-time, agency down time procedures will be followed.
6.19.2 Lines or spaces should not remain blank between record entries on paper progress notes.
6.19.3 A single line should be entered in the blank space. Do not line out vacant lines or physician order sheets.

6.20 When in the EHR, the following procedures will be followed:
6.20.1 The recording individual must use the APPEND function of Avatar to add the omitted information to a progress note
6.20.2 If incorrect information is entered in an assessment, the recording individual must use the Edit function to amend the error.
6.20.3 Late entries must be identified as a “late entry” with the actual date and time the entry was to be made.
6.20.3.1 The date and time that the entry should have been made must also, be documented.
6.20.4 In the event that a note is entered into the incorrect medical record, the note will be voided form the incorrect medical record.
6.20.4.1 The recording individual will enter the note into the correct medical record.

6.20.4.2 The person will notify the billing contact at their agency.

6.20.4.3 The billing staff will ensure that the void is reconciled so as not to generate an erroneous charge.

6.21 Entries in the patient record should not personally identify another client.

6.21.1 Incidents involving multiple clients cannot name or contain medical record number or any other identifiable information other than the gender of other clients.

6.21.2 Clients can be identified on an internal form, INCIDENT REPORT, which is never part of the medical record.

6.21.3 Contact Health Information Services if you discover another client's name or identification in a medical record.

6.22 Unusual occurrences, medication errors, or incidents should be recorded but not labeled as such in the medical record.

6.22.1 Notes on these events shall include a factual description of the event, remedial actions taken and the patient's condition following the event.

6.22.2 Conclusions relative to the event should be made within the scope of profession and discipline and be substantiated by objective findings and stated in factual; terms, free of subjective and personal opinions.

6.22.3 When a separate incident report is completed, this should not be referenced in the patient's record.

6.22.4 Incident reports will not be filed in the medical chart.

6.23 When patient abuse is observed or reported, facts relative to the abuse should be documented in the patient record, including action taken by the staff.

6.23.1 Conclusions relative to the event should be made within the scope of profession and discipline and be substantiated by objective findings and stated in factual; terms, free of subjective and personal opinions.

6.24 Do not use - DPBH Clinical Services Branch "Do Not Use Abbreviations or Symbols" when documenting in the medical record (Attachments A and B).

6.25 For each bill generated from a service provided, there must be a corresponding progress note completed by the provider describing in detail the billable service.

6.26 In the event duplicate records are determined to be for one (1) person contact HIS as soon as possible.

6.26.1 Health Information Services will notify Information Technology to process the record merge to include both the Avatar and WORx portions of the record to ensure that the most accurate record is

maintained for the client.

7.0 ATTACHMENTS:

7.1 IMRT 2.1 Basic Documentation Guidelines for Medical Records - Do Not Use Abbreviations Attachment A

7.2 IMRT 2.1 Basic Documentation Guidelines for Medical Records - Do Not Use Symbols List-Attachment B

7.3 IMRT 2.1 Basic Documentation Guidelines for Medical Records Attachment C

7.4 1) IMRT 2.1 Basic Documentation Guidelines for Medical Records -Medical Record Documentation Timeline Table Attachment D

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.

Supersedes: #4.030 – Basic Documentation Guidelines for Medical Records
Effective Date: 02/07/92
Revised/Review Date: 7/7/00; 5/11/01; 9/26/01; 12/4/01; 10/13/06; 11/19/07; 11/15/13, 01/2019
Approved by Administrator: 11/15/13, 01/2019
Approved by Commission: 11/1/5/13, 09/2018

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
HEALTH INFORMATION SERVICES DEPARTMENT
"DO NOT USE" ABBREVIATION LIST

Do No Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (international Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d. (daily) Q.O.D., QOD, q.o.d., qod (every other day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO_4 and $MgSO_4$	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

[1]Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or pre-printed forms.

***Exception**: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.*

Additional Abbreviations, Acronyms and Symbols
(For possible future inclusion in the Official "Do Not Use" List)

Do Not Use	Potential Problem	Use Instead
> (greater than) < (less than)	Misinterpreted as the number "7" (seven) or the letter "L" Confused for one another	Write "greater than" Write "less than"
Abbreviations for drug names	Misinterpreted due to similar abbreviations for multiple drugs	Write drug names in full
Apothecary units	Unfamiliar to many practitioners Confused with metric units	Use metric units
@	Mistaken for the number "2" (two)	Write "at"
cc	Mistaken for U (units) when poorly written	Write "mL" or "ml" or "milliliters" ("mL" is preferred)
μg	Mistaken for mg (milligrams) resulting in one thousand-fold overdose	Write "mcg" or "micrograms"

Δ	Change
# X =	Number of times
Ψ	Psychiatric
Ψ Rx	Psychotropic Medication
0 X # y	none for numbers of years
%	Percentage, percent
&	And
+	Positive
-	Negative
↓	Decreased, decrease ~~Decreased~~
↑	Increased, increase
"	Inches, inch
#	Number, pound, weight
# x =	Example 2 x is two times
#0 x # y	Example – none for number of years
lbs	Pounds
x	Times
1	Primary

For more Error Prone Abbreviations go to the Institute for Safe Medication Practices website: http://www.ismp.org/Tools/errorproneabbreviations.pdf (copy and paste into your browser).

Avatar Change Form

Date: Click here to enter a date.

Submitter Name: Click here to enter name.

Submitter Phone Number: Click here to enter phone number.

Region: Choose an item.

Unit Requesting Change: Click here to enter unit.

Does this change create/edit a report? Choose an item.

Does this change create/edit a template? (If so please attach template to request) Choose an item.

Does this change create/edit a widget? Choose an item.

Description of Change
Click here to enter text.

Reason for Change
Click here to enter text.

Requestor Signature: _____

Supervisor Signature: _____

Supervisor Name:

For use by Avatar Change Committee

Date Received: Click here to enter a date.

Priority: Choose an item.

Approved: ☐

Denied: ☐

Date of Resolution: Click here to enter a date.

Description of Resolution
Click here to enter text.

Change Number: Click here to enter text.

DPBH Medical Record Documentation Timeline

DOCUMENTATION	DISCIPLINE RESONSIBLE	REQUIREMENT
Admission Note	Nursing	Completed within 8 hours of admission
Nursing Assessment	Nursing	Completed within 24 hours of admission
Suicide Risk Assessment	Medical Staff	RSU: completed within 24 hours of admission and again at discharge; Acute: completed within 24 hours of admission or next business day and again at discharge
Violence & Aggressor	Medical Staff	RSU: completed within 24 hours of admission and again at discharge; Acute: completed within 24 hours of admission or next business day and again at discharge
LOCUS assessment	Nursing/Social Services	Completed within 24 hours of admission; Updated at the time of discharge transfer
Activities Therapy Assessment	Recreation Therapy Staff	Completed within 5 days of admission; Group participation documented daily
Psychosocial History	Social Services	Completed within 5 days of admission; Group participation documented daily
History and Physical	Medical Staff	Completed within 24 hours of admission
Psychiatric Evaluation	Medical Staff	Completed within 24 hours of admission
Treatment Plan	Treatment Team	Nursing initiates within 24 hours of admission; other disciplines add their goals, objectives, and interventions within 7 days of admission
Treatment Plan Update	Treatment Team	Updated on a weekly basis on when change in condition (psychiatric or medical)

DPBH Medical Record Documentation Timeline

Progress Notes	Treatment Team	**Social Worker**: RSU: within 24 hours of admission & weekly thereafter; Acute: within 24 hours of admission or next business day & weekly thereafter; **Psychiatry**: a minimum of 2 times/week; **Nursing**: every shift by RN for the 1st 3 inpatient days;then, daily and for significant change in condition by RN or MHT for days 7-30; then, RN weekly summary & RN or MHT for significant change in condition/ as soon as possible after rendering services, but not later than 48 hours if EMR down, follow policy.
Discharge Interdisciplinary Continuity of Care Plan	Social Service; Nursing; Medical staff	Started on Admission Completed at the time of discharge
Discharge Summary	Medical Staff	Completed within 30 days of discharge

Control #	Rev.	Title	Effective Date: 12/1997
SP 4.12		Intradivision Transfers	
			Next Review Date

1.0 POLICY:

It is the policy of the Department of Public and Behavioral Health (DPBH) to ensure that the transfer of clients between division facilities is handled in an expedient, efficient and consistent manner. The Division is responsible for any open case and assumes that division agencies will cooperate with one another and with the Division to ensure that services are properly provided to the client and family in accordance with NRS 433.484 (3); 435.077; 435.100.

2.0 PURPOSE:

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS: N/A

5.0 REFERENCES:

NRS 433.484
NRS 435.077
NRS 435.100

6.0 PROCEDURE:

6.1 A court-ordered or emergency admission is not considered a transfer and is not affected by this policy.

6.2 Referral and/or request for a client transfer from one division agency to another can originate from an adult client, a parent or guardian, or through an agency request. If the transfer request is agency generated, the Division Administrator must approve the transfer.

6.3 A client, or his/her parent or guardian, must give informed, written consent to a transfer. If the client, parent or guardian refuses to sign a consent form and the transfer request is to proceed, a Denial of Rights form must be filed, and the transfer must be ordered by the Division Administrator.

6.4 In an emergency, a client may be transferred from one division agency to another on the direction of the Division Administrator.

Control #	Rev.	Title	Effective Date: 12/1997
SP 4.12		Intradivision Transfers	
			Next Review Date

6.5 A need to transfer a client from one agency to another shall first be documented by the client's treatment team in the medical record under discharge/placement planning. The initiating agency shall provide a written justification of the appropriateness of the transfer, including type of transfer and whether the transfer is permanent or temporary. If temporary, anticipated length of stay should be estimated.

6.6 The agency initiating the transfer of a client is responsible for the transfer process and any associated cost, including staff escorts, transportation, etc.

6.7 The referring agency shall provide a summary of current information on the client, which shall include:

6.7.1 Current psychiatric and psychological evaluations.
6.7.2 Current physical and lab work.
6.7.3 Current social history, including placement history.
6.7.4 Summary of admissions to hospitals/programs and duration of stay.
6.7.5 Treatment Plan
6.7.6 Medication History.
6.7.7 Risk Assessment Evaluation.

6.8 Date of transfer shall be arranged between the two agencies, with priority given to the next available bed.

6.9 Agency managers involved in a client transfer are responsible for notifying their respective accounting and client records offices, as well as any other agencies or service providers involved with the client [Title XIX, Social Security, CTC, etc.] of the date of transfer. Any funds held for the client and client's personal effects, with an inventory of same, shall be transferred with the client.

6.10 For clients in a temporary transfer situation, the receiving agency shall provide weekly progress reports to the initiating agency.

Control #	Rev.	Title	Effective Date: 12/1997
SP 4.12		Intradivision Transfers	
			Next Review Date

6.11 The agency providing temporary/respite/trial placement care shall be responsible for payment for that care.

6.12 If a client is to be placed in respite care in another agency, approval must be obtained from the appropriate community services agencies and the Division Administrator.

6.13 For return of clients in temporary placement status, all steps in transferring must be taken except:

6.13.1 Informed consent is not required if return was included in original transfer plan.

6.13.2 All costs associated with client's return accrue to the initiating agency.

6.14 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:

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.

ADMINISTRATOR

EFFECTIVE DATE: 12/31/97
DATE APPROVED BY DPBH ADMINISTRATOR:
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH:

Control #	Rev.	Title	Effective Date: 12/1997
SP 4.12		Intradivision Transfers	
			Next Review Date

Control #	Rev. Date:	Title:	Effective Date: 4/2002
SP 4.29	7/2007	Suicidality Assessment Procedure	Next Review Date:

1.0 POLICY:

Division direct-care employees shall receive training ~~and certification~~ on suicide risk assessment and ~~prevention~~risk reduction. ~~following specific procedures and timeframes~~. All non-direct care ~~other~~ employees shall be apprised of this policy, the procedures. ~~and implications within certain timeframes~~.

2.0 PURPOSE:

~~It is the policy of the Division~~ Tto ensure that all consumers served by the Division Agencies are assessed for suicidality.

~~3.0~~ **3.0 SCOPE:** Clinical Services Branch

~~Division Wide~~

4.0 DEFINITIONS:

4.1 Suicide is ~~the act of intentionally causing one's own death~~self-inflicted death with explicit or implicit evidence ~~that~~that the person intended to die.

4.2 Aborted suicide attempt is potentially self-injurious behavior with explicit or implicit evidence that the person intended to die but stopped the attempt before physical damage occurred.

4.3 Suicidal ideation is thought of serving as the agent of one's own death.

4.4 Suicidal intent is subjective expectation and desire of a self-destructive act to end in death.

4.5 Suicide attempt is self-injurious behavior with a nonfatal outcome accompanied by explicit or implicit evidence that the person intended to die.

4.2~~6~~2 Parasuicide: ~~An apparent attempt at suicide, commonly called a suicidal gesture,~~ ~~in which the aim is not death~~.is a term that describes patients who injure themselves by self-mutilation (e.g., cutting the skin), but who do not wish to die. ~~For example, a sublethal drug overdose or wrist slash. Previous parasuicide is a predictor of suicide.~~

~~4.3~~ Qualified Clinician: Any Registered Nurse, Advanced Practice Registered Nurse, ~~Pysician~~Physician Assistant Psychiatrist, or clinician with a Master's Degree or higher in Psychology, Social Work, Marriage and Family Therapy, Counseling or a related field, who completed a clinical internship during the course of their education, and whose clinical training is congruent with assessing someone for risk of ~~suicidality~~suicide.

~~4.4 Qualified~~4.4 Qualified Registered Nurse (QRN): A registered Nurse who has received training and demonstrated competency to provide the ~~1 hour~~1-hour face-to-face assessment of patients in seclusion or restraint. Training for an RN to conduct the ~~1 hour~~1-hour face-to-face assessment includes:

a. All the training for all direct care staff described herein.

b. Additional content for evaluating the consumer's immediate situation, reaction to the intervention, medical and behavioral condition, and the need to continue or terminate the restraint or seclusion.~~N/A~~

5.0 REFERERNCES:

5.1 The Joint Commission National Patient Safety Goal (NPSG) 15.01.01~~1~~

5.2 Kaplan & Sadock's Synopsis of Psychiatry, Eleventh Edition, 2015

5.3 NRS 630. 253

~~N/A~~

~~1.0~~6.0 PROCEDURE:

6.1 Each employee shall be apprised of this policy and educated in its implication within ten (10) days of hire.

6.1.1 ~~6.1.1~~ All direct-care employees must receive annual ~~training and certification on~~training on suicide risk assessment/~~prevention~~ risk reduction.

6.1.2

~~6.1.2~~ Communication and hand off communication between all care providers is regarded as paramount and shall be emphasized in training.

~~1.1~~ 6.1.3 All training must be documented in the employees' personnel training files.

6.14 Per NRS 630.253 Medical Staff shall complete at least two (2) hours of instruction every four (4) years on evidence-based suicide prevention and awareness.

~~1.2~~6.2 Staff responsible for implementing this policy includes all administrative, clinical, and treatment staff.

~~1.3~~6.3 Each Division Agency will hold its clinical staff responsible for making the assessment of ~~suicidality~~the risk of suicide, the documentation of findings, and the development of a treatment plan to mitigate the risk of suicide. ~~address assessment findings regarding suicidality.~~

Control #	Rev. Date:	Title:	Effective Date: 4/2002
SP 4.29	7/2007	Suicidality Assessment Procedure	Next Review Date:

~~1.4 Each Division Agency will hold its clinical staff responsible for making the assessment of suicidality, the documentation of findings, and the development of a treatment plan to address assessment findings regarding suicidality.~~

~~1.5~~6.4 Each Agency shall ensure that an assessment of the risk of suicide ~~suicidality~~ is completed as part of an initial assessment of a consumer by staff who are competent in diagnostic assessment, recognizing that clinical judgment and thoroughness are essential.

~~Exceptions would be cases in which the consumer or prospective consumer openly expresses suicidal ideation and intent and/or plan.~~

~~These consumers would be categorized as imminently suicidal or likely to be so within the next 30 days and shall be protected by being placed on involuntary hold by any staff authorized to do so by NRS 433A.120 to 433A.330.~~

~~These consumers would be categorized as imminently suicidal or likely to be so within the next 30 days and shall be protected by being placed on involuntary hold by any staff authorized to do so by NRS 433A.120 to 433A.330.~~

6.5 All Inpatient unit~~s'~~ client admissions will be assessed for ~~suicidality~~ risk of suicide by staff who are competent in diagnostic assessment.

6.6.1 Those consumers with high suicide risk will be placed on ~~special watch~~precautions~~precautions~~ including special observation as per agencies' protocols until risk has subsided.

6.6.2 All ~~Such~~ consumers will be having suicide risk reassessed prior to discharge.

6.6.2.1 Reassessment must~~can~~ be reflected in the ~~clinical narrative~~ progress notes.~~.~~

~~1.6~~

6.6 A consumer who is deemed a high suicide risk will not be discharged from a Division ~~agency~~ inpatient facility unless the discharge is in response to:

6.7.1 ~~(1)~~ an admission to a hospital,
6.7.2 ~~(2)~~ an inter-hospital transfer, or

6.7.3 ~~(3)~~ a court order.

~~1.7~~6.8 If a consumer is identified, ~~by a psychiatrist, physician assistant, /advanced practice nurse, psychologist~~by medical staff, licensed clinical social worker, or licensed marriage and family therapist in either inpatient or outpatient settings, as having a reported history of suicide~~suicide attempt within the last 30 days~~ or is reporting current suicidal ideation, staff shall document the findings and the plan addressing the findings.

6.8.1 ~~6.8.1~~ The plan ~~may~~ should include ~~, but is not limited to:~~

6.8.1.1 a review of current static and modifiable risk factors for suicide, protective factors;

~~6.8.1.1~~

6.8.1.2 interventions designed to mitigate modifiable risk factors; and

6.8.1.3 interventions to enhance protective factors

6.8.1.4 any additional interventions designed to decrease the risk of suicide including but not limited to

6.8.1.5 Consultation with other professional staff;

~~6.8.1.2 Therapeutic intervention;~~

~~6.8.1.3~~ Appropriate referrals ~~Arrangement~~ for therapeutic intervention by other qualified staff when required interventions go outside of staff's scope of work or outside of scope of services that could be provided by the agency;

~~6.8.1.4~~ Psychological testing;
~~6.8.1.6~~
6.8.1.7 Medication assessment/adjustment;
6.8.2 Involuntary hold;
6.8.3 Voluntary hospitalization;
6.8.4 Notifying other Agency staff involved with the consumer's treatment; and
~~6.8.2~~ Notifying managers of programs in which the consumer is enrolled.

6.9 If there is disagreement between staff (psychiatrist, physician ~~assistant, /advanced~~assistant, advanced practice nurse, psychologist, social worker, or licensed marriage and family therapist,) regarding the level of suicide risk, or treatment plan development, the agency medical director or his/her designee is to be notified immediately for consultation.
6.9.1 The medical director's opinion is final.
If the agency has no medical director, the division medical director or his/her designee shall render the final opinion.

6.10 Each Agency shall specify procedures for tracking consumers identified as having a suicide attempt within the last 30 days or otherwise determined by the clinical staff to be at risk, as well as procedures for downgrading the risk when appropriate.
~~An assessment for downgrading risk must include the consumer's projections for the future (6) six months.~~
~~6.8.3 These projections must be realistic and the clinician recommending the change in risk must view them as authentic, within the limits of sound clinical judgment.~~

~~Support system and follow up care, Hand off communication.~~

~~1.7.1~~

~~1.7.2~~6.8.1 ~~Therapeutic intervention;~~
~~1.7.3~~6.8.1 ~~Arrangement for therapeutic intervention by other qualified staff;~~
~~1.7.4~~6.8.1 ~~Psychological testing;~~
~~1.7.5~~6.8.1 ~~Medication assessment/adjustment;~~
~~1.7.6~~6.8.1 ~~Involuntary hold;~~
~~1.7.7~~6.8.1 ~~Voluntary hospitalization;~~
~~1.7.8~~6.8.1 ~~Notifying other Agency staff involved with the consumer's treatment; and~~
~~1.7.9~~6.8.1 ~~Notifying managers of programs in which the consumer is enrolled.~~

~~1.8 If there is disagreement between staff (psychiatrist /advanced practice nurse, psychologist, social worker, or licensed marriage and family therapist,) regarding the level of suicide risk, or treatment plan development, the agency medical director or his/her designee is to be notified immediately for consultation. The medical director's opinion is final. If the agency has no medical director, the division medical director or his/her designee shall render the final opinion.~~

~~1.9 Each Agency shall specify procedures for tracking consumers identified as having a suicide attempt within the last 30 days or otherwise determined by the clinical staff to be at risk, as well as procedures for downgrading the risk when appropriate. An assessment for downgrading risk must include the consumer's projections for the future 6 months. These projections must be realistic and the clinician recommending the change in risk must view them as authentic, within the limits of sound clinical judgment.~~

6.11 Hand-off communication ensures continuity of care during patient transfers from one service to another and shall include a review of the patient's suicide risk assessment.

1. Hand-off communication shall be documented in the progress notes.
2. Upon acceptance of the patient the In-patient unit, the attending provider will review the record including the H&PE, suicide risk assessment, orders at time of transfer, all previous provider and psychiatric notes and will document the review by initialing the areas of the record reviewed.

6.12 The designated treating clinicians for any program in which a consumer is enrolled must review the most recent suicide risk assessment ~~for suicidality~~ in the consumer's chart at the time of the consumer's entry into the program and record the review in the chart.

6.12~~1~~.1 ~~**The agency will determine the form used for documenting suicide**~~

~~1.10~~ ~~risk assessment.~~ Zero suicide (Columbia Suicide Assessment – brief screening on every encounter) "Every Clinical Counter"

6.13 If no consumer behaviors trigger reassessment for ~~suicidality~~ risk of suicide more quickly (verbalization of suicidal ideation), the outpatient program staff will reassess suicide risk as part of ongoing ~~LOCUS/CASII~~ assessment.

6.14 If the designated treating clinician determines the need to document suicide risk findings on an approved form (i.e., trigger for reassessment), the reassessment will be documented in the chart.

~~1.11~~6.15 Each agency will develop an agency specific procedure as to how annual updates or changes in status will be recorded in the chart.

~~2.0~~7 ATTACHMENTS:

7.1 Columbia-Suicide Severity Rating Scale (C-SSR)) ~~Suicide Risk Assessment~~ Attachment A~~Form~~

~~2.1~~ 7.2 ~~Suicide Assessment Five-step Evaluation and Triage (SAFE-T)~~ Suicide Risk Assessment Avatar form Attachment B

~~3.07 REFERERNCES:~~

~~N/A~~

Control #	Rev. Date:	Title:	Effective Date: 4/2002
SP 4.29	7/2007	Suicidality Assessment Procedure	Next Review Date:

~~4.0~~8 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: 2/3/99; 4/1/02

Date Revised: 11/29/01; 12/10/01; 3/7/02; 7/2/07

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

RISK ASSESSMENT

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

Past 3 Months	Suicidal and Self-Injurious Behavior	Lifetime
☐	Actual suicide attempt	☐
☐	Interrupted attempt	☐
☐	Aborted or Self-Interrupted attempt	☐
☐	Other preparatory acts to kill self	☐
☐	Self-injurious behavior ***without*** suicidal intent	☐

Suicidal Ideation **Check Most Severe in Past Month**	
☐	Wish to be dead
☐	Suicidal thoughts
☐	Suicidal thoughts with method (but without specific plan or intent to act)
☐	Suicidal intent (without specific plan)
☐	Suicidal intent with specific plan
Activating Events (Recent)	
☐	Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)
Describe:	
☐	Pending incarceration or homelessness
☐	Current or pending isolation or feeling alone
Treatment History	
☐	Previous psychiatric diagnoses and treatments
☐	Hopeless or dissatisfied with treatment
☐	Non-compliant with treatment
☐	Not receiving treatment
Other Risk Factors	
☐	
☐	
☐	

Clinical Status (Recent)	
☐	Hopelessness
☐	Major depressive episode
☐	Mixed affective episode (e.g. Bipolar)
☐	Command hallucinations to hurt self
☐	Highly impulsive behavior
☐	Substance abuse or dependence
☐	Agitation or severe anxiety
☐	Perceived burden on family or others
☐	Chronic physical pain or other acute medical problem (HIV/AIDS, COPD, cancer, etc.)
☐	Homicidal ideation
☐	Aggressive behavior towards others
☐	Method for suicide available (gun, pills, etc.)
☐	Refuses or feels unable to agree to safety plan
☐	Sexual abuse (lifetime)
☐	Family history of suicide (lifetime)
Protective Factors (Recent)	
☐	Identifies reasons for living
☐	Responsibility to family or others; living with family
☐	Supportive social network or family
☐	Fear of death or dying due to pain and suffering
☐	Belief that suicide is immoral; high spirituality
☐	Engaged in work or school
Other Protective Factors	
☐	
☐	
☐	

Describe any suicidal, self-injurious or aggressive behavior (include dates)

DPBH Suicide Risk Assessment

Patient/Consumer:
Completed by:
Assessment Date:

PATID:
Chart #:
Episode Number:

SUICIDE INQUIRY

Current or recent
Passive suicidal ideation:

Current or recent
Active suicidal ideation:

Suicide ideation frequency, intensity, and duration
Last 48 hours:

Access to firearms:

Plan - Means by which attempt will be made:

Implementation - action(s) taken in furtherance of the plan:

Intent

Key Symptoms:

Precipitating events:

RISK FACTORS

Previous suicide attempts:

Number of attempts in the last 18 months:

Total life-time number of attempts:

Medical care

Emergency room medical treatment requried:

Intensive care hospitalization requried:

Psychiatric hospitalization requried:

Client History
History of self-injurious behavior:

Suicide History
Family history of suicide:

Friends who have committed suicide?:

Patient/Consumer: PATID:
Completed by: Chart #:
Assessment Date: Episode Number:

Family Hospitalization History

Family history of psychiatric hospitalization:

PROTECTIVE FACTORS

Protective factors:

SUICIDE RISK ASSESSMENT

Suicide risk assessment:

High Risk Patients include those who:

> Have made a serious or nearly lethal suicide attempt
OR
> Have persistant suicide ideation and/or planning
AND :

* Have command hallucinations
* Are psychotic
* Have recent onset of major psyciatric syndromes, especially depression
* Have been recently discharged from psychiatric inpatient unit
* Have a history of Acts/threats of aggression

Moderate Risk Patients include those who:

>Have multiple risk factors and few protective factors
>Display suicidal ideation with a plan, but do not have intent or behavior

Low Risk Patients include those who:

>Have modifiable risk factors and strong protective factors
>have thoughts of death, but do not have a plan, intent or behavior

Electronically reviewed,
Authenticated by:

Control #	Rev. Date:	Title:	Effective Date: 02/1992
SP 4.~~0~~31	11/2018	**Treatment Plan and Treatment Team** Civil Inpatient /Outpatient and Forensic	**Next Review Date: 11/2020**

1.0 POLICY:

It is the policy of the Division that each individual served have a written, individualized treatment plan based on an assessment of the individual's strengths and needs entered into the record of treatment in keeping with this policy and in keeping with the state and federal law (NRS 433.494 through NRS 433.750).

2.0 PURPOSE:

The purpose of Treatment Planning shall be to define the least restrictive treatment that may be expected to benefit the patient and improve their level of functioning. The Treatment Plan shall provide active, recovery-based treatment strategies that may reasonably be expected to benefit the patient and improve their level of functioning.

~~This policy sets the minimal standards for the treatment planning process within the Division. The treatment plan includes how the treating clinician and/or treatment team will assist the individual in meeting their individualized treatment goals. The plan provides both a synopsis of, and an index to, the individual's treatment history. The plan will include:~~

~~2.1 The goals of treatment specific to each client~~individual;

~~2.2 The title and the name of the specific staff person, or agency (when service is provided by another agency), who will assist the consumer to achieve maximum self-sufficiency, including duration and frequency of contacts;~~

~~2.3~~2.1 ~~Where the individual is in the process and progress of treatment with current target date. Since the plan is a summary statement, details of specific treatment steps followed in reaching each objective, specifics of progress, and proposed revisions are all recorded in the progress notes. The plan serves as a guide to locating these details.:~~

3.0 SCOPE: Clinical Services Branch

Commented [JM1]: I would delete the word reasonably

Commented [CS2]: Both "client" and "patient" used throughout document. Stephanie references the APA (psych, or psychiatric?) perspective. Recovery focus may use "client" or "consumer" preferentially, although some also refer to "patient."

Control #	Rev. Date:	Title:	Effective Date: 02/1992
SP 4.0~~0~~31	11/2018	**Treatment Plan and Treatment Team** Civil Inpatient /Outpatient and Forensic	**Next Review Date: 11/2020**

~~4.0~~ ~~4.0~~ **DEFINITIONS:**

4.1 **Treatment Plan:** An Individualized treatment or diagnostic plan with services expected to improve the condition of patients based on an evaluation of the patient's restorative needs and potentialities. It is developed by an interdisciplinary team of clinicians and the patient.

4.2 **Interdisciplinary Team:** A group of health care professionals from diverse fields who work in a coordinated fashion toward common goals with the patient. The patient is a member of the interdisciplinary team.

~~2.4~~ ~~4.1~~ 4.3 **Initial And Current Diagnosis** – This is a diagnosis of the current DSM 5 classification system. It indicates that the individual's problems are primarily the result of a mental disorder and that treatment in a Division inpatient setting is appropriate~~.~~

~~2.5~~ 4.2~~1~~ Individual Consumer Strengths and Resources – The individual's strengths must be utilized in the development of the goals and treatment plan. These strengths must be descriptive and not interpretive. Strengths are personal attributes, i.e., knowledge, interests, skills aptitudes, personal experiences, education, resources, talents and employment status, which may be useful in developing a meaningful treatment plan.

~~2.6~~4.3 Problems/Needs – These are the symptoms, behaviors, social, legal or family circumstances which led to the need for treatment and which, when resolved or the patient has reached optimal self-care, will enable goal attainment. Problem statements should describe specific, observable behaviors or circumstances in order to facilitate the clear statement of measurable treatment objectives.

4.4 **Interventions:** Therapeutic, systematic actions that members of the treatment team will implement to ameliorate the problems of the patient which resulted in admission to the hospital. Interventions can include medications ordered and administered, psychoeducational and psychotherapeutic groups, behavioral

support, and interactions of the treatment staff with the patient.

~~2.7~~ Treatment methods (interventions) are the planned clinical/therapeutic interventions and activities, which will be used in resolution of each problem/need. For example, the use of neuroleptic medication and behavioral modification techniques might be combined to reduce the observable effects of delusional symptoms. Interventions might also require the use of more than one agency/entity. In this instance, the name of the agency/entity must be entered into the section titled responsible staff. For example, a Group Home provider might be utilized to provide Activities of Daily Living Skill Training.

~~2.8~~4.5 Treatment Planning Objectives are statements of desirable, and where possible, measurable behavioral symptom, social, legal or family change that demonstrate elimination or significant reduction of the individual's identified problem/need. These objectives must relate back to the active problems/needs defined on the problem list. Treatment planning objectives are the short and long-term goals of treatment. Short-term goals are usually related to the desired resolution of acute or otherwise significant conditions that prevent discharge from the program. Long-term goals are the end point of treatment with the patient reaching optimal self-sufficiency (all identified problems/needs resolved).

~~2.9~~4.6 Target date – For each objective outcome, a date is given for when the objective is expected to be met.

4.10 Date M~~m~~et – This is the date the objective is met.

4.11 Emancipated Minor - NRS 129.030 Consent for examination and treatment.

1. Except as otherwise provided in NRS 450B.525, a minor may give consent for the services provided in subsection 2 for himself or herself or for his or her child, if the minor is:

(a) Living apart from his or her parents or legal guardian, with or without the consent of the parent, parents or legal guardian, and has so lived for a period of at least 4 months;

(b) Married or has been married;

(c) A mother, or has borne a child; or

(d) In a physician's judgment, in danger of suffering a serious health hazard if health care services are not provided.

~~4.10~~

Control #	Rev. Date:	Title:	Effective Date: 02/1992
SP 4.0 31	11/2018	**Treatment Plan and Treatment Team** Civil Inpatient /Outpatient and Forensic	**Next Review Date: 11/2020**

5.0 ~~5.0~~ **REFERERNCES:**

~~5.1~~N/A ~~NRS 129.030~~

5.1 Nevada Revised Statutes 129.030; 433; 433.224; 433.484; 433.494

5.2 Center for Medicare and Medicaid Services (CMS) regulations for Psychiatric Hospitals; §482.61

5.3 The Joint Commission CAMH and CAMBHC; current edition; Provision of Care; Treatment and Services chapter

Control #	Rev. Date:	Title:	Effective Date: 02/1992
SP 4.~~0~~31	11/2018	**Treatment Plan and Treatment Team** Civil Inpatient /Outpatient and Forensic	**Next Review Date: 11/2020**

6.0 ~~PROCEDURE :~~PROCEDURE:

6.1 ~~———~~On client's admission, identified problems are entered on the problem list form by the attending clinician.

6.1.1 Attending clinician must then enter the problem on the treatment plan and develop appropriate treatment methods, objectives, target dates, and identification of responsible staff within the time frame specified by the agency policy.

6.1.1.1 Additional problems may be placed on the problem list form at any time during the individual's course of treatment by the attending clinician or by a treatment team member working with that client.

6.1.1.2 The treatment team member initiating a problem shall discuss revision of the problem list in the treatment team meeting with the physician present.

6.2 A plan shall be considered initiated when:

6.2.1 The treatment objectives and diagnosis have been entered; and

6.2.1.1 At least one (1) treatment method, related to the objective, with date and responsible staff has been written for each problem/need ~~–~~ identified.

6.2.1.2All active problems/needs entered on the problem list must be addressed either by intervention, referral or deferred on the treatment plan.

6.3 Entries are made on the treatment plan as follows:

6.3.1 Diagnosis as determined by the medical staff~~.~~ ;

6.3.2 Date, number and problem statement of each problem identified on the problem list;

~~6.3.2.1~~ Enter at least one (1) treatment method for each problem; 6.3.2.1

6.3.3 Enter the measurable objectives; and

6.3.3.1 Enter the name and title of the staff, or other agency/entity responsible for each method.

6.4 All treatment activities delineated in an individual's treatment plan will be recorded in the facility progress notes by:

~~6.4.2~~ 6.4.1 Using the approved format (i.e. SOAP, DAP, Narrative, etc.)

~~6.4.3~~6.4.2 All treatment activities delineated in an individual's treatment plan will be recorded in the facility progress notes by:

~~6.4.4~~6.4.3 Each staff member providing a service will make entries:

~~6.4.5~~6.4.4 Each entry will be dated, timed, and signed by the person making the entry; and

~~6.4.6~~6.4.5 Each entry will refer to one or more problem(s) being addressed by the problem number.

6.5 When new problems are entered after the treatment plan has been developed, a "signature" form will be used to continue with the treatment planning.

6.6 Treatment Plan and Review:

6.6.2 Each time a treatment plan is developed, it must be reviewed with the consumer as to the nature and consequences of the treatment, the reasonable risks and benefits of the treatment and alternative procedures and treatments available, if any. The treatment plan must also be signed by:

6.6.2.1 The consumer if he/she is over 18 years old and legally competent; or is an emancipated minor,

~~Consenting to treatment under 18. NRS (parent, ever married ect…..)~~

6.6.2.2 The individual's parent or legal guardian if under age 18; or

6.6.2.3 The legal guardian of a consumer adjudicated mentally incompetent; and

6.6.2.4 The attending psychiatrist; and

6.6.2.5 Any other disciplines included.

6.7 If the individual refuses to sign, it must be noted and dated on the form and reasonable action must be taken on an ongoing basis to get the consumer to sign. This process needs to be documented in the progress notes.

6.8 Treatment plans must be formally reviewed with the individual at a minimum of every ninety (90) days, pursuant to NRS 433.494 and facility policy.

6.8.1 Each treatment plan review is recorded on the progress notes, or specific agency form, as follows:

6.8.1.1 Date and time of review; and 6.8.1.2Current ~~diagnosis ,~~diagnosis, or if diagnosis has not changed note "no change"; and

6.8.1.3 Enter problem number and statement for each unresolved problem from problem list; and

~~6.8.1.5~~ **6.8.1.4** Identify the status of each problem at the time of the treatment plan review. If the problem/need is deemed resolved:

~~6.8.1.5.1~~ 6.8.1.4.1 Enter date in "date met" column on the problem list and treatment plan; and

~~6.8.1.5.2~~ 6.8.1.4.2 Make entry in progress notes indicating rationale for problem resolution indicating the reason the problem will not be addressed beyond this date.

6.8.1.5~~6~~ Revised Problem/Need: If there is a need for reformulating a problem, the responsible staff will:

~~6.8.1.6.1~~ 6.8.1.5.1 Enter the new problem number in the "revised problem" column; and

6.8.1.5~~6~~.2 Enter the problem number and the revision on the next available line of the plan review form. The new problem must be entered on the problem list; and

6.8.1.~~7~~6 Make entry in the progress notes indicating the reason for the change; and

~~6.8.1.7~~6.8.1.6 Appropriate methods and criteria must be developed for each new problem.

6.8.2 Each time a treatment plan review is completed, it must be signed by;

6.8.2.1 The individual ~~consumer;~~ consumer;
6.8.2.2 The facility psychiatrist or primary clinician; and
6.8.2.3 Any other disciplines involved.

6.9 If the individual refuses to sign, it must be noted and dated on the form, and action taken as per agency policy.

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY:

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

Effective Date: 02/07/92
Date Revised: 08/11/98; 09/26/01; 12/04/01; 06/01/07

Control #	Rev.	Title: COORDINATION OF SERVICES FOR PERSONS WITH DUAL DIAGNOSIS	Effective Date:
SP 4.~~0~~43			Next Review Date:

1.0 **POLICY:**

~~1.0~~ It is the policy of the Division that its agencies work cooperatively on behalf of persons with both intellectual~~developmental~~ disabilities and mental illness in order to coordinate the provision of ~~high qualit~~quality ~~y~~quality services, address treatment needs, avoid duplication of services and billing errors, and to maximize continuity and security for each person within their community.

2.0 **PURPOSE:**

To define the role and responsibilities of agencies, service coordinators, clinicians and other mental health professionals, and contract providers and implement a process so appropriate services and supports are delivered to individuals in need of services from both Developmental Services and Mental Health agencies.~~.~~

~~2.0~~

~~3.0~~

3.0 ~~3.0~~ **SCOPE:** Clinical Services Branch

4.0 DEFINITION:

4.1 ~~Cooperatively~~Cooperatively Served Individual ~~(CSI)~~ (CSI) persons with both intellectual disabilities and mental illness served by two or more agencies

4.2 461 Clients: incompetent clients committed to the custody of the Administrator.

5.0: **REFERENCES:**

~~4.0~~ **6.0 PROCEDURES:**

6.1 CSI Committee: (Regional Committee) MOU between agencies - complex services

~~4.1~~

3.1.1 There will be a statewide CSI Committee representing ~~in~~ the south, north and rural regions.

~~4.1.1~~3.1.2 Membership of CSI Committee should include civil and forensic agency directors and clinical staff from each agency including service coordinators, psychologist, or other clinical professionals as determined by the agency director.

~~4.1.2~~3.1.3 The ~~MHDS~~DPBH Medical Director shall provide leadership and overall coordination of committee activities and shall attend committee meetings whenever possible.

~~4.1.3~~3.1.4 Representatives from community provider organizations should be included at meetings when indicated.

~~4.1.4~~3.1.5 The CSI Committee~~s~~ will meet at least semiannually ~~quarterly~~ with minutes recorded. The minutes will be distributed to committee members as well as the corresponding committees (north, south, or rural); the Division Administrator, Deputy Administrator, and Medical Director of the Division of ~~MHDS~~DPBH.

3.1.6 ~~A statewide system-wide meeting should be held annually using teleconferencing technologytechnology, so the regions can exchange information and address commonly held issues~~.

~~4.1.5~~

~~4.1.6~~3.1.7 The responsibilities of the CSI Committees ~~is~~ ~~are~~:

~~4.1.6.1~~3.1.7.1 Identify and maintain a data base of individuals who have ~~developmental~~ intellectual disabilities and mental illness and who are receiving or have a need for cooperative services between DS and MH agencies;~~.~~

3.1.7.2 Develop a state~~-~~wide data base for cooperatively served individuals and identify needed services on an individual basis.

~~4.1.6.2~~

~~4.1.6.3~~3.1.7.3 Be a resource for service coordinators or other agency staff who, as part of proactive service planning, identify a person as “at risk” and needing cooperative services ~~. Determine~~and determine the need for a cooperative service plan;~~.~~

~~4.1.6.4~~3.1.7.4 Review all cooperative service plans as needed, at least annually;~~.~~ and

~~4.1.6.5~~3.1.7.5 At least every two (2) years, make recommendations to ~~Central Office~~ ? Division Administration ~~—~~and the agencies regarding resource development and needs of individuals with intellectual ~~developmental~~ disabilities and mental illness.

~~4.1.6.5.1~~3.1.7.5.1 Conduct a needs assessment for use in the biennial report and budget planning. The needs assessment should be completed by August 1 in even numbered years and will be submitted to DPBH Administration ~~Central office~~ and agency directors; and ~~.~~

~~4.1.6.5.2~~3.1.7.5.2 Review resource allocation for individual regions, agencies and communities served as part of the needs assessment process.

~~4.1.6.6~~3.1.7.6 Develop and provide CSI appropriate education for the following purposes:

~~4.1.6.6.1~~3.1.7.6.1 To develop service capacity and skills in providers of services for people with intellectual ~~developmental~~ disabilities and mental illness;

~~4.1.6.6.2~~3.1.7.6.2 To promote cooperation between Mental ~~H~~health and Developmental Services agencies by providing education relating to eligibility decisions, service provision, and access to service components to employees of the sister agency or agencies;

~~4.1.6.6.3~~3.1.7.6.3 To educate appropriate staff of all agencies in the provision of services to CSI.

~~4.2~~3.2 Referral for Cooperative Services:

~~4.2.1~~3.2.1 Individuals identified by a~~n~~ ~~MHDS~~DPBH agency as needing services from the corresponding sister agency (mental health or ~~developmental~~ intellectual disability services) shall be referred for those

services by following the approved intake process for the agency from which additional dual diagnosis services are requested.

~~4.2.2~~3.2.2 ~~MHDS~~DPBH agencies will facilitate the intake process through communication and coordination between the ~~feral~~ referral source (agency service coordinator or clinician) and the intake contact person.

~~4.2.3~~3.2.3 The agency referral source will notify the agency Cooperatively Served Individuals (CSI) Committee contact person of the person identified as a candidate for ~~both developmental~~both intellectual and mental health services ~~in order to~~to place the person on the agenda for discussion at the next scheduled CSI meeting.

~~4.3~~3.3 Cooperative Service Provision:

3.3.1 All individuals who receive services from Developmental Services have an assigned service coordinator and, as a rule, the DS service coordinator will bill for targeted case management services.

6.3.1.1 An exception shall be when the Mental Health agency is funding residential services.

~~4.3.1~~ 6.3.1.2 The assignment of the primary service coordinator for billing purposes shall be mutually agreed upon by both agencies and may be determined by the nature of the services being provided.

~~4.3.2~~3.3.2 Individuals who receive services from both Developmental Services and Mental Health agencies shall have appropriate representatives from both agencies on their individual support/treatment team who will be responsible for attending team planning meetings.

~~4.3.3~~3.3.3 All individuals cooperatively served by MH and DS agencies shall have their support/treatment plans reviewed by the team every 90 days. Changes in the support/treatment plan will only occur within the context of a team meeting attended by the service coordinator and representatives of both agencies.

3.3.4 Both MH and DS agencies shall have access to all records and information in the cooperative served person's records as needed for planning and coordination of services.

~~4.3.4~~3.3.5 Release of information is not required for MH and DS agencies to share information as needed for the proper provision of services.

Control #	Rev.	Title: COORDINATION OF SERVICES FOR PERSONS WITH DUAL DIAGNOSIS	Effective Date:
SP 4.~~0~~43			Next Review Date:

3.3.6 No Division agency will close its record and files for a person who is cooperatively served until after a discharge plan has been developed by the support/treatment team including representatives of both agencies.

7.0 ATTACHMENTS:

8.0 IMPLEMENTATION STATEMENT:

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

~~4.3.5~~

Administrator

Effective Date: 11/02/01

Date Revised: 06/01/07

Date Approved by MHDS Commission: 11/02/01

Control #	Rev. Date:	Title:	Effective Date: 04/2003
SP 4.53	06/2007	LOCUS/CASII Screening and Rating Instruments	Next Review Date:

1.0 POLICY:

It is the policy of the Division to utilize the Level of Care Utilization System, or LOCUS Screening/Rating instrument with adults, and the Child and Adolescent Services Intensity Instrument, or CASII (formerly CALOCUS) screening tool, with children in Rural Clinics. All mental health agencies will document results using the attached LOCUS and CASII Rating Worksheet(s).

2.0 PURPOSE:

To define the use and timeframes required with completing and utilizing the LOCUS and CASII screening/rating instruments that rate consumers on six evaluation dimensional aspects, which result in placement in one of six levels of care, and recommended services for those levels of care.

~~3.0~~ SCOPE: Clinical Services Branch

~~Division Wide~~

~~4.0~~3.0 DEFINITIONS:

N/A

~~5.0~~4.0 PROCEDURE:

~~5.1~~4.1 The LOCUS screening/rating instrument will be completed on admission~~in the POU~~ on admission.

~~5.2~~4.2 All consumers admitted directly to inpatient services will be assessed using the LOCUS within 24 hours of the admission.

~~5.3~~4.3 All consumers entering community services will receive a LOCUS or CASII screening on~~within 30 days of~~ admission and every three (3) months. ~~Cross check – service coordination quicker than thirty days. – check with Ellen or Tina, Consumers entering outpatient services will receive a LOCUS or CASII~~

5.44.4 Regardless of how many outpatient services the consumer is receiving (service coordination, outpatient counseling, psychosocial rehabilitation, med clinic, etc.), there is to be one LOCUS (or CASII with children and adolescents in Rural Clinics) screening per consumer every 90 days, unless the consumer's condition changes to warrant more frequent LOCUS (or CASII) screenings. The primary purpose of the one LOCUS (or CASII) screening per 90 days is to best determine which level of care (one through six) is most appropriate for the consumer, and the services recommended within that level of care. LOCUS or CASII screenings are not to be conducted to justify a consumer's placement into services after the fact, but before the fact. DPBH agencies have the flexibility to determine which agency representative performs the LOCUS or CASII for determining level of care.

5.54.5 Any change in the consumer's clinical status that results in a change in their level of care will require a re-assessment using the LOCUS (or CASII with children and adolescents in Rural Clinics).

5.64.6 All adults will be reassessed using the LOCUS, and all children and adolescents reassessed using the CASII, every three (3) months.

5.74.7 DPBH agencies must continue to complete the LOCUS/CASII screening assessments in Avatar. All ongoing input will be completed by the mental health professionals designated by their agency to perform the LOCUS/CASII screening assessments. At a minimum, the following LOCUS and CASII data will be entered Avatar:

5.7.14.7.1 Client/Consumer Name

5.7.24.7.2 Date of Rating

5.7.34.7.3 Staff Entering Data

5.7.44.7.4 Program

5.7.54.7.5 DPBH Agency Site Location

5.7.64.7.6 Evaluation Dimensions (LOCUS):

~~5.7.6.1~~4.7.6.1 Risk of Harm

~~5.7.6.2~~4.7.6.2 Functional Status

~~5.7.6.3~~4.7.6.3 Co-Morbidity

~~5.7.6.4~~4.7.6.4 Recovery Environment

~~5.7.6.4.1~~4.7.6.4.1 Level of Stress
~~5.7.6.4.2~~4.7.6.4.2 Support

~~5.7.6.5~~4.7.6.5 Treatment and Recovery History

~~5.7.6.6~~4.7.6.6 Engagement

~~5.7.7~~4.7.7 Evaluation Dimensions (CASII)

~~5.7.7.1~~4.7.7.1 Risk of Harm
~~5.7.7.2~~4.7.7.2 Functional Status
~~5.7.7.3~~4.7.7.3 Co-Morbidity
~~5.7.7.4~~4.7.7.4 Recovery Environment – Stress and Support
~~5.7.7.5~~4.7.7.5 Resiliency and Treatment History
~~5.7.7.6~~4.7.7.6 Treatment, Acceptance and Engagement
~~5.7.7.7~~4.7.7.7 Scale A - Child/Adolescent
~~5.7.7.8~~4.7.7.8 Scale B - Parents/Primary Caretaker

~~5.7.8~~4.7.8 Composite Score

~~5.7.9~~4.7.9 Level of Care/Service Recommendation (consult grid)

~~5.7.10~~4.7.10 Actual (Disposition) Level of Care

~~5.7.11~~4.7.11 All DPBH agency staff required to perform LOCUS and CASII screenings will be trained to do so.

~~5.8~~4.8 Forensic inpatient facilities of units (Lakes Crossing Center) Forensic inpatient facilities or units shall be exempt from completing the LOCUS Screening/Rating Instrument on consumer admitted to those facilities. Forensic inpatient units shall provide alternative assessment measures, such as HCR-20 assessment for risk of violence, both within the institution and within the community. In addition, a standardized instrument for suicide risk, such as the Adult Suicidal Ideation Questionnaire, shall be completed. These instruments will be used in all cases where consumers are admitted from or discharged to another criminal justice agency.

All staff who have admitting and discharge responsibilities involving consumers from DPBH forensic units shall be trained in the administration of these designated risk assessment instruments.

Individual clients who are discharged to the community as un-restorable or on conditional release after a Not Guilty By Reason of Insanity finding shall also be assessed with the LOCUS assessment instrument.

Each individual forensic unit shall institute their own risk assessment policy and designate the specific tools to be used at the facility in this policy.

~~6.0~~5.0 ATTACHMENTS:

~~6.1~~5.1 LOCUS Assessment Rating Form
~~6.2~~5.2 CASII Assessment Rating Form

~~7.0~~6.0 REFERERNCES:

N/A

~~8.0~~7.0 IMPLEMENTATION OF POLICY:

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

Effective Date: April 18, 2003
Date Revised: 08-12-03; 10-08-03; 11-07-03; 03-29-04; 04-15-04; 08-27-04; 10-05-06; 01-01-05; 10-05-06; 06-04-07

LOCUS ASSESSMENT (Version 2000)

Consumer Name: _____ Facility Chart Number: _____
Rater Name: _____ Date of Rating: _____

1. Please check the applicable ratings within each dimension and record the score in the lower right hand corner. Total your score and determine the recommended level of care using either the Placement Grid or the Decision Tree.

I. Risk Of Harm

O 1 Minimal Risk of Harm
O 2 Low Risk of Harm
O 3 Moderate Risk of Harm
O 4 Serious Risk of Harm
O 5 Extreme Risk of Harm

Score_____

II. Functional Status

O 1 Minimal Impairment
O 2 Mild Impairment
O 3 Moderate Impairment
O 4 Serious Impairment
o 5 Severe Impairment

Score_____

III. Co-Morbidity

O No Co-Morbidity
O Minor Co-Morbidity
O Significant Co-Morbidity
O Major Co-Morbidity
O Severe Co-Morbidity

Score_____

IV-A. Recovery Environment - Level of Stress

O Low Stress Environment
O Mildly Stressful Environment
O Moderately Stressful Environment
O Highly Stressful Environment
O Extremely Stressful Environment

Score_____

IV-B. Recovery Environment – Support

O 1 Highly Supportive Environment
O 2 Supportive Environment
O 3 Limited Support in Environment
O 4 Minimal Support in Environment
O 5 No Support in Environment

Score_____

V. Treatment and Recovery History

O 1 Full Response to Treatment/Recovery Mgmt
O 2 Significant Response to Treatment/Recovery Mgmt
O 3 Moderate or Equivocal Resp to Treatment/Recovery Mgm
O 4 Poor Response to Treatment and Recovery Mgmt
O 5 Negligible Response to Treatment/Recovery Mgmt.

Score_____

VI. Engagement

O 1 Optimal Engagement
O 2 Positive Engagement
O 3 Limited Engagement
O 4 Minimal Engagement
O 5 Unengaged

Score_____

Total Composite Score (Total I –VI, above):_____

Care Level I= Recovery/Health Maintenance = 10 – 13
Level II = Low Intensity Community Based Services = 14 – 16
Level III = High Intensity Community Based Services = 17 – 19
Level IV = Medically Monitored Non-Residential Services = 20 – 22
Level V = Medically Monitored Residential Services = 23 – 27
Level VI = Medically Managed Residential Services = 28 or more

Note: Due to independent criteria, some scores require automatic admissions to a higher level of care regardless of combined score. A score of 4 on dimensions I, II or III results in placement at level five and a score of 5 on dimensions I, II or III results in placement at level six. These automatic higher level placements may be waived if "2" equals the sum of the IVA and IVB scores.

2. LOCUS Derived Level of Care Recommendation (consult grid): _____

3. Actual (Disposition) Level of Care: _____

Reason for Deviation from LOCUS Level of Care Recommendation (at #2 above) if applicable:

_____

_____

DPBH CASII (formerly CALOCUS) CHILD ASSESSMENT (Version 2000)

Consumer Name:_____ Client Episode #: _____

Rater Name (Print):_____ Facility Chart Number: _____

1. Clinical Level of Care Recommendation (The level assigned or which you estimate before using score sheet below): _____

2. Please circle the applicable ratings within each dimension and record the score in the lower right hand corner. Total your scores at #3, and determine the recommended level of care (at #4) using the Placement Grid.

I. Risk of Harm 1. Low Potential for Risk of Harm 2. Some Potential for Risk of Harm 3. Significant Potential for Risk of Harm 4. Serious Potential for Risk of Harm 5. Extreme Potential for Risk of Harm Score_____	**IV. B. Recovery Environment – Environment Support** 1. Highly Support Environment 2. Supportive Environment 3. Limited Support in Environment 4. Minimally Supportive Environment 5. No Support in Environment Score_____
II. Functional Status 1. Minimal Function Impairment 2. Mild Functional Impairment 3. Moderate Functional Impairment 4. Serious Functional Impairment 5. Severe Functional Impairment Score_____	**V. Resiliency & Treatment History** 1. Fully Resiliency and/or Response to Treatment 2. Significantly Resiliency and/or Response to Treatment 3. Moderate or Equivocal Resiliency and/or Response to Treatment 4. Poor Resiliency and/or Response to Treatment 5. Negligible Resiliency and/or Response to Treatment Score_____
III. Co-Morbidity: Developmental Medical, Substance Use, and Psychiatric 1. No Co-Morbidity 2. Minor Co-Morbidity 3. Significant Co-Morbidity 4. Major Co-Morbidity 5. Severe Co-Morbidity Score_____	**VI. A. Child/Adolescent: Treatment, Acceptance and Engagement** 1. Optimal 2. Constructive 3. Obstructive 4. Adversarial 5. Inaccessible Score _____
IV. A. Recovery Environment – Environment Stress 1. Minimally Stressful Environment 2. Mildly Stressful Environment 3. Moderately Stressful Environment 4. Highly Stressful Environment 1. Extremely Stressful Environment Score_____	**VI.B. Parent/Primary Caretaker: Treatment, Acceptance & Engagement** 1. Optimal 2. Constructive 3. Obstructive 4. Adversarial 5. Inaccessible Score_____

Note: Due to independent criteria, some scores require automatic admissions to a higher level of care regardless of combined score. A score of 4 on dimensions I, II or III results in placement at level five and a score of 5 on dimensions I, II or III results in placement at level six. These automatic higher level placements may be waived if "2" equals the sum of the IVA and IVB scores.

3. Total composite score from the above work sheet scores: _____

4. CASII (CALOCUS) Derived Level of Care Recommendation (Consult Grid): _____

Care Level I = Recovery/Health Maintenance = 10 – 13 Level II = Outpatient = 14 – 16

Level III = Intensive Outpatient = 17 – 19 Level IV = Intensively Integrated Services w/o 24 hr. psychiatric monitoring = 20–22

Level V = Non-secure 24 hr. Svcs. w/psychiatric monitoring = 23 – 27 Level VI = Secure 24 hr. Services with psychiatric management = 28 or more

5. Actual (Disposition) Level of Care: _____

Reasons for Deviation from CASII (CALOCUS) Level of Care Recommendation shown at #4 above:

_____

_____

Patient/Family Name: _____ Signature of Scorer/Rater: _____

Date of Scoring: _____

Control #	Rev. Date:	Title:	Effective Date: 04/2003
SP 6.~~0~~14	07/2007	HIPAA Employee Training Requirements	Next Review Date:

1.0 POLICY:

All members of the Division workforce will be trained regarding privacy policies and procedures including an individual's right of access with respect to use and disclosure of protected health information (PHI), as necessary and appropriate for the members of the workforce to carry out their duties and responsibilities.

Training will include policies and procedures pursuant to all applicable laws and regulations regarding the privacy, confidentiality, use, and disclosure of individual health information.

Training will occur ~~initially prior to April 14, 2003, for all employees or~~ upon initial employment and annually thereafter. Periodically, privacy reminders will be sent to inform employees of privacy concerns, initiatives, and/or changes.

2.0 PURPOSE:

The Division is committed to ensuring the privacy and security of individual's health information. Furthermore, the Division recognizes that individual rights are a critical aspect of maintaining quality care and service and is committed to allowing individuals to exercise their rights to access their health information while respecting and protecting these rights. Federal, state, and/or local laws and regulations have established standards with which health care organizations must comply to ensure the security and confidentiality of PHI when using or disclosing an individual's health information. To support our commitment to individual's confidentiality while ensuring the individual access to their health information, all employees of the Division will receive appropriate training regarding the policies and ~~procedures~~ protocols for ensuring the secure and confidential receipt, transmission, storage, use, and/or disclosure of PHI.

3.0 SCOPE:

Division Wide

Control #	Rev. Date:	Title:	Effective Date: 04/2003
SP 6.~~0~~14	07/2007	HIPAA Employee Training Requirements	Next Review Date:

4.0 DEFINITIONS:

4.1 PHI-Protected Health Information~~N/A~~

4.2 PII-~~Personsally~~Personally Identifiable Information

5.0 PROCEDURE:

5.1 Whenever a policy or procedure regarding the protection of individual health information is changed that affects and employee's job function, all employees so affected will receive training regarding the revision within a reasonable timeframe after the effective date of the change.

5.2 Within thirty (30) days of initial employment, all new employees will receive training regarding the privacy and confidentiality, use and disclosure, and the individual's right of access to their health information.

5.3 Training regarding the privacy and confidentiality of individuals PHI will include the following:

5.3.1 Uses and disclosures of PHI for treatment, payment, and health care operations.

5.3.2 Uses and disclosure of PHI pursuant to an individual's authorization.

5.3.3 Uses and disclosure of PHI pursuant to the individual's opportunity to agree or disagree with the use or disclosure.

~~5.3.3~~

5.3.4 Uses and disclosure of PHI that do not require an individual's authorization or their opportunity to agree or disagree.

5.3.5 An individual's rights concerning their PHI,

5.3.6 Any other information as necessary for the respective members of the workforce to carry out their duties and responsibilities with respect to the proper use of disclosure of PHI, and

5.3.7 Disclosure of PHI to business associates.

5.4 Employee training regarding the use and disclosure of PHI will include the following:

5.4.1 The process by which and individual may request access to his/her PHI,

5.4.2 The documents to be used for individuals to request access to their PHI,

5.4.3 The process by which the agency or the Division may request the use of disclosure of an individual's PHI,

5.4.4 The documents to be used for the Division to solicit a request for an individual's PHI,

5.4.5 The right of the individual to revoke the authorization,

5.4.6 The identification of defective or invalid authorizations, and

5.4.7 The recognition of when the Division may condition the provision to an individual of treatment, payment, enrollment, or eligibility for benefits on the provision of obtaining an authorization.

5.5 Employee training regarding individual rights in relation to the use and disclosure of and access to their PHI will include the following:

5.5.1 Allowing individuals to file complaints concerning the Division's policies and procedures required by the HIPAA privacy rule or its compliance with such policies and procedures.

5.5.2 Allowing individuals to receive an accounting of instances when their PHI has been disclosed.

5.5.3 Allowing individuals to access, inspect, and/or obtain a copy of their PHI that is maintained in a designated record set.

5.5.4 Denying a request from an individual to access, inspect, and/or obtain a copy of their PHI.

5.5.5 Providing an individual with a written statement of the reason for a denial to inspect and/or copy his/her PHI.

5.5.6 Allowing individuals to request confidential communications of PHI.

5.5.7 Allowing individuals to request restriction of the uses and disclosures of their PHI.

5.5.8 Allowing individuals to request an amendment or correction to their PHI that they believe is erroneous or incomplete.

5.5.9 Denying a request from an individual to amend or correct their PHI that they believe to be erroneous or incomplete, and

5.5.10 Appropriate forms to use in each of the above situations.

5.6 Documentation regarding training for the Division workforce will be retained for a period of at least six years from the date of its creation.

5.7 The Division Information Security Officer will be responsible for implementing activities and employee training relating to the safeguarding of electronic transmission and storage of PHI.

~~5.7~~5.8 The Division HIPAA Privacy Officer will be responsible for implementing training ~~activities, NvElearn~~activities, NvElearn, revision of the Division's HIPAA Manual, Policies and Procedures, Risk Analysis for privacy breach and

concerns, consulting the Deputy Attorney General, attending meetings with DHHS Privacy Officers.

6.0 ATTACHMENTS:

6.1 Notice of Privacy Practices, English~~N/A~~
6.2 Notice of Privacy Practices, Spanish

7.0 REFERERNCES:

~~CMS, 45~~CMS, 45 CFR 164.530, Administrative Requirements

2018 HIPAA Manual, PolicyTech~~N/A~~

~~7.0~~8.0 IMPLEMENTATION OF POLICY:

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

Effective Date: 04/15/03

Revised/Review Date: 04/15/03, 10/33/04, 07/11/07

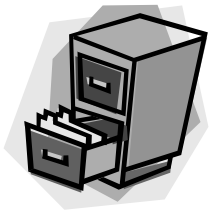
Approved by DPBH Administrator:

Approved by Commission:

Estado de Nevada –Departamento de salud y servicios humanos
División de Salud Pública y de Comportamiento
Aviso de Prácticas de Privacidad

ESTE AVISO DESCRIBE CÓMO LA INFORMACIÓN MÉDICA SOBRE USTED PUEDE SER UTILIZADA Y DIVULGADA Y CÓMO USTED PUEDE OBTENER ACCESO A ESTA INFORMACIÓN. POR FAVOR LÉALO CUIDADOSAMENTE

Sobre nosotros: Nevada Servicios de salud Mental para Adultos del Sur de Nevada demostrado servicio psiquiátrico de emergencia, servicios de emergencia psiquiátrica para pacientes internados, servicios de laboratorio y servicios de farmacia, así como servicios comunitarios incluyendo ambulatorios consejería, coordinación de servicios, apoyo residencial, medicina clínica, rehabilitación psicosocial y recuperación de abuso de sustancias. Este aviso cubre todos estos servicios y programas.



Información sobre su salud es personal y privada. La ley dice que, nosotros, la División de Salud Publica y del comportamiento debe proteger esta información. Cuando usted inicialmente pidió nuestra ayuda o servicios, nos dio información que nos ayudaron a decidir si usted califica. Se convirtió en parte de su archivo, que mantenemos en nuestras oficinas. También en su archivo esta información que fue dada a nosotros por hospitales, médicos y otras personas que le tratan. Una ley federal dice que le debemos darle este aviso para ayudarle a comprender cuáles son nuestras obligaciones legales y cómo protegeremos su información de salud.

¿Cuándo está bien que compartamos su información de salud?

Si usted firma un formulario especial que nos dice que está bien compartir su información médica con alguien, entonces vamos a compartir la información. Usted puede cancelar en cualquier momento notificándonos por escrito, excepto si ya hemos compartido la información.

Su información puede ser compartida sin su autorización cuando necesitamos aprobar o pagar por servicios. También podemos compartirla cuando repasamos nuestros programas y tratar de mejorarlos. Bajo la ley, estos usos se denominan tratamientos, pagos y operaciones de atención médica.

La ley dice que hay algunas otras situaciones cuando quizá necesitemos compartir información sin su autorización. Estos son algunos ejemplos.

Para su tratamiento médico y pago

√ Cuando usted necesite cuidado de emergencia
√ Para dejarle saber opciones de tratamiento
√ Para recordarle de citas
√ Para ayudar a nuestros asociados en su trabajo
√ Para ayudar a revisar la calidad del programa

Por razones de salud pública

√ Para ayudar a investigadores a estudiar los problemas de salud
√ Para ayudar a funcionarios de salud pública para detener la propagación de enfermedad o prevenir lesión
√ Para proteger a usted u otra persona si creemos que está en peligro

Sus motivos personales

√ Para decirle a su familia y otras personas que ayudan con las cosas de su cuidado lo que necesitan saber
√ Para aparecer en un directorio de pacientes
√ Para compensación de trabajadores (workers compensation)
√ para decirle a director de funeraria de su muerte
√ Si ha firmado documentos de donación de órganos, para asegurarse de que sus órganos son donados según sus deseos

Otros usos especiales

√ Para ayudar a la policía, los tribunales y otras personas que hacen cumplir la ley
√ Para obedecer las leyes acerca de informes de abuso y negligencia
√ Para reportar información a el ejercito
√ Para ayudar a las agencias gubernamentales revisar nuestro trabajo e investigar problemas
√ Para obedecer órdenes de la corte

¿Cuáles son sus derechos?

- Puede solicitarnos que no compartamos su información en algunas situaciones. Sin embargo, la ley dice que no siempre tenemos que estar de acuerdo usted.
- Si estás leyendo este aviso en Internet o en un tablón de anuncios, puede pedir una copia propia de papel.
- Usted puede pedir ver información sobre su salud y obtener una copia. Usted quizá tenga que pagar por las copias basado en la política de la División. Sin embargo, tienes que recordar que no tenemos un historial médico completo sobre ti. Nuestros archivos mayormente contienen información de los pagos a sus médicos y otras personas que le proveen cuidado. Si desea una copia de su expediente médico completo, pídala a su médico o proveedor de atención médica. Si usted piensa que algo falta o está equivocado en su expediente médico que tenemos, usted puede pedirnos que hagamos cambios.
- Usted puede pedir una copia de su información médica en formato electrónico si está disponible.
- Puede solicitarnos una lista de las ocasiones (después de 14 de abril de 2003) que hemos compartido su información médica con otra persona. No se incluirán las veces que hemos compartido su información para propósitos de tratamiento, pago u operaciones de atención médica.
- Usted puede pedir restringir la publicación de su información médica a un plan de salud cuando usted ha pagado de su bolsillo plenamente por artículos o servicios.
- Puede solicitar que su información de salud sea enviada por correo a una dirección distinta de su domicilio habitual o proveerle la información de otra manera.

¿Qué pasa si usted tiene una queja?
Si cree que no hemos mantenido nuestra promesa de proteger su información de salud, usted puede quejarse con nosotros o al Departamento de Salud y Servicios Humanos. Nada te pasará si te quejas.

¿Cuáles son nuestras responsabilidades?

- Bajo la ley, debemos mantener su información médica privada excepto en situaciones como las que figuran en este aviso.
- Debemos darle este aviso que explica nuestras obligaciones legales sobre privacidad.
- Debemos seguir lo que le hemos dicho en este aviso.
- Estaremos de acuerdo cuando haces solicitudes razonables para enviar su información médica a una dirección diferente o entregarla en una forma que no sean de correo ordinario.
- Debemos notificarle si hay alguna violación de su información médica.
- Sólo usaremos o compartiremos la cantidad mínima de su información médica necesaria para llevar a cabo nuestros deberes.
- Debemos informarle si no estamos de acuerdo cuando nos pide que limitemos cómo se comparte su información.

Information de contacto

Si usted tiene preguntas o quejas acerca de nuestras normas de privacidad, por favor contáctenos a: Nombre de la División : SNAMHS Privacy Officer: Rolande A. Werner, Health Information Services Director Domicilio: Rawson-Neal Psychiatric Hospital 1650 Community College Drive Ciudad: Las Vegas, NV 89146 Teléfono: 702-486-6077	O comuníquese con el Departamento de Salud y Servicios Humanos en: Oficina de derechos civiles 90 7th Street, Suite 4-100 San Francisco, CA 94103 Customer Response Center: 800-368-1019 Fax: 202-619-3818 TDD: 800-537-7697 Email: ocrmail@hhs.gov o www.hhs.gov/ocr

La División de Salud Pública y Comportamiento (DPBH) tiene el derecho de cambiar este aviso y cambiar la forma de su información de salud está protegido. Si eso sucede, vamos a hacer las correcciones y lo publicaremos en nuestras oficinas y en nuestro sitio web.

English
Attention: If you speak Spanish, you have access to free linguistic services.
Call: 1-866-569-1746 (TTY: 7-1-1)

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-569-1746 (TTY: 7-1-1).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-569-1746 (TTY: 7-1-1).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-569-1746 (TTY: 7-1-1)

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-569-1746 (TTY: 7-1-1)번으로 전화해 주십시오.

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-569-1746 (TTY: 7-1-1).

Amharic
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-569-1746 (መስማት ለተሳናቸው: 7-1-1).

Thai
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-866-569-1746 (TTY: 7-1-1).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-569-1746 (TTY: 7-1-1) まで、お電話にてご連絡ください。

Arabic
مقر) xxx-xxx-xxxx-1 :ةظوحلم ناجملاب كل رفاوتت ةيوغللا ةدعاسملا تامدخ نإف ،ةغللا ركذا ثدحتت تنك اذإ .مقرب لصتا .
(1-1-7 YTT) 6471-965-668-1 :مكبلاو مصلا فتاه

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-569-1746 (телетайп: 7-1-1).

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-569-1746 (ATS : 7-1-1).

Persian
توجه: گر به زبا فا سی گفتگو می کنید، تسهیلا زبانی بصو ر ر ریگا بر ی شما فر ا ام می باشد .با **س ت ت ا** 1-866-569-1746
ن ن ر ت ه ا ا ه (TTY: 7-1- 1(.تما بگیرید

Samoan
MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1- 866-569-1746. TTY 7-1-1

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-569-1746 (TTY: 7-1-1).

Ilocano
PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-866-569-1746 (TTY: 7-1-1).

Relay Nevada

Hamilton Relay provides traditional relay services for the state of Nevada including TTY, Voice Carry Over (VCO), Hearing Carry Over (HCO), Speech-to-Speech (STS), Spanish-to-Spanish and CapTel®.

Details regarding all of the available services in Nevada can be found under the Options tab above.

When you connect with Relay Nevada, an Operator (OPR) will connect on the phone with you. Simply give the OPR the number you wish to call and your call will be processed promptly, professionally and accurately.

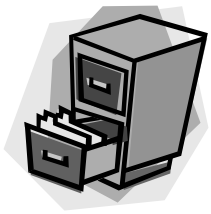
How to Connect

Dial 7-1-1 to use Hamilton Relay in Nevada or call one of the toll free numbers below:
TTY/ASCII/HCO: 800-326-6868
Voice: 800-326-6888
Spanish: 800-877-1219
STS: 888-326-5658
VCO: 800-326-4013
If you are traveling out of State or you are in a State that is not served by Hamilton Relay, you can place interstate calls by calling:
TTY: 800-833-5833 (toll-free)
Voice: 800-833-7833 (toll-free)

State of Nevada – Department of Health and Human Services
Division of Public and Behavioral Health
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

ABOUT US: Southern Nevada Adult Mental Health Services (SNAMHS) provides psychiatric emergency service, inpatient psychiatric emergency services, laboratory services, and pharmacy services as well as community-based services including outpatient counseling, service coordination, residential support, medication clinic, psychosocial rehabilitation, and recovery from substance abuse. This notice covers all these services and programs.



Your health information is personal and private. The law says that we, the Division of Public and Behavioral Health, must protect this information. When you first asked for our help or services, you gave us information that helped us decide if you qualified. It became part of your file, which we keep in our offices. Also, in your file is information that is given to us by hospitals, doctors and other people who treat you. A federal law says that we must give you this notice to help you understand what our legal duties are and how we will protect your health information.

When is it okay for us to share your health information?

If you sign a special form that tells us it is okay to share your health information with someone, then we will share it. You can cancel this at any time by notifying us in writing except if we have already shared the information.

The law says that there are some other situations when we may need to share information without your consent. Here are some examples:

For your medical treatment and payment
- √ When you need emergency care
- √ To tell you about treatment choices
- √ To remind you about appointments
- √ To help our business partners do their work
- √ To help review program quality

For your personal reasons
- √ To tell your family and others who help with your care things they need to know
- √ To be listed in a patient directory
- √ For workers compensation
- √ To tell a funeral director of your death
- √ If you have signed organ donation papers, to make sure your organs are donated according to your wishes

For public health reasons
- √ To help researchers study health problems
- √ To help public health officials stop the spread of disease or prevent an injury
- √ To protect you or another person if we think that you are in danger

Other special uses
- √ To help the police, courts and other people who enforce the law
- √ To obey laws about reporting abuse and neglect
- √ To report information to the military
- √ To help government agencies review our work and investigate problems
- √ To obey court orders
- √ To other state agencies under Division Public and Behavioral Health

Federal rules prohibit disclosure of Alcohol and Drug Abuse records unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR, Part 2.

What are your rights?

- You can ask us not to share your information in some situations. However, the law says that we do not always have to agree with you.
- If you are reading this notice on the Internet or on a bulletin board, you can ask for a paper copy of your own.
- You can ask to look at your health information and get a copy of it. You may be charged a fee for the copies based on Division policy. However, you need to remember that we do not have a complete medical record about you. If you want a copy of your complete medical record, which includes your medical treatment, you should ask your primary care doctor or provider of health care.
- If you think that something is missing or is wrong in your health record that we have, you can ask us to make an amendment. You must complete the Request to Amend Health Information form. We will respond within 60-days of receiving the written request.
- You can ask to have a copy of your health information provided in electronic format if it is available.
- You can ask us to give you a list of the times (after April 14, 2003) that we have shared your health information with someone else. This will not include the times we have shared your information for the purposes of treatment, payment or health care operations.
- You may ask to restrict the release of your health information on Uses and Disclosure of you PHI. A request for restriction must be in writing. We will consider your request but are only legally required to accept it. You may not limit the uses and disclosures that we are legally required to make.
- You can ask us to mail health information to an address that is different from your usual address or to deliver the information to you in another way.
- You have the right to request different ways for us to communicate with you.
- You have the right to revoke or cancel your authorization in writing at any time; unless the PHI has already been released. The form necessary for the revocation/cancelling an authorization may be done by contacting the individual listed below.

MARKETING:

We will not use or sell you name or PHI for marketing purposes or fundraising.

What if you have a complaint?

If you think that we have not kept our promise to protect your health information, you may complain to us or to the Department of Health and Human Services. Nothing will happen to you if you complain.

What are our responsibilities?

- Under the law, we must keep your health information private except in situations like the ones listed in this notice.
- We must give you this notice that explains our legal duties about privacy.
- We must follow what we have told you in this notice.
- We must agree when you make reasonable requests to send your health information to a different address or to deliver it in a way other than regular mail.
- We must notify you if there is a breach of your unsecured health information.
- We will only use or share the minimum amount of your health information necessary to perform our duties.
- We must tell you if we cannot agree when you ask us to limit how your information is shared.

Contact Information

If you have any questions or complaints about our privacy rules, please contact us at: DPBH, Clinical Services HIPAA Privacy Officer: Rolande Werner Health Information Services Director/SNAMHS Address: Rawson-Neal Psychiatric Hospital 1650 Community College Drive Las Vegas, NV 89146 Phone: 702-486-6077	Or contact the Dept. of Health and Human Services at: Office for Civil Rights 90 7th Street, Suite 4-100 San Francisco, CA 94103 Customer Response Center: 800-368-1019 Fax: 202-619-3818 TDD: 800-537-7697 Email: ocrmail@hhs.gov or www.hhs.gov/ocr

The Division of Public and Behavioral Health (DPBH) has the right to change this notice and change the way your health information is protected. If that happens, we will make corrections and we will post it in our offices and on our website.

English
Attention: If you speak Spanish, you have access to free linguistic services.
Call: 1-866-569-1746 (TTY: 7-1-1)

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-569-1746 (TTY: 7-1-1).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-569-1746 (TTY: 7-1-1).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-569-1746 (TTY: 7-1-1)

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-569-1746 (TTY: 7-1-1)번으로 전화해 주십시오.

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-569-1746 (TTY: 7-1-1).

Amharic
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-569-1746 (መስማት ለተሳናቸው: 7-1-1).

Thai
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-866-569-1746 (TTY: 7-1-1).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-569-1746 (TTY: 7-1-1) まで、お電話にてご連絡ください。

Arabic
مقر) xxx-xxx-xxxx-1 إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية متاحة لك مجانا. اتصل برقم
:ةظوحلم .

(1-1-7 YTT) 6471-965-668-1 :مکبلاو مصلا فتاھ

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-569-1746 (телетайп: 7-1-1).

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-569-1746 (ATS : 7-1-1).

Persian

توجه :گر به زبا فا سی گفتگو می کنید، تسهیلا زبانی بصو ر ر ریگا بر ی شما فر ا ام می باشد .با **س** 1-866-569-1746 تما بگیرید.)1 -7-1 :TTY) **ھ ا ا ھ ت ر ن ن ا ت ت**

Samoan

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1- 866-569-1746. TTY 7-1-1

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-569-1746 (TTY: 7-1-1).

Ilocano

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-866-569-1746 (TTY: 7-1-1).

Relay Nevada

Hamilton Relay provides traditional relay services for the state of Nevada including TTY, Voice Carry Over (VCO), Hearing Carry Over (HCO), Speech-to-Speech (STS), Spanish-to-Spanish and CapTel®.

Details regarding all of the available services in Nevada can be found under the Options tab above.

When you connect with Relay Nevada, an Operator (OPR) will connect on the phone with you. Simply give the OPR the number you wish to call and your call will be processed promptly, professionally and accurately.

How to Connect

Dial 7-1-1 to use Hamilton Relay in Nevada or call one of the toll free numbers below:
TTY/ASCII/HCO: 800-326-6868
Voice: 800-326-6888
Spanish: 800-877-1219
STS: 888-326-5658
VCO: 800-326-4013
If you are traveling out of State or you are in a State that is not served by Hamilton Relay, you can place interstate calls by calling:
TTY: 800-833-5833 (toll-free)
Voice: 800-833-7833 (toll-free)