Division of Mental Health and Developmental Services
Policy #1.007 - Attorney General's Office - Function/Communication

Policy: The attorney general and his/her duly appointed deputies are the attorneys for all state-elected and appointed officials, boards, departments, agencies, commissions and institutions.

Procedure:

1. Services provided by the deputy attorney general (DAG) assigned to the Division of Mental Health and Developmental Services include the rendering of oral and written legal advice, formal and informal written opinions, prosecution and defense of litigation, preparation and/or approval of legal documents such as contracts and leases, and negotiations regarding personnel matters and administrative hearings.

2. The Division of Mental Health and Developmental Services pays the salaries of the DAG and DAG's secretary, through the attorney general's administration budget.

3. The Division also provides travel and subsistence allowances for the deputy attorney general, plus necessary equipment and supplies.

4. The caseload maintained by the deputy attorney general consists of general litigation, administrative/personnel cases and fee-collection cases.

5. The deputy attorney general, as needed, conducts seminars, to advise and educate personnel on the legal aspects involved in their specific work areas. Examples of past seminars are those on client confidentiality and clients' rights and on the writing of contracts.

6. Requests for any services requiring a formal written response by the deputy attorney general **must** be made in writing, **must** be processed and **must** be approved by the Division Administrator. The DAG office must provide copies of all written opinions to the Director, Department of Human Resources.

7. Effective immediately, and until further notice, referrals to the deputy attorney general for demand letters for delinquent patient accounts shall be handled as follows:

   A. On a monthly basis, each agency will prepare its own "demand letter" on the deputy attorney general's letterhead, for submittal to the deputy attorney general for signature (copy attached).

   B. Northern Nevada and Rural Clinics agency letters will be submitted for signature to the division's deputy attorney general in Carson City. Southern Nevada agency letters will be submitted for signature to the division's deputy attorney general in Las Vegas.

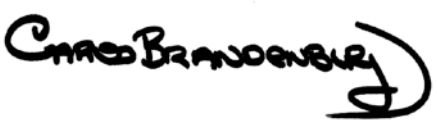
   C. The signed letters will then be returned to the agencies for mailing. Each agency should maintain copies of all letters it sends.

   D. Attorney general letterhead is to be used only for demand letters and must be

signed by a deputy attorney general before mailing.

E. Except as otherwise changed herein, policy #3.004, Collection of Delinquent Bills, remains in effect.

8. 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.



Administrator

Attachment A – Agency Demand Letter

Effective Date: 4/30/98
Revised Date: 7/25/01
Review Date: 3/10/05

Attachment A

AGENCY DEMAND LETTER

Mr. John Doe
0000 Any Street
Any town, NV 89XXX

Re: (Agency Name)
Your account in the amount of $_____.

Dear Mr. Doe:

Our files indicate that you have failed to respond to repeated billings and have ignored a demand letter from the Attorney General's office.

If you do not contact his office and arrange for payment of your account within ten (10) days of your receipt of this letter, we will have no choice but to proceed with legal action against you.

Thank you.

Sincerely,

CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Policy: The MHDS Division has the responsibility of defining acceptable use and conduct regarding internet use by MHDS Division and Agency employees.

Purpose: This policy is intended to interface with Policy 4.068 Email Use. The purpose of this policy is to address the use of the internet by:

I. Identifying the circumstances under which employees of the Division of Mental Health and Developmental Services (MHDS) may access the Internet through Division agencies, or be identified on the Internet as MHDS employees;

II. Defining what MHDS considers acceptable use and conduct once an employee connects to the network;

III. Defining what MHDS considers unacceptable use and conduct once an employee connects to the network;

IV. Providing guidelines which agencies will follow when/if there are suspected violations of either the Internet Use (#4.040) or Email Use (4.068); and

V. Other responsibilities.

Procedures:

I. Circumstances under which employees of the Division of Mental Health and Developmental Services (MHDS) may access the Internet:

A. Internet services include, but are not limited to, Internet or Intranet, World Wide Web, computer-based online services, electronic mail and messaging systems, electronic bulletin board systems. These are provided by MHDS to support open communication and exchange of information, and the opportunity for collaborative government-related work. MHDS encourages the use of electronic communications by its agencies and employees. Although access to information and information technology is essential to the missions of government agencies and their users, use of Internet is a revocable privilege.

B. Employees must review this Internet use policy and affix their signature to a written verification document signifying their awareness of acceptable and unacceptable uses when using Internet services and agreement to the provisions of this policy.

C. Use of remote access: MHDS personnel must adhere to this policy (4.040) when using remote (offsite) Internet-accessed system or resources.

D. Employees must use Division-provided Internet for legitimate state business; however, brief and occasional personal internet use is allowed.

E. Personal use of the Internet on state systems is a privilege, not a right. As such, the privileges may be revoked at any time at the discretion of the Agency or Division administrator. Abuse of the privilege or violation of this policy will result in disciplinary action up to and including termination.

F. Employees have no right to privacy with regard to Internet usage on state systems. Management has the right to view employee usage patterns and take action to assure that agency Internet resources are devoted to maintaining the highest level of productivity.

G. Personal Internet use shall not impede the conduct of state business; only incidental amounts (less than 15 consecutive minutes) of employee time shall be used to attend to personal matters. In no event should both internet and email acess for personal use exceed 60 cumulative minutes in an 8 hour work shift. These 60 minutes include, but are not in addition to, breaks and lunches.

H. Accessing, posting, or sharing any racist, sexual, sexist, threatening, violent, obscene or otherwise objectionable materials as identified in this policy (i.e., visual, textual or audible) is strictly prohibited. This can include, but is not limited to; videos, pictures, websites, and audio or text files.

I. Employees shall not use state systems to subscribe to mailing lists or mail services strictly for personal use.

J. Personal Internet use shall not cause the state to incur any costs in addition to the general overhead; employees shall not intentionally use the Internet to disable, impair, or overload the performance of any computer system or network, or to circumvent any system intended to protect privacy or security of the systems or another user.

K. Passwords: Password sharing is prohibited under all circumstances. Do not use passwords associated with a State of Nevada information system on any other information systems that will be used to access the Internet. Passwords should not be so obvious that others could easily guess them and passwords should be changed at least every 90 days.

L. Logoff (Exiting): MHDS personnel must always complete the logoff or other termination procedure(s). This will help prevent potential breaches of security. Failure to log off may result in disciplinary action.

M. Large File Transfers and Internet Capacity: While routine electronic mail and file transfer activities do not affect service levels significantly, large file transfers and intensive multimedia activities will affect the service levels of other users. Users contemplating file transfers over 10 megabytes per transfer or interactive video activities should schedule these activities after business hours or early or late in the day, or compress fields to result in attachments less than 10 megabytes.

N. Users should be aware of existing and evolving rules, regulations, and guidelines on ethical behavior of government employees, and the appropriate use of government resources, and apply these to the use of electronic communications systems supplied by Division.

II: Acceptable Internet Use(s) include:

A. Communication and information exchange directly related to the mission, charter, or work tasks of the Division agency;

B. Communication and exchange for professional development, to maintain currency of training or education, or to discuss issues related to the user's Division governmental activities;

C. Use in applying for or administering grants or contracts for Division research or programs;

D. Use for advisory, standards, research, analysis, and professional society activities related to the user's Division work tasks and duties;

E. Announcement of new State and/or MHDS laws, procedures, policies, rules, services, programs, information, or activities; and

F. Teaching consumers of services how to use the Internet.

III. Prohibited Internet Use(s) include, but are not limited to:

A. Use of the Internet for any purpose which violates a U.S. or state Law (NRS 205, 239, & 603), Code or applicable policies, standards and procedures;

B. Use for commercial advertising or selling/auctioning of any materials from which the user receives any form of remuneration;

C. Use of, access to, or and distribution of:

1. Indecent material. The Federal Communications Commission defines indecent as follows: Indecent is defined as descriptions or depictions of sexual or excretory functions that are patently offensive under contemporary standards applicable to public, educational, and government access channels;
2. Pornography involving adults or children.
3. Any materials or images which are sexually explicit, or display nudity, partial nudity.
4. Violent materials, including fight videos.

D. Use of computer games that have no bearing on the agency's mission. Some games that help teach, illustrate, and provide training may be acceptable. In this case, approval from the agency management is required.

E. Use of Internet services so as to interfere with, or disrupt, network users, services, or equipment.

F. Use of Internet to seek out information, distribute information, obtain copies of, or modify files and other data which is private, confidential, or not open to public inspection, or release such information (as set forth in NRS 239 or MHDS policy) unless specifically authorized to do so once the legal conditions for release are satisfied.

G. No intentional copy is to be made of any software, electronic file, program, or data without a prior good faith determination that such copying is, in fact, permissible. Any efforts to obtain permission should be adequately documented.

H. Users shall not misrepresent themselves as other persons on the Internet without the expressed consent of those other persons. Users shall not circumvent established policies defining eligibility for access to information or systems.

I. Users shall not use the Internet to develop programs designed to harass other users, or infiltrate a computer or computing system, and/or damage or alter the software components of same. Examples are viruses and Trojan Horse programs.

J. Use for fund raising or public relations activities not specifically related to state government activities.

IV. Guidelines for Reporting Possible Violations of this Policy:

A. Suspected violations must be reported by staff and supervisors. Such allegations should be made in writing to the agency director or the MHDS Information Security Officer.

B. Agency directors must report any suspected violations of this policy.

C. The Division Information Security Officer shall receive request of investigation from agency supervisor/manager or report of alleged inappropriate use from a contractor/employee/officer.

D. The requests must have approval prior to investigation being conducted either by written and established policy or by direction of the appointed authority. Reports of alleged inappropriate use must be received in writing to the Division Information Security Officer.

E. After validation of the request; Division Information Security Officer ensures requests for investigations to be recorded in the Investigative Log File, include:
1. Requesters name;
2. Date access or alleged violation occurred;
3. Time access or alleged violation occurred;
4. Date of agency referral;
5. Description of access or violation;
6. Reasonable explanation justifying need for review/access;

7. Name of each person who may have access to pc or medium;
8. Name of each person allowed to examine information on system; and
9. Name of each person authorized to archive, maintain, store, transfer, transmit or destroy information.

F. This log is maintained as confidential.

G. Division Information Security Officer or his designee completes the investigation and file a written report of the findings discovered.

H. Division Information Security Officer reviews the report within 5 working days, makes determination of resolving any discoveries or allegation, and makes a recommendation to the Division Administrator who will then make a final MHDS determination.

I. Both the Division Information Security Officer and each agency will retain a copy of the report /findings in secured storage.

J. If during the course of carrying out their duties, a technician comes across evidence of what they perceive to be inappropriate use of State computing resources, they must notify Division Information Security Officer. If it is determined that further investigations is warranted and/or claims are substantiated; if substantiated, the access or violation must be recorded by the agency and may be logged after the fact; and all reports/findings are required to be maintained.

K. The MHDS Division administrator or his designee will promptly contact the Director of the Department of Health and Human Services (DHHS).

L. DHHS Director authorizes involvement of the Department of Information Technology (DoIt).

V. Other Responsibilities:

A. MHDS agency directors, or their delegated representatives, are responsible for establishing and maintaining agency policies, practices, or guidelines that support adherence to the requirements of this policy.

B. MHDS agencies will assure any software/files downloaded are virus checked prior to use.

C. MHDS agencies will assure contractors and other non-MHDS employees are granted access to State Government provided Internet services at the discretion of the contracting authority.

D. Uses of personal computers are prohibited in MHDS facilities.

E. MHDS agencies will ensure acceptable use of the state government provided Internet by contractors and other non-Division employees working for MHDS is the responsibility of the contracting agency. The contracting agency is expected to provide contractors who use MHDS

provided Internet services with Division policy and to have them sign the employee verification form on Internet usage.

F. Each MHDS agency shall develop specific written procedures to implement the provisions of Policy #4.040 or shall incorporate this policy into each agency policy manual(s). These agency policies must include:

1. Publishing written Internet use guidelines for each agency.

2. Enabling Internet access for approved MHDS employees. By approving an employee for Internet use, the agency agrees to:

   a. Acquire or be charged for any hardware, software, (including encryption software) or access fees that are necessary to enable access to the Internet.

   b. Assure that MHDS employees have read MHDS Policy #4.040, and have completed the signature form verifying their agreement to abide by these policies and requirements.

3. Temporary addresses must be under supervision with appropriate audit techniques implemented. Temporary addresses must be deleted immediately upon non-State employee and contractor's departure, or at the end of project requiring access to the Internet.

4. The agency director or designee must be notified of the need to terminate access or change the user information within one business day of an employee's death, disability, retirement, termination, or transfer.

5. Agency Director or designee must be notified within one business day if, at some future point, an MHDS Internet user no longer requires Internet access.

Administrator

Effective Date: 4/8/03
Date Revised: 2/15/07
Date Approved by MHDS Commission: 2/7/03
Attachment: MHDS Internet/Email Use
2/6/07 KC

MHDS Internet/Email Use

Employee Verification of Policies 4.040 (Internet) and 4.068 (E-Mail)

An employee of the Mental Health and Developmental Services Division (MHDS) has an implicit responsibility to safeguard the public trust. The employee further affirms to follow all rules, regulations, and statutes governing the integrity and security of data, systems, and procedures prescribed by MHDS Policies 4.040 (Internet Use) and/or 4.068 (E-mail use).

The employee will guard against and report to the proper authority any accidental or premeditated disclosure or loss of material such as, but not limited to, confidential data, sensitive information, developmental or operation manuals, encoding systems, activation passwords for teleprocessing or any material entrusted to the employee when such disclosure or loss could be detrimental to the MHDS, State of Nevada or citizenry thereof.

The employee acknowledges the responsibility to safeguard computer access privileges that with which he/she may be entrusted using, for example, a user password, and will not disclose this sensitive information to anyone. The employee will be responsible for all activity conducted under his/her user registration. The employee understands that the password is intended for the sole use of the person to whom it is assigned, and is not to be loaned or used by any other individual.

The employee recognizes and acknowledges that electronic communications channels developed or supplied by MHDS, as a condition of employment, must be used according to terms and conditions set out by MHDS. These channels include, but are not limited to, the following: A) Internet, B) World Wide Web, C) Computer-based online services, D) Electronic mail and messaging systems, E) Electronic bulletin board systems.

The employee acknowledges that the distribution of information through these and other channels, supplied by the MHDS, is subject to the scrutiny and approval of the MHDS, and that the confidentiality of said information is set by statute and MHDS policies #4.040 and 4.068. The employee acknowledges that any disclosure of confidential information, even inadvertent disclosure, would cause irreparable harm and damage to the MHDS and/or a third party associated with the information. While the employee is employed by MHDS, and after termination of employment for any reason, the employee agrees not to disclose any confidential information. The employee acknowledges that all of the items comprising the confidential information are confidential, whether or not MHDS specifically labels such information as confidential, or internally restricts access to such information. During the course of employment, the employee acknowledges that he or she may work with increasingly sensitive or valuable information. In these cases, even more specific understandings regarding confidential information may be required. These understandings would supplement, rather than replace, the terms of employment and disclosure stated above.

The employee further agrees that he/she will not knowingly engage in any activity that will jeopardize the integrity of the State and/or MHDS. The employee is also aware that he/she will be subject to warning, suspension or dismissal, and/or appropriate legal action for any proven infringements or violations of these policies.

Employee Name: (Print)	Agency Name:
I have read and understand MHDS Division Policies 4.040 and 4.068 which delineate my responsibilities as a State employee regarding use of the Internet/email, and other electronic communications channels, and agree to be bound by its content. I understand that my computer usage may be audited at random for compliance with this policy. I am aware that I may be subject to disciplinary action, and/or appropriate legal action for any proven infringement or violation of Nevada Executive Branch Information Technology Policies, Standards and Procedures, or MHDS Division Polices #4.040/4.068 regarding Internet and/or email usage.	
Employee Signature/Date:	Supervisor Signature/Date:

INCLUDE IN PERSONNEL FILE MHDS 07-01

Policy: The MHDS Division has the responsibility of defining acceptable use and conduct regarding e-mail use by MHDS Division and Agency employees.

Purpose: This policy is intended to interface with Policy 4.040 Internet Use. The purpose of this policy is to address the use of e-mail by:

I. Identifying the circumstances under which employees of the Division of Mental Health and Developmental Services (MHDS) may access e-mail through Division agencies or be identified on e-mail as MHDS employees;

II. Defining types of E-Mail Transmittals and Appropriate Disposition;

III. Defining what MHDS considers acceptable use e-mail;

IV. Defining what MHDS considers unacceptable use of e-mail;

V. Providing guidelines which agencies will follow when/if there are suspected violations of either the Internet Use (#4.040) or Email Use (#4.068); and

VI. Other responsibilities.

Procedures:

I. Circumstances under which employees of the Division of Mental Health and Developmental Services (MHDS) may access e-mail:

A. E-mail services include, but are not limited to, electronic mail and messaging systems, electronic bulletin board systems. These are provided by MHDS to support open communication and exchange of information, and the opportunity for collaborative government-related work. MHDS encourages the use of electronic communications by its agencies and employees. Although access to information and information technology is essential to the missions of government agencies and their users, use of e-mail services is a revocable privilege.

B. Employees must review this e-mail use policy and affix their signature to a written verification document signifying their awareness of acceptable and unacceptable uses when using Internet/e-mail services and agreement to the provisions of this policy.

C. Employees must avoid uses of the network that reflect poorly on their agency, MHDS, or Nevada State Government. Assume e-mail is a written document with possible readers that are unknown. Assume any client materials may be read and accessed by others.

D. Use of remote access: MHDS personnel must adhere to this policy (4.068) when using remote (offsite) systems or resources.

E. Employees must use Division-provided e-mail services for legitimate state business; however, brief and occasional e-mail messages of a personal nature may be sent and received if the following conditions are met.

F. Personal use of e-mail on state systems is a privilege, not a right. As such, the privileges may be revoked at any time at the discretion of the Agency or Division administrator. Abuse of the privilege or violation of this policy may result in disciplinary action.

G. Employees shall be informed that all e-mail sent on state systems can be recorded and stored along with source and destination.

H. Employees have no right to privacy with regard to e-mail message usage on state systems. Management has the right to view employee usage patterns and take action to assure that agency e-mail resources are devoted to maintaining the highest level of productivity.

I. Recorded e-mail messages from state systems are the property of the agency.

J. Employees shall be informed that when sending e-mail of a personal nature on a state system, there is always a danger of the employee's words being interpreted as official agency policy or opinion. Therefore, when an employee sends a personal e-mail on a state system, the employee should use the following disclaimer at the end of the message *"This e-mail contains the thoughts and opinions of (employee name) and does not represent official (agency name) policy".*

K. All business related e-mails transmitted from MHDS e-mail systems must close with the following text: *"This message and accompanying documents are covered by the electronic Communications Privacy Act, 18 U.S.C. §§ 2510-2521, and may contain confidential information intended for the specified individual(s) only. If you are not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, copying, or the taking of any action based on the contents of this information is strictly prohibited. If you have received this communication in error, please notify us immediately by E-mail, and delete the original message.*"

L. Personal email use shall not impede the conduct of state business; only incidental amounts (less than 15 consecutive minutes) of employee time shall be used to attend to personal matters. In no event should both internet and email access for personal use exceed 60 cumulative minutes in an 8-hour work shift. These 60 minutes include, but are not in addition to, breaks and lunches.

M. Accessing, posting, or sharing any racist, sexist, threatening, obscene or otherwise objectionable materials as identified in this policy (i.e., visual, textual or audible) is strictly prohibited. This includes but is not limited to:

1. Indecent material: The Federal Communications Commission defines indecent as follows: Indecent is defined as descriptions or depictions of sexual or excretory functions that are patently offensive under contemporary standards applicable to public, educational, and government access channels;
2. Pornography involving adults or children;
3. Any materials or images which are sexually explicit, or display nudity, partial nudity; and
4. Violent materials.

N. Employees shall not use state systems to subscribe to mailing lists or mail services strictly for personal use.

O. Personal e-mail shall not cause the state to incur any costs in addition to the general overhead of e-mail; employees shall not intentionally use e-mail to disable, impair or overload the performance of any computer system or network, or to circumvent any system intended to protect privacy or security of the systems or another user.

P. Employees should know and follow the generally accepted etiquette of e-mail services. All information sent via e-mail should be prepared under the assumption that:

1. Information sent via e-mail is not confidential.
2. The targeted recipient may not be the final recipient.
3. The information sent may be determined to be and maintained as a public record by another party. As such, public employees should prepare <u>all</u> e-mail transmittals to be a professional representation of the agency for which they work. This includes, but is not limited to, the appropriate level of formality for the targeted and possible recipient(s), correct spelling, grammar, and punctuation, and use of appropriate labels, titles, salutations, and closings.
4. Providing the consumer's social security number is prohibited.
5. Employees should avoid providing the first and last name of consumers when possible.

Q. Users of MHDS e-mail communications must always:

- Use civil forms of communication;
- Respect the privacy of others;
- Respect the legal protection provided by copyright and license to programs and data;
- Respect the privileges of other users.

R. E-Mail Security. Unencrypted electronic mail sent or received outside the state e-mail or Intranet system cannot be expected to be secure. Use encryption and digital signatures to protect secure materials. Use discretion when sending documents over the Internet that are confidential in nature.

S. Users should be aware of existing and evolving rules, regulations, and guidelines on ethical behavior of government employees, and the appropriate use of government resources, and apply these to the use of electronic communications systems supplied by Division.

II. **Types of E-Mail Transmittals and Appropriate Disposition**. In accordance with Nevada State Records, program information contained within e-mail transmissions should be classified into four basic categories:

1. Personal Messages;
2. Transitory Messages;
3. Duplicate Records; and
4. Public Records.

Every MHDS employee who uses e-mail to transmit or receive information in the course of conducting state business must be trained and knowledgeable on his/her responsibilities for managing public records. The difficulty in this responsibility lies in determining which e-mail messages contain information that constitutes a public record. This issue is further complicated as the classification of a message as a public record may differ between the sender and the receiver(s), since it depends on the effect the information has on the business operations of the party who may subsequently receive the information. MHDS employees should be trained in classifying information contained within e-mails into one of the following categories. Once properly classified, the information contained within the e-mail will be processed within each agency per the recommended disposition.

1. *Personal Messages:* E-mail has evolved into a substitute for the telephone and is a cost-effective means of communication that is often used by state employees for communication that has no bearing or relevance to conducting state business (i.e. “let’s do lunch” or “can I catch a ride home” types of messages). State employees should be aware that there is no guarantee of privacy or confidentiality for personal messages transmitted via the e-mail system as all messages are owned by the State and their contents may be monitored, viewed, printed, and further distributed at any time by other State employees.

Disposition: Personal messages are not public records and may be deleted immediately after receipt.

2. Transitory Messages: These types of messages do not set policy, establish guidelines or procedures, document agency business, certify a transaction, or become a receipt. The informal tone of transitory messages might be compared to communication during a telephone conversation or conversation in an office hallway. These messages tend to convey information of temporary importance in lieu of oral communication and have a very limited administrative value. Many of these may have an official context, but may not be part of a business transaction. Examples of messages that are not public records include general departmental correspondence regarding routine business activities (transmittal messages and responses to routine questions); minor non-policy announcements; interoffice messages regarding employee activities (holiday parties, etc.); phone calls; published reference materials; invitations and responses to work-related events (meetings, etc.); listserv messages other than those posted in an official capacity (unless the messages are relied upon in the development of management, financial, operating procedures, or policy matters).

Disposition: Transitory messages are considered non-records and may be deleted based on the transmission's time value to the business functions of the agency.

3. Duplicate Records: E-mail as a medium promotes expedited communication to multiple users with great ease. Consequently, e-mail systems frequently contain duplicates of a record, such as copies or extracts of documents distributed for convenience or reference. "All Agency Memorandums" are often forwarded via e-mail within the State system in order to speed up distribution of certain critical and/or time-sensitive information. Information transmitted in this manner is simply a duplicate or non-record. The paper document received in the State mail system is the actual public record.

Disposition: Duplicate records are not public records and may be deleted immediately.

4. Public Records: Public records are information and other documents created or assimilated in the course of conducting public business that document the activities and business of public employees. An official State record includes "any materials which are made or received by a State agency and preserved by that agency or its successor as evidence of the organization, operation, policy or any other activity of that agency or because of the information contained in the material" (NRS 239.080(4)(d). If there is any doubt, a State employee should assume the information is a public record. Examples of information that could be transmitted in an e-mail that may constitute a public record include:

- Policies and directives;
- Correspondence or memoranda related to official business (excluding duplicates);
- Work schedules and assignments;
- Agendas and minutes of meetings;
- Drafts of documents circulated for comment or approval;

- Any document that initiates, authorizes, or completes a business transaction; and
- Final reports or recommendations.

Disposition: Once an e-mail transmittal is determined to be a public record, public employees of the State of Nevada have an obligation to apply the appropriate records retention schedule. Options for meeting those requirements include:

a. Sender/receiver prints out a copy and maintains per record retention requirement, **or**
b. Sender/receiver maintains electronic file for records retention period.

Public records should be retained for the period appropriate to their content and handled in accordance with approved records disposition authorizations (RDAs) (NRS 239.080).

III. Acceptable E-mail Uses include:

A. Communication and information exchange directly related to the mission, charter, or work tasks of the Division agency;

B. Communication and exchange for professional development, to maintain currency of training or education, or to discuss issues related to the user's Division governmental activities;

C. Use in applying for or administering grants or contracts for Division research or programs;

D. Use for advisory, standards, research, analysis, and professional society activities related to the user's Division work tasks and duties;

E. Announcement of new State and/or MHDS laws, procedures, policies, rules, services, programs, information, or activities; and

F. Teaching consumers of services how to use E-mail.

IV. Prohibited E-mail Uses include:

A. Use of e-mail for any purpose which violates a U.S. or state Law (NRS 205, 239, & 603), Code or applicable policies, standards and procedures;

B. Use for commercial advertising or selling/auctioning of any materials;

C. Streaming video and Audio unless state regulated;

D. No instant messaging;

E. Use of, access to, or and distribution of:

1. Indecent material. The Federal Communications Commission defines indecent as follows: Indecent is defined as descriptions or depictions of sexual or excretory functions that are patently offensive under contemporary standards applicable to public, educational, and

2. Government access channels;
3. Pornography involving adults or children.
4. Any materials or images which are sexually explicit, or display nudity, partial nudity.
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F. Use of e-mail services so as to interfere with, or disrupt, network users, services, or equipment.

G. Users shall not misrepresent themselves as other persons on e-mail, without the expressed consent of those other persons. Users shall not circumvent established policies defining eligibility for access to information or systems.

H. Users shall not use e-mail services to develop programs designed to harass other users, or infiltrate a computer or computing system, and/or damage or alter the software components of same. Examples are viruses and Trojan Horse programs.

I. Use for fund raising or public relations activities not specifically related to state government activities.

V. Guidelines for Reporting Possible Violations of this Policy:

A. Suspected violations must be reported by staff and supervisors. Such allegations should be made in writing to the agency director or the MHDS Information Security Officer.

B. Agency directors must report any suspected violations of this policy.

C. The Division Information Security Officer shall receive request of investigation from agency supervisor/manager or report of alleged inappropriate use from a contractor/employee/officer.

D. The requests must have approval prior to investigation being conducted either by written and established policy or by direction of the appointed authority. Reports of alleged inappropriate use must be received in writing to the Division Information Security Officer.

E. After validation of the request; Division Information Security Officer ensures requests for investigations to be recorded in the Investigative Log File, include:
1. Requesters name;
2. Date access or alleged violation occurred;
3. Time access or alleged violation occurred;
4. Date of agency referral;
5. Description of access or violation;
6. Reasonable explanation justifying need for review/access;
7. Name of each person who may have access to pc or medium;

8. Name of each person allowed to examine information on system; and
9. Name of each person authorized to archive, maintain, store, transfer, transmit or destroy information;

F. This log is maintained as confidential.

G. Division Information Security Officer or his designee completes the investigation and file a written report of the findings discovered.

H. Division Information Security Officer reviews the report within 5 working days, makes determination of resolving any discoveries or allegation, and makes a recommendation to the Division Administrator who will then make a final MHDS determination.

I. Both the Division Information Security Officer and each agency will retain a copy of the report /findings in secured storage.

J. If during the course of carrying out their duties, a technician comes across evidence of what they perceive to be inappropriate use of State computing resources; they must notify Division Information Security Officer. If it is determined that further investigations is warranted and/or claims are substantiated; if substantiated, the access or violation must be recorded by the agency and may be logged after the fact; and all reports/findings are required to be maintained.

K. The MHDS Division administrator or his designee will promptly contact the Director of the Department of Health & Human Services (DHHS).

L. DHHS director authorizes involvement of the Department of Information Technology (Dolt).

VI. Other Responsibilities:

A. MHDS agency directors, or their delegated representatives, are responsible for establishing and maintaining agency policies, practices, or guidelines that support adherence to the requirements of this policy.

B. MHDS agencies will assure any software/files downloaded are virus checked prior to use.

C. MHDS agencies will assure contractors and other non-MHDS employees are granted access to State Government provided e-mail services at the discretion of the contracting authority.

D. Personal computers are prohibited in MHDS facilities.

E. MHDS agencies will ensure acceptable use of the state government e-mail services by contractors and other non-Division employees working for MHDS is the responsibility of the contracting agency. The contracting agency is expected to provide contractors who use MHDS provided e-mail services

with Division policy and to have them sign the employee verification form on Internet and e-mail usage.

F. Each MHDS agency shall develop specific written procedures to implement the provisions of Policy #4.068 or shall incorporate this policy into each agency policy manual(s). These agency policies must include:

1. Publishing written e-mail use guidelines for each agency.

2. Enabling e-mail access for approved MHDS employees. By approving an employee for Internet and e-mail use, the agency agrees to:

   a. Acquire or be charged for any hardware, software, (including encryption software) or access fees that are necessary to enable access to e-mail, and
   b. Assure that MHDS employees have read MHDS Policy #4.068, and have completed the signature form verifying their agreement to abide by these policies and requirements.

3. Temporary addresses must be under supervision with appropriate audit techniques implemented. Temporary addresses must be deleted immediately upon non-State employee and contractor's departure, or at the end of project requiring access to e-mail.

4. The agency director or designee must be notified of the need to terminate access or change the user information within one business day of an employee's death, disability, retirement, termination, or transfer.

5. Agency Director or designee must be notified within one business day if, at some future point, an MHDS e-mail user no longer requires e-mail access.

6. Agencies may establish more restrictive policies or standards to limit the receiving and distribution of personal e-mail on state owned equipment and networks, but shall not be less restrictive than this standard.

7. Agencies maintaining e-mail transmittals determined to be public records in an electronic format face unique challenges that must be addressed as agencies develop policies to meet Nevada record retention requirements. MHDS agencies must establish policies and procedures, taking the following minimum requirements into consideration:

a. Establishment of a repository for holding and managing electronic files. Policies which ensure that metadata information contained within the e-mail transmission is included in the public record (such as; headers, forward headers, and transmission data);
b. Procedures which address the ability to efficiently locate specific files when necessary;
c. Policies and procedures that ensure records remain fully accessible throughout the entire records retention period, including hardware, software, and data migration plans for electronic records that must be retained for six (6) years or more. When there is doubt about the retrievability of an electronic record over its life span, the record should be printed and maintained in a hard copy format; and
d. Permanent public records are archival records with legal, administrative, or historical value that must be retained indefinitely. These records must be preserved in a medium that can be used by future generations. Records appraised as permanent must be converted to paper, microfilm, CD, or another acceptable medium for permanent records retention (NAC 239.760(3)(5).

Administrator

Effective Date: 3/8/07
Date Revised:
Date Approved by MHDS Commission: 3/8/07

03/08/07 KC

MHDS Internet/E-mail Use

Employee Verification of Policies 4.040 (Internet) and 4.068 (E-Mail)

An employee of the Mental Health and Developmental Services Division (MHDS) has an implicit responsibility to safeguard the public trust. The employee further affirms to follow all rules, regulations, and statutes governing the integrity and security of data, systems, and procedures prescribed by MHDS Policies 4.040 (Internet Use) and/or 4.068 (E-mail use).

The employee will guard against and report to the proper authority any accidental or premeditated disclosure or loss of material such as, but not limited to, confidential data, sensitive information, developmental or operation manuals, encoding systems, activation passwords for teleprocessing or any material entrusted to the employee when such disclosure or loss could be detrimental to the MHDS, State of Nevada or citizenry thereof.

The employee acknowledges the responsibility to safeguard computer access privileges that with which he/she may be entrusted using, for example, a user password, and will not disclose this sensitive information to anyone. The employee will be responsible for all activity conducted under his/her user registration. The employee understands that the password is intended for the sole use of the person to whom it is assigned, and is not to be loaned or used by any other individual.

The employee recognizes and acknowledges that electronic communications channels developed or supplied by MHDS, as a condition of employment, must be used according to terms and conditions set out by MHDS. These channels include, but are not limited to, the following: A) Internet, B) World Wide Web, C) Computer-based online services, D) Electronic mail and messaging systems, E) Electronic bulletin board systems.

The employee acknowledges that the distribution of information through these and other channels, supplied by the MHDS, is subject to the scrutiny and approval of the MHDS, and that the confidentiality of said information is set by statute and MHDS policies #4.040 and 4.068. The employee acknowledges that any disclosure of confidential information, even inadvertent disclosure, would cause irreparable harm and damage to the MHDS and/or a third party associated with the information. While the employee is employed by MHDS, and after termination of employment for any reason, the employee agrees not to disclose any confidential information. The employee acknowledges that all of the items comprising the confidential information are confidential, whether or not MHDS specifically labels such information as confidential, or internally restricts access to such information. During the course of employment, the employee acknowledges that he or she may work with increasingly sensitive or valuable information. In these cases, even more specific understandings regarding confidential information may be required. These understandings would supplement, rather than replace, the terms of employment and disclosure stated above. The employee further agrees that he/she will not knowingly engage in any activity that will jeopardize the integrity of the State and/or MHDS. The employee is also aware that he/she will be subject to warning, suspension or dismissal, and/or appropriate legal action for any proven infringements or violations of these policies.

Employee Name: (Print)	Agency Name:
I have read and understand MHDS Division Policies 4.040 and 4.068 which delineate my responsibilities as a State employee regarding use of the Internet/email, and other electronic communications channels, and agree to be bound by its content. I understand that my computer usage may be audited at random for compliance with this policy. I am aware that I may be subject to disciplinary action, and/or appropriate legal action for any proven infringement or violation of Nevada Executive Branch Information Technology Policies, Standards and Procedures, or MHDS Division Polices #4.040/4.068 regarding Internet and/or email usage.	
Employee Signature/Date:	Supervisor Signature/Date:

INCLUDE IN PERSONNEL FILE MHDS 07-01

NEW

Control #	Rev. Date:	Title:	Effective Date: 9/2019
A 1.2	New	Statewide Department or Discipline Procedures	**Next Review Date:** 9/2021

1.0 POLICY:

The Clinical Services Branch ensures that all department or discipline procedures procedures are relevant, current, consistent with regulatory standards and support Division policy, and agency protocol.

2.0 PURPOSE:

To establish a system for development and standardization of department/discipline procedures

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 Centers for Medicare and Medicaid Services - CMS
4.2 The Joint commission - TJC
4.3 Occupational Safety and Health Administration - OSHA
4.4 Policy: Clinical Service Branch guideline upon which a program or course of action is based.
4.5 Agency Protocol: Agency directive that supports implementation of Division Policy.
4.6 Procedure: Outline of established steps or specific method of completing a course of action. Discipline procedures will outline discipline specific processes.
4.7 Policy Tech: Policy and procedure data platform used by the Division of Public and Behavioral Health Clinical Services branch to store, manage and distribute agency policy, protocol and procedure.

5.0 REFERENCES: N/A

6.0 PROCEDURES:

6.1 Disciplines and departments will develop statewide procedures to provide guidance and direction to staff.
- 6.1.1 Discipline specific procedures will cross walk across DPBH Clinical Service Branch agencies. Agencies within the Clinical Services Branch will collaborate on the development of statewide procedures for both Civil and Forensic Services.
- 6.1.2 Department Managers from the respective agencies will approve final statewide procedures.
- 6.1.3 Statewide department procedures will be formatted on the Clinical Services Branch department procedure template, Attachment A.
- 6.1.4 Once Department Managers agree and approve, the procedure will be submitted to the DPBH Clinical Services Branch Policy Manager for upload into Policy Tech.

6.2 Department procedures will be consistent with and support DPBH Clinical Services Branch Policy, Agency Protocol and be compliant with CMS, TJC, OSHA and other discipline specific regulatory bodies.

6.3 All DPBH procedures will be reviewed on a minimum reoccurring two (2) year cycle; except for Emergency Management and Specific Communicable Disease procedures, which will be reviewed everyone (1) year.

6.3.1 Procedures may be reviewed and updated as needed when events trigger a need.

6.3.2 Triggering events include. A DPBH policy change, a process change within the agency or department, a regulatory change, or a legislative change.

6.4 All disciplines / departments within Clinical Services will develop statewide procedures.

6.4.1 When processes vary between agencies, those variances can be highlighted in the statewide procedure. See Attachment B for an example.

6.5 Cited references must be current within five (5) years or less and must be updated to remain five (5) years or less on every review cycle.

6.6 The Clinical Services Statewide Policy and Procedure Manager or designee within each agency or department will assign a procedure number and upload the procedure into Policy Tech.

6.7 The procedure identification convention is described as an example below;
The Identification code will precede with SW (Statewide), the initials of the department MS (Medical Staff), followed by the document number. SWMS 01-100.

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.

EFFECTIVE DATE:
APPROVED BY THE DPBH COMMISSION ON BEHAVIORAL HEALTH:

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: Statewide Department

SUBJECT: Policy or Procedure Title **NUMBER:**

EFFECTIVE DATE: Start (mo./year) **NEXT REVIEW DATE:** Two years from start

APPROVED BY: /s/ Department Lead Name
Title

SUPERSEDES: New

I. PURPOSE: Brief procedure purpose

II. PROCEDURE: How To…..

III. REFERENCES: References may not be older than five years, unless an older document is the most current.

IV. ATTACHMENTS:

Replace your information in the highlighted areas and remove the highlights

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: **Pharmacy**

SUBJECT: Pharmacy Security **NUMBER:** SW1711

EFFECTIVE DATE: 10/17 **NEXT REVIEW DATE:** 07/19

APPROVED BY: /s/Stan Barta /s/Trung Tran, MS, Pharm. D.
NNAMHS Pharmacy Director SNAMHS Pharmacy Director

SUPERSEDES: 05/91, 08/03, 08/05, 08/07, 08/09, 05/11, 02/13, 03/15, 05/17

I. DIRECTIVE:

It is pharmacy procedure to have directives that insure the pharmacy shall be secured from potential thefts and unauthorized persons.

II. PURPOSE:

The purpose of this directive is to establish procedures to provide a secure pharmacy area both during working hours and during non-business hours.

III. PROCEDURE:

A. Only a pharmacist shall possess the means sufficient to open the pharmacy when it has been secured.

B. Once opened the pharmacy technicians and the pharmacy students shall have the means to secure access to the pharmacy.

C. Other personnel must have the pharmacist's approval before entering the pharmacy and must be supervised at all times. The following list of personnel shall serve as a partial list of who may enter the pharmacy on a case by case basis:

1. Medical Director
2. Medication delivery personnel
3. Janitorial personnel
4. Maintenance personnel
5. Pharmacy students
6. Contract pharmacists and technicians
7. Supply delivery personnel
8. Patient Safety Officer

D. Door Access:

1. SNAMHS - No persons(s) shall enter / exit pharmacy via back rear door, with the exception of medication delivery and emergency access.
2. NNAMHS Pharmacy allows access to both front and rear doors. Both entries are visible from the main pharmacy area.

E. Alarm System:
   1. SNAMHS alarm systems cover the pharmacy and will be activated whenever the pharmacy is secured.
   2. NNAMHS Outpatient Pharmacy is alarmed and will be activated whenever the pharmacy is secured.
   3. Inpatient pharmacy is secured within the 24-hour hospital.

F. All full-time pharmacists shall each have their own deactivation codes for the alarm system.

G. The deactivation codes shall be changed whenever compromised or when an employee terminates.

H. A pharmacist as soon as practicable not to exceed 24 hours during normal business days will do alarm reset after violation of the perimeter.

I. The pharmacist resetting the alarm will inspect the pharmacy for possible intrusion. If none is apparent a report will be sent to the Director of Pharmacy regarding the incident. If the pharmacy has been compromised and items taken the following steps will be taken:
   1. Follow the procedures of policy on unusual incidents with the following exceptions:
      a. The nursing supervisor does not need to be notified;
      b. Notify the person currently listed in the appendix since these Persons may change;
   2. A written report to the Director of Pharmacy itemizing losses;
   3. The Police Department will be notified immediately;
   4. The Agency Director of Pharmacy will be contacted, and the incident reported to the hospital security and Medical Director;
   5. The Nevada State Board of Pharmacy will be notified by the Agency Director of Pharmacy.

J. The pharmacy will not open until a complete investigation has been made or until authorized by the police.

K. No clients or other unauthorized personnel will be allowed into the pharmacy at the time.

L. In the event of a robbery, the pharmacy staff will cooperate fully with the Police department.

IV. REFERENCES

A. NRS 639

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

1.0 POLICY:

It is the policy of DPBH that each hospital agency implements a Utilization Management Program.

2.0 PURPOSE:

2.1 The purpose of the program is to maximize the efficiency of service provision and to ensure that services are appropriate, necessary, and effective.

2.2 Utilization Management is a Performance Improvement process.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

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

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

5.0 REFERENCES: N/A

6.0 PROCEDURE:

6.1 Each hospital agency will establish a Utilization Management Plan to meet the goals of the program.

6.2 The plan will include the establishment of a standing committee, the Utilization Management Committee. The Committee is responsible for the maintenance and implementation of the Utilization Management Plan.

6.2.1 The Utilization Management Committee will meet regularly to conduct business.

6.2.2 Minutes will be recorded in the approved format for the meeting. The minutes will include summaries of findings/conclusions and reports presented.

6.2.3 The Utilization Management Committee will submit quarterly reports to the Director of Program Planning. Reports will be submitted in a

6.2.4 format developed by the Planning office.

6.3 The Utilization Management Plan must include the following elements:

6.3.1 The composition of the Utilization Management Committee.

6.3.2 The responsibilities of the Utilization Management Committee.

6.3.3 The process by which cases are analyzed.

6.3.4 The process by which data from case analyses are aggregated.

6.3.5 The process by which the Utilization Management Committee will effect necessary changes to policy or procedure of the agency.

6.3.6 The frequency and content of reports to the agency leadership.

6.3.7 The process by which the Division reporting requirements are met.

6.4 The Agency is funded by the State of Nevada. Therefore, employees do not have a financial interest except to be as cost effective as possible.

6.5 The function of reviewing patient cases, including patients eligible for Medicare and Medicaid, shall be in compliance with applicable Medicare and Medicaid Utilization Review criteria.

6.6 All information generated from Utilization Management Reports and analyses shall be considered confidential and privileged information.

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

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

NEW MHDS-DPBH

Control #	Rev. Date:	Title:	Effective Date: 11/2007
A 4.71 (SP 4.071)		Requests for Public Record Documents	Next Review Date:

1.0 POLICY:

It shall be the policy of DPBH to comply with all requests for a public record document or for copies of information by members of the public, media, and state and federal government officials. Per Nevada Revised Statute 239, all such requests should be handled as expeditiously as possible.

2.0 PURPOSE:

To clarify the circumstances and process for providing copies of information to various entities following specific timeframes and requirements.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS: N/A

5.0 REFERENCES:

5.1 NRS 239
5.2 NAC 284.718
5.3 NRS 439C.140, 120 and 210
5.4 NRS 239.055

6.0 PROCEDURE:

6.1 Per NRS 239, upon receipt for a written request to inspect or copy a public book or record, the Nevada Department of Health and Human Services (DHHS) will comply with any such request within five (5) business days.

6.2 Documents Not considered public record:

6.2.1 Per NAC 284.718, personnel-related documents are not considered public records.

6.2.2 Per NRS 439C.140, 120 and 210 emergency response plans are also not considered public documents.

6.2.3 Information deemed confidential under the Health Insurance Portability and Accountability Act (HIPAA) is not public record.

6.2.3.1 Further, any personal identifying formation, including social security numbers, MUST be redacted when making copies of public record documents.

6.3 A state agency is not required, nor is it obligated, to comply with a request for information that is not compiled or tracked as a standard procedure of the agency, or that is compiled or tracked in a different way by the agency.

6.3.1 Further, the agency is not obligated to create new materials to comply with a public record document request.

6.4 As a note, the *Freedom of Information Act* is a federal law and does NOT apply to state government entities.

6.4.1 If a member of the media or a constituent refer to *the Freedom of Information Act* as the basis for their request to be fulfilled, but that is not applicable to state government records.

6.5 Upon receipt of a written request to inspect or copy a public book or record, the Agency must immediately refer such a request for information to the Division Administrator or Deputy Administrator.

6.5.1 The Division agency shall not respond to request to inspect or copy a public book or record other than to forward the request to Division administration.

6.6 The following procedures are the responsibility of the DPBH Administrative Office only:

6.6.1 When a request for information is made by a legislator, state or federal government official, or by a member of the media, the Director's Office Public Information Officer (PIO) and the appropriate Deputy Attorney General for the Division should be notified as quickly as possible.

6.6.1.1 The PIO will notify the Director and any other appropriate DHHS employees of such a request.

6.6.1.2 Notification should include expected timeline for completion of request, or any problems associated with the request.

6.6.1.3 All requests by a legislator or a state/federal government official should be completed as expeditiously as possible.

6.6.1.3.1 As quickly as possible, notify the legislator or government official via phone or email of the expected time for completion of the request.

6.6.1.4 A request by a member of the media should be completed in a timely manner, keeping in mind the five (5) day rule associated with NRS 239.

6.6.1.5 After receiving the request, the PIO will notify the reporter via phone or email of the expected time for completion of the request.

6.6.1.6 A request by a member of the public should be completed within a reasonable period, keeping in mind the five (5) day rule associated with NRS 239.

6.6.1.6.1 Notify the requester via phone or email of the expected time for completion of the request and of any applicable costs that may be associated with the request (see Public Information Requests Policy).

6.6.2 Applicable charges and fees:

6.6.2.1 No charges related to requests for public record documents by a legislator or a state/federal government official will be assessed by any DHHS Division.

6.6.2.2 Unless the request by a member of the media is more than 50 pages, no charges or fees will be assessed by any DHHS Division.

6.6.2.2.1 In accordance with NRS 239.055, a fee of 15 cents per page will be assessed for all requests of more than 50 pages of documents.

6.6.2.2.2 All documents are reproduced in single-sided, black and white format.

6.6.2.2.3 NOTE: The copy fee may also be waived if approved by the Director or appropriate Administrator.

6.6.2.3 All DHHS Divisions will not charge a fee for printed copies of public record documents requests by a member of the public that are less than 50 pages.

6.6.2.3.1 In accordance with NRS 239.055, a fee of 15 cents per page will be assessed for all requests of more than 50 pages of documents.

6.6.2.3.2 All documents are reproduced in single-sided, black and white format.

6.6.2.4 In accordance with NRS 629.061, requests for copies of medical records may be assessed at not more than 60 cents per page, beginning with the first page being copied.

6.6.2.5 The requestor may also be charged a fee of $19 per hour for staff time needed to print or copy the requested information.

6.6.2.6 The requester may also be charged a fee for delivery of the requested information via regular mail or via FedEx or other similar shipping services as assessed by the delivery agent.

6.6.2.7 If a fee is to be assessed, the requester must be notified immediately. Once the fee has been determined, the requester must remit a money order for the entire amount, payable to "DHHS-Director's Office," prior to the completion of the request.

6.6.2.7.1 If the actual fee is less than anticipated, as quickly as possible, the requester will be mailed a check for the balance.

6.6.2.8 In all circumstances where a billing for fees is either determined but not completed due to the requester aborting the request, or if an actual billing does occur, a detailed, written record of the work including who completed the request, how many pages were copied, when the work was performed and completed, and when and how the information was transmitted, must be sent to the Director's Office PIO.

6.6.3 Completing a request for public record documentation(s):

6.6.3.1 Once the Division has completed a request for information or copies from a legislator, government official, or a member of the media, the Division must notify the Director's Office PIO as soon as possible.

6.6.3.2 If a copy and/or deliver fee is being assessed due to the volume of the request for information, the Division complying with the request should be sure a money order made payable to "DHHS Director's Office" has been received by the Accounting Division within the Director's Office before complying with the request.

6.7 Notification of the completion of a public record document(s) request:

6.7.1 Upon completion of any request for a public record document, the DHHS Director, the Director's Office PIO, and the Division Administrator should be notified via email.

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: 10/01/07
Revised/Review Date:
Approved by Commission: 11/30/07

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

CLINICAL SERVICES

TWO YEAR REVIEW – NO CHANGES

Control #	Date:	Title:	Effective Date: 10/16
A 6.1	10/16	Psychological First Aid Counselor Response	Next Review Date: 10/18

1.0 POLICY

The Division of Public and Behavioral Health (DPBH), Clinical Services branch is responsible for maintaining the capacity for the Psychological First Aid Counselor (PFA) response within the state of Nevada.

2.0 PURPOSE:

This policy serves to ensure that the DPBH is prepared to assist a statewide disaster response through the deployment of Psychological First Aid (PFA) Counselors in collaboration with other disaster response efforts at state and local levels and within the National Incident Command Management System (NIMS).

3.0 SCOPE: State and Local Official request for PFA support.

4.0 DEFINITIONS: N/A

5.0 REFERENCES:

6.0 PROCEDURE:

6.1 The Statewide Disaster Preparedness and Response Coordinator has the responsibility for overall statewide DPBH disaster preparedness and response operations.

6.1.1 This position is the liaison between the Division and other state agencies with roles and responsibilities in disaster situations.

6.1.2 This position is also responsible for assuring that all disaster response program activities are compatible with the National Incident Management System (NIMS).

6.2 DPBH will identify five (5) regional Preparedness and Response Coordinators [one (1) in the north, one (1) in rural, one (1) statewide forensic services and one (1) in the south] who report to the Statewide Disaster Preparedness and Response Coordinator.

6.3 The DPBH Regional Preparedness and Response Coordinators will be responsible to cooperate and collaborate with the regional authority to incorporate agency level Psychological First Aid Counselor response for behavioral health needs.

Control #	Date:	Title:	Effective Date: 10/16
A 6.1	10/16	Psychological First Aid Counselor Response	Next Review Date: 10/18

6.4 During a presidential or governor declared disaster, the Statewide Disaster and Response Coordinator or designess will be responsible for reporting to the State's Emergency Operations Center (SEOC) in Carson City when requested by the Department of Emergency Management (DEM).

6.4.1 The Northern and Rural preparedness and Response Coordinators will provide back up or be deployed by the Statewide Coordinator. This includes primary responsibility to operate and direct the Emergency Support Function (ESP) 8-1.

6.4.2 The Southern Regional Preparedness and Response Coordinator will serve as a backup for SEOC functions, as well as participate, if needed, in the Clark County Emergency Operations.

6.5 The Regional Coordinators are responsible for coordinating with Division Agency staff to identify and maintain contact information for crisis counselors through the use of NXT Communicator.

6.6 The Regional Coordinators will distribute and monitor Psychological First Aid Counselor "Go Bags" for use in deployment.

6.7 Psychological First Aid Counselors will be easily identifiable by their Division identification badge, a secondary form of government issued identification and their light blue Community Support Vest, which will be provided by the Division within the "Go Bags" response kits.

6.8 The specific duties and overall responsibilities of the Division are outline in the DPBH ALL Hazards Disaster Response and Preparedness Plan, and the Behavioral Health Annex.

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 protocol as necessary to do so effectively.

Regional Emergency Management Coordinators:

Five (5) Coordinators: DPBH, Rural, Forensic, Northern, Southern

Responsibilities:

1) Membership in the DPBH Emergency Management Committee (meets every other month)
2) Communicate and coordinate with agency Emergency Management Agency personnel at facilities in their region.
3) Coordinate and Communicate with Psychological First Aid Counselors in their Region.
4) Participate in regional and /or local Emergency Preparedness Coalitions on an ongoing basis.
5) Assist agencies within the region with development and annual review of Emergency Operations plans as well as Emergency Management policy and procedure.
6) Encourage regional agencies to participate in statewide or regional disaster drills and exercises.
7) Hold regional meetings with emergency management coordinators from agencies in their region for:
    a) Information sharing
    b) Share regulatory changes
    c) Assisting with annual HVA in regional agencies
    d) Training Needs Assessment
    e) Education on and promote the use of Everbridge Communicator for emergency communication
    f) Establish back up communication systems with agency emergency management coordinators.
    g) Assist with coordination of statewide or regional training opportunities.
    h) Monitors drills, actual events and After-Action Reports from the regional agencies.
    i) Collaborate with the DPBH Emergency Preparedness Manager.
    j) Staff the ESF-8 Desk in the command Center as requested.
        1. Complete the standardized training needed to staff the ESF-8-1 desk during drills and actual events. These include FEMA courses: FEMA 100, 200, 700, 800 (on line) 300 and 400 live 2-day trainings.
8) Maintain contact information both via Everbridge Communicator and an alternate contact with Psychological First Aid and Crisis Counselors in their region.
9) Assist with activation of Psychological First Aid Counselors on an as needed basis.

UPDATED

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Control #	Rev.	Title	Effective Date: 03/01/2018
		DPBH Clinical Services	
CD 7.3	New	Legionella Prevention and Control	Next Review Date: 03/01/2020

1.0 POLICY:

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

2.0 PURPOSE:

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

3.0 SCOPE: Division of Public and Behavioral Health Facilities

4.0 DEFINITIONS:

4.1 **Legionella:** common aquatic bacteria occurring naturally in freshwater environments. Legionella bacteria become a concern when there are favorable conditions to colonize and grow such as institutional water systems.

4.2 **Legionnaire's Disease (LD):** a serious type of pneumonia caused by bacteria, called *Legionella*, that live in water. *Legionella* can make people sick when they ***inhale*** contaminated water from building water systems that are not adequately maintained. Legionella will proliferate in water systems held at temperatures between 20°C and 45°C.

4.3 **Dead Legs:** are areas of a piping system that rarely see flow, yet are still exposed to process, even if not explicitly cut off. Dead legs are often lines closed by welded caps, flanges, or other fittings. Though they can also take the form of blanked branches, lines with normally closed block valves, lines with one end blanked, pressurized dummy support legs, stagnant control

valve bypass piping, spare pump piping, level bridles, relief valve inlet and outlet header piping, pump trim bypass lines, high-point vents, sample points, drains, bleeders, and instrument connections.

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

5.0 REFERENCES:

5.1 CMS **Ref: S&C 17-30-*Hospitals/CAHs/NHs* REVISED 06.09.2017**
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-30.pdf

5.2 42 CFR §482.42 for hospitals:
"The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases."

~~5.3 42 CFR §483.80 for skilled nursing facilities and nursing facilities:~~
~~"The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections."~~

~~5.4 42 CFR §485.635(a)(3)(vi) for critical access hospitals (CAHs):~~
~~CAH policies must include: "A system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel."~~

~~5.5~~5.3 Guidelines
Guideline 12—Minimizing the Risk of Legionellosis Associated with Building Water Systems, ASHRAE, Published 2000

www.techstreet.com/ashrae/products/232891 (currently under revision)

~~5.6~~5.4 Legionellosis Guideline: Best Practices for Control of Legionella Cooling Technology Institute, Published 2008 www.cti.org/downloads/WTP-148.pdf

~~5.7~~5.5 ELITE Program: Centers for Disease Control and Prevention and Wisconsin State Laboratory of Hygiene wwwn.cdc.gov/ELITE/Public/EliteHome.aspx

5.6 Healthcare Facilities Water Management, Legionella Awareness, Training Program; Deborah Ellis, PH.D., MSPH, MT(ASCP), CIC, February 2018, DPBH SharePoint Video Library.

5.7

5.8 ANSI/ASHRAE S~~s~~tandard 188-2018

6.0 PROCEDURE:

6.1 Infection Prevention and Facilities staff will work cooperatively to conduct an annual risk assessment using the CDC Toolkit.

6.2 A site survey of water systems will include:

6.2.1 A list of all associated plant equipment such as calorifiers, boilers and pumps

6.2.2 Schematics that show the configuration of the system and indicate normal operating parameters, maintenance schedules and

6.2.3 Corrective action to be taken when abnormal situations occur.

6.3 All taps, outlets, dead legs or other associated components or associated pipework which are not used or are under-used should be removed.

6.4 Taps, outlets and dead legs that cannot be removed should be monitored for corrosion, isolated and drained at a minimum of every six (6) months.

6.5 The Facility Managers will perform semi-annual sampling of all water sources, taps, outlets, and other components or pipework inclusive of:

6.5.1 Cooling Towers

6.5.2 HVAC plant and ductwork

6.5.3 Hot and Cold-Water Systems

6.5.4 Showers and spray heads

6.5.5 Water-hammer arrestors

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6.5.6 Pipes, valves and fittings
6.5.7 Expansion tanks
6.5.8 Water filters
6.5.9 Faucet flow restrictors
6.5.10 Misters, atomizers, air washers and humidifiers
6.5.11 Non-steam generating humidifiers
6.5.12 Eyewash stations
6.5.13 Ice machines
6.5.14 Dead Legs

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

6.7 The results will be reviewed by:
6.7.1 The Director of Laboratory Services, Infection Control and Employee Health
6.7.2 The Infection Preventionist
6.7.3 The Consultant for Communicable Disease Control (as available)
6.7.4 The Hospital Administrator
6.7.5 The Medical Director
6.7.6 The Director of Nursing

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

~~Legionella CFU/Liter~~	~~Proportion of site/s positive~~	~~Action~~
~~< 10^2 CFU/Liter~~	~~0 – 50%~~	~~Maintain normal controls. Disinfect affected site.~~
~~<10^2~~	~~> 50%~~	~~Review controls, consider additional measures, examine outlets in detail, retest, consider disinfection~~
~~10^2 – 10^3~~	~~0 – 50%~~	~~Review controls, consider additional measures, examine outlets in detail, disinfect system and retest, alert clinicians~~

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~~10^2 – 10^3~~	~~60 – 100%~~	~~Review controls, consider additional measures, examine outlets in detail, disinfect system and retest, alert clinicians~~
~~> 10^3~~	~~10 – 20%~~	~~Review controls, consider additional measures, strip down all positive outlets replacing synthetic rubber components with new and cleaning and disinfecting the other components, disinfection of the system and retest, alert clinicians~~

Level	CFU/mL	Recommendation
1	No Growth to <10	Retest at normal interval.
2	10-99	Review biocide program and modify treatment as necessary to maintain Legionella bacteria at <10. Retest as soon as possible to monitor the effectiveness of biocide treatment.
3	100-999	Contact experts in system maintenance and treatment and, in conjunction with these experts, devise and execute a plan to maintain Legionella concentrations at <10. Retest as soon as possible to monitor the effectiveness of maintenance and biocide program revisions.
4	>1,000	Urgent response is required. Immediately clean and disinfect the water system. Contact experts in system maintenance and treatment and, in conjunction with these experts, devise and execute a plan to maintain Legionella concentrations at <10. Retest as soon as possible to monitor the effectiveness of maintenance and biocide program revisions. Increase the frequency of testing during the current cooling season.

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"The presence of Legionella bacteria in building water systems is not in itself sufficient to cause LD. Other necessary factors include building water system design and use conditions that promote the growth of Legionella ; a means of transmitting the bacteria to people in the building, such as aerosol generation; and exposure of susceptible persons to LD colonized water that is inhaled or aspirated into the lungs. Legionella bacteria is not generally transmitted into the lungs through normal eating or drinking of contaminated water. Susceptible persons considered at-risk for Legionnaires' disease include, but are not limited to, those receiving treatment for burns, chemotherapy for cancer, solid organ transplant, or bone marrow transplant; those with underlying diseases, such as cancer, renal disease, diabetes, and chronic lung disease; and people that are immunocompromised, such as the elderly, smokers, and those taking drugs that weaken the immune system.", Reference: ANSI/ASHRAE standard 188-2018

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UPDATED

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Control #	Rev.	Title	Effective Date: 03/01/2018
		DPBH Clinical Services	
CD 7.3	New	Legionella Prevention and Control	**Next Review Date:** 03/01/2020

1.1 Discussion regarding the interpretation and action of sampling results will be documented in a semi-annual report and maintained with the Department of Infection Prevention.

2.0 ATTACHMENTS:

2.1 CD 7.3 DPBH Clinical Services Legionella Prevention and Control CDC Guidelines for Control and Prevention of Legionnaires Disease Attachment A
2.2 CD 7.3 DPBH Clinical Services Legionella Prevention and Control Legionella Environmental Assessment Form Attachment B

3.0 IMPLEMENTATION OF POLICY:

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

EFFECTIVE DATE: 03/16/2018
DATE APPROVED BY DPBH ADMINISTRATOR: 03/16/2018
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 03/16/2018

TITLE: Guidelines for Control and Prevention of Legionnaires Disease

PURPOSE: To take every reasonable precaution to protect persons occupying, working and visiting Rawson-Neal Hospital from exposure to Legionalla species that may propagate in water environments in buildings and pose a risk to disease.

BACKGROUND

Legionnaires' disease is a serious type of pneumonia caused by bacteria, called *Legionella*, that live in water. *Legionella* can make people sick when they inhale contaminated water from building water systems that are not adequately maintained.
Legionella are common aquatic bacteria occurring naturally in freshwater environments, such as lakes, rivers and streams. There they are found in very low numbers, but the bacteria can become a health concern when it finds favorable conditions to grow (multiply) and colonize in human-built water systems.

CDC investigations of building-associated outbreaks show the most common places for getting the disease are hotels, long-term care facilities, and hospitals. In these types of buildings, the sources for spreading water droplets contaminated with *Legionella* can include: Showers and faucets of large (potable water) plumbing systems; Cooling towers; Hot tubs; Decorative fountains and aerosolizing water features.

	Cooling water systems	Hot and cold-water systems	Hot tubs Natural spa pools Thermal springs	Humidifiers Respiratory equipment	Potting mixes Compost
Commonly implicated *Legionella* species	Predominantly *L. pneumophila* sg 1	*L. pneumophila* sg 1, 2, 4, 6, 12, *L. micdadei*, *L. bozemanii*, *L. feeleii* and others	*L. pneumophila* sg 1, *L. micdadei*, *L. gormanii*, *L. anisa*	*L. pneumophila* sg 1, 3, and others,	Exclusively *L. longbeachae*
Modes of transmission	Inhalation of aerosol	Inhalation of aerosol, aspiration	Inhalation of aerosol, possible aspiration	Inhalation of aerosol	Not known
Disease outbreaks	Rapid onset over wide area, resolve within incu-bation period	Low numbers of cases over prolonged periods	Rapid onset confined to users and those in close proximity	Low numbers over prolonged periods. Rapid onset confined to users and those in close proximity	Low numbers of cases over prolonged periods
Risk factors (environmental)	Proximity of population, seasonal/ climatic conditions, Intermittent use, poor maintenance, poor design	Complex water systems, long pipe runs, poor temper-ature control, low flow rates/ stagnation	Poor maintenance, stagnant areas in system	Use of non-sterile water, poor mainten-ance/cleaning, operation at temperatures conducive to *Legionella* growth	Seasonal (spring and autumn), use of potting mixes/compost, gardening

sg = serogroup

ISBN 92 4 156297 8 (NLM classi cation: WC 200)

Disease causation is not simple. The mere presence of Legionella in a water system or device is not sufficient to cause disease. To cause disease, the bacteria must ultimately be inhaled or aspirated (going down the "wrong tube" when swallowing) into the lungs of a susceptible person. People with conditions that have reduced their ability to fight off infections are especially susceptible.

ASHRAE has developed ANSI/ASHRAE Standard 188-2015, Legionellosis: Risk Management for Building Water Systems to assist designers and building operators in developing a Water Management Plan specific to the systems that exist in their building or campus. Water services, in particular hot water services, humidifiers, cooling towers, together with air supply systems are the sensitive areas requiring close scrutiny regarding maintenance methods, monitoring, testing and procedures. Legionellae will proliferate in water systems, held at temperatures of between 20^{o}C and 45^{o}C. The Human blood temperature of approximately 37^{o}C is that at which the bacterium is most active. The ideal conditions for Legionellae is stagnant water held between 20^{o}C and 45^{o}C.

Legionellae will survive at temperatures below 20°C but is considered to be in a dormant state with no colonisation activity. The bacterium does not survive temperatures maintained constantly at 60°C or above.

Infection Prevention and Hospital Facilities will work cooperatively to facilitate an annual risk assessment using guidance from the CDC toolkit (Appendix XX). Secondly, Infection Prevention and Hospital Facilities will work cooperatively to survey hospital water sources and environments every 6 months for Legionella species. Infection Prevention will work with Hospital Facilities to interpret these data and document these results.

CMS Regulatory Authorities Pertinent regulations include, but are not limited to, the following: 42 CFR §482.42 for hospitals: "The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases." Page 3 – State Survey Agency Directors

42 CFR §483.80 for skilled nursing facilities and nursing facilities: "The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections."

42 CFR §485.635(a)(3)(vi) for critical access hospitals (CAHs): CAH policies must include: "A system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel."

HIGH RISK CONDITIONS

These will be systems where:

1) Water temperatures are between 20°C and 50°C, therefore, water supplies should be held out of this range wherever practicable.
2) There is sediment, sludge, scale, organic materials and iron oxide in storage tanks and service pipework. Therefore, regular cleaning of such services is essential to reduce the risk.
3) Algae, amoebae and other bacteria, survive a regular disinfection and cleaning programme, which must be monitored to prevent the build-up of biofilms etc.
4) The use of some rubbers, leathers, jointing compound, mastics, wooden packing and certain plastics should be avoided as they can provide a nutrient source for Legionella.
5) The formation of biofilms within a water system also provides a nutrient source and a safe harbour for Legionella. A biofilm is primarily a layer of micro-organisms combining a matrix, which forms a surface slime when in contact with water.
6) Exposure of water to sunlight may stimulate the growth of algae and the formation of slimes. Also, stagnant water encourages colonisation of Legionella.
7) The water is allowed to become stagnant.

High Risk Areas

These are areas that have:

1) Air conditioning systems, humidifiers and chiller battery installations
2) Hot water services and storage cylinders
3) Cold water services and storage tanks
4) Water systems which produce aerosols that may exceed a temperature of 20^{o}C
5) Spa baths, whirlpools, hydro therapy and swimming pools
6) Water systems incorporating a cooling tower

High Risk Patients

These are patients being treated for:

a) Respiratory illness
b) HIV/AIDs
c) Head/ neck cancer
d) Renal dialysis and organ transplant
e) Leukaemia/ oncology/ bone marrow transplant
f) Immuno-suppressed patients

Methods of Prevention

Mechanical Services

a) Removing all taps and outlets and associated pipework which are not used or are under-used.

Systems

b) Ensure that the hot water temperatures for calorifiers and hot water storage vessels are maintained at a temperature at or above 60^{o}C and that this temperature does not fall below 50^{o}C at any point within the circulation pipework.

c) Ensure that all pipework carrying blended water at temperatures of between 25^{o}C and 43^{o}C minimum is restricted to as short a distance from the outlet as is practically possible.

d) Reduce the length of any deadlegs or spurs away from the main hot water circulatory system to a minimum.

e) Avoid stagnation.

f) Maintain stringent cleanliness of water systems and ventilation systems.

g) Use of the proper water treatment regime in wet cooling towers.

h) Introduce the correct level of maintenance to ensure correct and safe operation and compliance with statutory regulations.

i) Reduce the amount of water stored in tanks to a minimum (24 hours maximum).

j) Keep all water storage systems clean and sealed from extraneous matter and contamination; also maintain temperatures below 20^{o}C for cold-water services.

k) Introduction of a system of continuous dosing of the incoming cold-water services using a recognised chemical solution or other approved means would assist in reducing the risk from Legionella and other water borne micro-organisms. This may also allow domestic hot water temperatures to be reduced, thereby, considerably reducing the risk of scalding by patients, staff and visitors.

ROLES AND RESPONSIBILITIES

Infection Control and Facilities Management Team

Infection control is involved in the production of the policy and management procedures for the control of Legionellae. Similarly, the team has a key role in formulating the plans and ensuring its implementation by working with Facilities for assisting in annual risk assessments and legionella water sampling every 6 months.

ACTION ONE – Annual Risk Assessment

Infection Control and Facilities Manager will cooperatively perform a risk assessment for Legionella based on CDCs Toolkit. Refer to:
https://www.cdc.gov/legionella/downloads/legionella-environmental-assessment.pdf

A number of factors are required to increase the risk of acquiring Legionellosis, namely:

1. Condition of the water and the existence of suitable conditions for the organism to grow and multiply in the storage and distribution systems, i.e. suitable temperatures ideally between (20^{o}C – 45^{o}C) and a source of nutrients e.g. organic matter such as sludge, scale, rust or algae.
2. The presence of people to expose, particularly the vulnerable e.g. patients in healthcare premises.
3. A means of creating an aerosol or small breathable droplet such as from a shower.
4. The presence of the bacteria

If at least one of these factors is missing, then Legionnaires Disease is less likely to occur. If all factors are present then the objective must be to remove one or more of them. In practice, the risk can be dealt with by identifying potential sources of dissemination and preventing conditions, which may allow the proliferation of Legionella bacteria.

If all factors are present then the Legionella risk is increased. A site survey of the water systems should be undertaken for the premises, and it shall include a list of all associated plant and equipment, such as calorifiers, boilers and pumps etc. Either as fitted drawings or schematic drawings showing the configuration of services is also required, as is a description of the water system indicating the normal operating parameters; maintenance schedules and actions to be taken if and when abnormal situations occur.

When a risk is identified the findings must be recorded and employees informed. Appropriate actions to reduce control the risk must be taken, vigorously monitored to ensure effectiveness.

Infection control will advise on the susceptibility of patients that may influence the control measures.

In carrying out the risk assessment so the following should be borne in mind:

- The HSE considers Legionella infection to be preventable
- Legionella is present in most water systems, we cannot eradicate it, but we can control the risk.

ACTION TWO – Semi-annual sampling in building water sources for Legionella

The Facilities Manager will perform semi-annual sampling of water sources. Infection Control and Facilities Manager will review results, interpret, document and share with the hospital administrator, the executive medical team and the infection prevention committee.

Schematic Drawings and Sampling Sites every 6 months:

The following sources will be sampled every 6 months for Legionella because these are sites where these bacteria can thrive and are capable of creating droplets, which become airborne and in turn can be inhaled. Pat/Brett to prepare checklist for sampling every six months. Place on a schematic map.

Full list – select those relevant to SNAHMS

- Cooling Towers

- Air Conditioning Plant and Ductwork. Within an air conditioning system, accumulations of water occur at various points throughout the distribution ductwork, depending on weather conditions and the demands of the control system. This is a potential habitat for Legionella.

- Hot and Cold Water Systems. The potential risk within hot and cold water systems can be increased by a number of indicators including; excess water storage capacities, inadequate sealing of water tanks by the lack of lids, ill fitting lids, unscreened overflow pipes; and inadequate or unsuitable thermal insulation. The lack of circulation flow in water tanks created by unsuitable or incorrect positioning of water inlet and discharge connections resulting in stagnation should also be considered.Temperature stratification, stagnation and sediment build up can occur in domestic hot water calorifiers and heaters.Hot water systems should supply water to all outlets; taps etc.; at a temperature of at least 40oC, this is for all public and patient accessible outlets. In some cases, this may prove difficult to achieve because of inadequate insulation or poor circulation. In such cases, careful risk assessment of these circuits and outlets must be made to determine appropriate action. Pipework dead-legs have often contributed to the proliferation of Legionella in that they often contain sediment, sludge and scale; and in some instances, where the outlet being served is infrequently used, water temperatures stabilise within the critical range. Positioning of drain cocks on distribution pipework should be given due consideration to prevent the creation of avoidable dead-legs.

- Showers and Spray Heads. Showers are a potential source of infection by Legionellae bacterium. The risk potential increases with reduction in use, and the lack of a facility to dump blended water between operations. Water retained within the shower rose and hose can remain within the ideal proliferation temperature range until the next user operates the shower, thereby creating an aerosol spray from water, which may have remained stagnant. Further consideration within the category of showers should be given to the equipment utilised in kitchens to pre-wash dirty pots, pans and dishes. This type of spray unit is invariably complete with hand operated control linked by a flexible hose or solid connection to the hot and cold taps, whose valves are left at preset positions to give the temperature required buy the operator. This has the potential to give an ideal breeding temperature for the bacteria when not in use, but can also cause cross-contamination between hot and cold systems as a result of pressure variations.

- Spray taps attached to wash hand basins within toilet facilities. These taps again create an ideal spray to promote water aerosol.

- Water-hammer arrestors

- Pipes, valves, and fittings

- Expansion tanks

- Water filters

- Electronic and manual faucets

- Aerators

- Faucet flow restrictors

- Centrally-installed misters, atomizers, air washers, and humidifiers

- Nonsteam aerosol-generating humidifiers

- Eyewash stations

- Ice machines

- Hot tubs/saunas

- Cooling towers

- Medical devices (such as CPAP machines, hydrotherapy equipment, bronchoscopes, heater-cooler units)

ACTION THREE

If remedial action is needed, detailed Major Cleaning and Disinfection will be done for the affected site.

ACTION FOUR

Further samples will be taken to verify decontamination.

Action to be taken in the event of a possible Outbreak of Legionnaires Disease

ACTION ONE

Liase with the Medical team to confirm the diagnosis and place of acquisition and ensure correct patient samples are sent.

ACTION TWO

Infection Preventionist will review the location of the patient/ staff member and in conjunction with a responsible person Legionella will arrange a review of any relevant water systems and arrange sampling.

ACTION THREE

Measures must be taken to reduce exposure of any other susceptible persons.

ACTION FOUR

A group should be set up to review the water sampling results and decide what further actions need to be taken. The group will include:

- Infection Preventionist
- Consultant for Communicable Disease Control
- Hospital Administrator
- Facilities Manager
- Representatives of the Medical Executive Team
- Director of Nursing

For the levels at which action needs to be taken and what action needs to be taken after a positive test result is received please refer Table below.

Action in Response to Legionella Counts in Hot and Cold Water Systems

Legionella / Litre	Proportion of site/s positive	Action
$< 10^2$	0 – 50%	Maintain normal controls
$<10^2$	> 50%	Review controls, consider additional measures, examine outlets in detail, retest, consider disinfection
10^2 - 10^3	0 – 50%	Review controls, consider additional measures, examine outlets in detail, disinfect system and retest, alert clinicians
10^2 - 10^3	60 – 100%	Review controls, consider additional measures, examine outlets in detail, disinfect system and retest, alert clinicians
$> 10^3$	10 – 20%	Review controls, consider additional measures, strip down all positive outlets replacing synthetic rubber components with new and cleaning and disinfecting the

		other components, disinfection of the system and retest, alert clinicians
> 10^3	> 30%	Evacuate high-risk patients and consider complete closure until problem eliminated. Review controls, consider additional measures, strip down all positive outlets replacing all synthetic rubber components and disinfecting the other components, disinfect the system and retest, alert clinicians

REFERENCES

Standard

Standard 188—Legionellosis: Risk Management for Building Water Systems
(ANSI Approved)
ASHRAE
Published 2015
www.techstreet.com/ashrae/products/1897561

Guidelines

Guideline 12—Minimizing the Risk of Legionellosis Associated with Building Water Systems
ASHRAE
Published 2000
www.techstreet.com/ashrae/products/232891
(currently under revision)

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

Laboratory Resources

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

Centers for Disease Control and Prevention

Legionella Environmental Assessment Form

HOW TO USE THIS FORM

This form enables public health officials to gain a thorough understanding of a facility's water systems and assist facility management with minimizing the risk of legionellosis. It can be used along with epidemiologic information to determine whether to conduct *Legionella* environmental sampling and to develop a sampling plan. The assessment should be performed on-site by an epidemiologist and an environmental health specialist with knowledge of the ecology of *Legionella*. Keep in mind that conditions promoting *Legionella* amplification include water stagnation, warm temperatures (77-108°F or 25-42°C), availability of organic matter, and lack of residual disinfectant such as chlorine. For training and information, please visit CDC's legionellosis resources webpage at: http://www.cdc.gov/legionella/outbreak-toolkit/.

Complete the form in as much detail as possible. Do not leave sections blank; if a question does not apply, write "N/A". If a question applies but cannot be answered, explain why. Where applicable, specify the units of measurement being used (e.g., ppm). Completion of the form may take several hours.

BEFORE ARRIVING ON SITE

- ❒ Request the attendance of the lead facility manager as well as others who have a detailed knowledge of the facility's water systems, such as a facility engineer or industrial hygienist.
- ❒ Request that they have maintenance logs and blueprints available for the meeting.
- ❒ Bring a plastic bottle, thermometer, pH test kit, and a chlorine test kit that can detect a wide range of residual disinfectant (<1 ppm for potable water and up to 10 ppm for whirlpool spas).
- ❒ If the epidemiologic information available suggests a particular source (e.g., whirlpool spa, cooling tower), request that they shut it down (but do not drain or disinfect) in order to stop transmission.

INSTRUCTIONS FOR MEASURING WATER PARAMETERS IN THE PREMISE PLUMBING *(TABLE P. 8)*

It is very important to measure and document the current physical and chemical characteristics of the potable water, as this can help determine whether conditions are likely to support *Legionella* amplification.

STEP 1: Plan a sampling strategy that incorporates all central hot water heaters/boilers and various points along each loop of the potable water system. For example, if the facility has one loop serving all occupant rooms, an occupant room near (proximal) the central hot water heater and another at the farthest point (distal) of the loop should be sampled.

STEP 2: For each sampling point (e.g., tap in an occupant room):

a. Turn on the hot water tap. Collect the first 50 ml from the tap. Measure the free chlorine residual and pH. Document the findings in the table on p. 8. Note: If there is no residual chlorine in the hot water, measure it in the cold water. Note: Total chlorine should be measured instead of free chlorine if the method of disinfection is not chlorine (e.g., monochloramine).

b. Allow the hot water tap to run until it is as hot as it will get. Collect 50 ml and measure the temperature. Document the temperature and the time it took to reach the maximum temperature.

LEGIONELLA ENVIRONMENTAL ASSESSMENT FORM

Persons completing the assessment:

Name: _____ Job Title: _____ Organization: _____

Telephone: _____ E-mail: _____

Name: _____ Job Title: _____ Organization: _____

Telephone: _____ E-mail: _____

Assessment details:

Facility Name: _____ Date of Assessment: _____

Facility Address: _____
street city state zip

Person(s) interviewed during assessment:

Name: _____ Job Title: _____

Name: _____ Job Title: _____

Name: _____ Job Title: _____

Facility Characteristics

1. Is this a healthcare facility or senior living facility with skilled nursing care (e.g., hospital, long term care/rehab/assisted living/skilled nursing facility, or clinic)?
   - ❑ YES ➔ If yes, skip to Q.3 & also complete Appendix A.
   - ❑ NO
2. If NO, indicate type of facility (check all that apply):
   - ❒ Senior living facility (e.g., retirement home without skilled nursing care)
   - ❒ Other residential building (e.g., apartment, condominium)
   - ❒ Hotel, motel, or resort
   - ❒ Recreational facility (e.g., health club, water park)
   - ❒ Office building
   - ❒ Manufacturing facility
   - ❒ Restaurant
   - ❒ Other _____
3. Total number of buildings on campus: _____ Total number of buildings being assessed: _____
4. Total number of rooms that can be occupied overnight (e.g., patient rooms, hotel rooms): _____
5. Does occupancy vary throughout the year? ❑ YES ❑ NO

   If YES, seasons with lowest occupancy (check all that apply):

   ❑ Winter ❑ Spring ❑ Summer ❑ Fall
6. Are any occupant rooms taken out of service during specific parts of the year, e.g., low season?

   ❑ YES ❑ NO

   If YES, which rooms? _____

7. Average length of stay for occupants (check one):

   ❑ 1 night ❑ 2-3 nights ❑ 4-7 nights ❑ >7 nights

8. Does the facility have emergency water systems (e.g., fire sprinklers, safety showers, eye wash stations)?

   ❑ YES ❑ NO

   If YES, are these systems regularly tested (i.e., sprinkler head flow tests)? ❑ YES ❑ NO

   If YES, how often and when was the last test? _____

9. Are there any cooling towers or evaporative condensers on the facility premises?

   ❑ YES ➔ If yes, also complete Appendix B.

   ❑ NO

10. Are there any whirlpool spas, hot tubs, or hydrotherapy spas on the facility premises?

    ❑ YES ➔ If yes, also complete Appendix C.

    ❑ NO

11. Are there any decorative fountains, misters, water features, etc. on the facility premises?

    ❑ YES ➔ If yes, also complete Section D.

    ❑ NO

12. Does the facility have centralized humidification (e.g., on air-handling units) or any room humidifiers?

    ❑ YES ❑ NO

    If YES, describe their location and operation: _____

    _____

    _____

13. Has there been any recent (last 6 months) or ongoing major construction on or around the facility premises?

    ❑ YES ➔ If yes, also complete Appendix E.

    ❑ NO

14. Has this facility been associated with a previous legionellosis cluster or outbreak?

    ❑ YES ❑ NO

    If YES, please describe number of cases, dates, source if found, and any interventions (immediate and long-term) to prevent recurrence: _____

    _____

    _____

15. Does the facility have a water safety plan or *Legionella* prevention program?

    ❑ YES ❑ NO

    If YES, does the facility ever test for *Legionella* in water samples?

    ❑ YES ➔ If yes, obtain copies of results ❑ NO

    If YES, please describe the plan briefly here (does it include clinical disease surveillance and/or environmental *Legionella* surveillance?) and **obtain a written copy** of the program policy:

    _____

    _____

    _____

    _____

16. Describe each building that shares water or air systems, including the main facility

Building Name (List main facility building first)	**Original Construction** Year Completed	**Later Construction** (renovation, expansion) From/To or "N/A"	**Stories or Levels** # Rate (%) or "N/A"	**Occupancy rate** (%)* Rate (%) or "N/A"	**Daily Census** (yr. avg.) #/day or "N/A"	**Use** (List all types of uses) e.g., occupant rooms, utilities, heating/AC plant For healthcare, specify: Outpatient = O Inpatient (acute) = I Chronic = C Intensive care = ICU Transplant = Tx
1.						
2.						
3.						
4.						
5.						
6.						
7.						

*[occupancy rate = (# of rooms occupied overnight / total # of rooms) X 100]

Water Supply Source

17. What is the source of the water used by the facility? (Check all that apply)

- ❑ **Municipal water** if YES:
  - Name of supplier _____
  - How is the municipal water disinfected? (Check one) ❑ Chlorine ❑ Monochloramine ❑ Other _____
  - Has treatment of municipal water changed in the past year? ❑ YES ❑ NO
    - If YES, specify _____
- ❑ **Non-municipal well** if YES:
  - How is the well water disinfected? (Check one) ❑ Chlorine ❑ Other _____ ❑ Not disinfected
  - Is the water filtered onsite? ❑ YES ❑ NO
- ❑ **Other** _____

18. Have there been any pressure drops, boil water advisories, or water disruptions (e.g., water main break) to the facility in the past 6 months? ❑ YES ❑ NO

If YES, describe what happened and which buildings or parts of buildings were affected: _____

_____

_____

19. Does the facility monitor incoming water parameters (e.g., residual disinfectant, temperature, pH)?

❑ YES ➔ If yes, obtain copies of the logs ❑ NO

If YES, what is the range of disinfectant residual, temperature, and pH entering the facility? _____

_____

Premise Plumbing System

Note: It is important to gain an understanding of where and how water flows, starting where it enters the facility and including its distribution to and through buildings to the points of use. Understand water processes, including but not limited to: heating, storage, filtration, UV irradiation, and addition of secondary disinfectants. Refer to a facility map and blueprints; *obtain copies of these and/or draw a diagram* and include with the completed assessment.

20. Are cisterns and/or water storage holding tanks used to store potable water before it's heated?

❑ YES ❑ NO

21. Is there a recirculation system (a system in which water flows continuously through the piping to ensure constant hot water to all endpoints) for the hot water?

❑ YES ❑ NO

If YES, please describe where it runs and delivery/return temperatures if they are measured: _____

_____

_____

22. Are thermostatic mixing valves used?

❑ YES ❑ NO

If YES, describe where they are located (ideally, mixing valves are close to the point of use): _____

_____

_____

23. How is the hot water system configured to deliver hot water to each building?

Building name	**Type of system** (e.g., instantaneous heater, hot water heater with a storage tank, solar heating)	**Name of system** (e.g., Boiler #1, Loop #1)	**Areas served** (e.g., floor, rooms)	**Date of installation**	**Total capacity** (gallons)	**Usual temperature setting** (°F)
1.						
2.						
3.						
4.						
5.						
6.						
7.						

Comments/notes: _____

_____

_____

24. What is the maximum **hot** water temperature at the point of delivery permitted by state / local regulations?

_____ °F or _____ °C

25. Are **hot** water temperatures ever measured by the facility at the points of use?

❑ YES ➔ If yes, obtain copies of the temperature logs

If YES, what is the **lowest** documented **hot** water temperature measured at any point within the facility?

_____ °F or _____ °C documented on (Month/Date/Year) _____/_____/_____

❑ NO

26. Are **cold** water temperatures ever measured by the facility at the points of use?

❑ YES ➔ If yes, obtain copies of the temperature logs

If YES, what is the **highest** documented **cold** water temperature measured at any point within the facility?

_____ °F or _____ °C documented on (Month/Date/Year) _____/_____/_____

❑ NO

27. Are the potable water disinfectant levels (e.g., chlorine) ever measured by the facility at the points of use?

❑ YES ➔ If yes, obtain copies of the logs

If YES, how often are they measured? _____

If YES, list the range of disinfectant residuals _____

❑ NO

28. Does the facility have a supplemental disinfection system for long term control of *Legionella* or other microorganisms?

❑ YES ❑ NO

If YES, obtain SOPs for routine use and maintenance as well as maintenance logs and records of disinfection levels, and complete the table:

Buildings with supplemental disinfection	**Type of system** (e.g., chlorine, chlorine dioxide, copper-silver)	**Date installed**	**Describe any maintenance in the past year** (include routine and emergency)

Comments/Notes: _____

_____

_____

_____

29. Please describe any maintenance (either routine or emergency) carried out on the potable water system in the past year. Obtain records/SOPs if available. _____

_____

_____

_____

30. Measured Water System Parameters (see instructions on p. 1)

Copy from table for question 23 (p. 6)		Part of system (Central heater/ boiler=C Proximal occupant room=P Distal occupant room=D)	Sampling site (e.g., heater #1, hot water tap in room #436)	Free chlorine (ppm)	pH	Maximum measured temperature (°F)	Time to reach max temp (min)
Building name	Name of system (e.g., incoming water, Boiler #1, Loop #1)						

APPENDIX A. HEALTHCARE FACILITIES

Note: Complete for all healthcare facilities, including but not limited to hospitals, long term care/rehab/assisted living/skilled nursing facilities, or clinics.

1. Type of healthcare facility (check all that apply):
   - ❒ Acute care hospital

     If YES, does the facility have a solid organ or bone marrow transplant program?

     ❑ YES ❑ NO
   - ❒ Long term care facility (i.e., nursing home, long term acute care)
   - ❒ Rehabilitation facility or other skilled nursing care
   - ❒ Assisted living facility
   - ❒ Outpatient surgical center
   - ❒ Other outpatient clinic (describe): _____
   - ❒ Other healthcare facility (describe): _____
2. Number of beds: _____
3. Are ice machines used to provide ice for patient consumption or processing medical equipment?

   ❑ YES ❑ NO

   If YES, list manufacturer and model or catalog number: _____
4. Has this facility experienced previous Legionnaires' disease cases that were "possibly" or "definitely" facility-acquired?

   ❑ YES ❑ NO

   If YES, describe (e.g., number of cases, dates): _____

   _____

   _____

   _____

APPENDIX B. COOLING TOWERS AND EVAPORATIVE CONDENSERS

Note: It is important to gain an understanding of where the cooling towers are located, how they work, and how they are maintained. Cooling towers are frequently maintained by an outside contractor, and you may need to contact them directly if facility management does not have an in-depth knowledge of these systems. Request copies of the maintenance logs.

1. List all cooling towers and evaporative condensers on the facility premises:

Name of device (e.g., CT1)	Date Installed	Manufacturer	Location of device	Distance to nearest air intake*/location of the air intake/ passive or forced	Drift eliminators used? (Y/N)	Party responsible for maintenance

*intakes to air handling units (AHUs)

2. List details of how each cooling tower is chemically disinfected:

Name of device from Table 1 (e.g., CT1)	List type/name of bactericide(s) used	Range in which the bactericide(s) is regularly maintained (e.g., 5–10 ppm)	Schedule and method of adding bactericide (e.g., daily, weekly, as needed, automatic, by hand)	Are cooling towers turned off at any time? (e.g., seasonally) (Y/N) If yes, include schedule

3. List recent (last 6 months) special (non-routine) treatments, maintenance, or repairs to cooling devices:

Name of device from Table 1 (e.g., CT1)	Action taken	Date	Comments

4. Does the cooling tower water come from a branch of the potable water system inside the facility?

❑ YES ❑ NO

If YES, are backflow prevention devices in place to ensure cooling tower water is not introduced into the potable water system?

❑ YES ❑ NO

If NO, what is the source of water for the cooling towers and evaporative condensers? _____

_____

_____

_____

5. Can any windows in any occupant rooms or common areas be opened? ❑ YES ❑ NO

If YES, describe which rooms or which buildings have windows that can be opened: _____

_____

_____

_____

APPENDIX C. WHIRLPOOL SPAS, HOT TUBS, AND HYDROTHERAPY SPAS

Note: Do NOT complete Appendix C for Jacuzzis or whirlpool baths that are filled from the tap and drained after each use. In many jurisdictions, whirlpool spas are publicly permitted and inspected by the local health authority. An environmental health specialist with expertise in pool and spa inspection should participate in assessment of spas and will be aware of local regulations and enforcement powers, as well as have access to a pool sampling kit. Request copies of the last inspection report as well as routine maintenance logs.

1. Who performs the spa maintenance (e.g., on-site facilities management, name of outside contractor)? _____
2. Describe each whirlpool spa and how it is disinfected:

Spa Questions	Spa Descriptor/Location (e.g., main pool, private room #)			
Indoor or outdoor?				
Max. bather load				
Filter type S = sand DE = diatomaceous earth, C = cartridge				
Date filter was last changed				
Date of last filter backwash				
Compensation tank present?				
Type of disinfectant used (include chemical name, formulation, and amount used)				
Current measured disinfectant level (e.g., free chlorine, bromine) (ppm)				
Current measured pH				
Method used for adding disinfectant (e.g., automatic feeder, by hand)				
Method used for monitoring and maintaining disinfectant and pH levels (e.g., automatic controllers)				
Date last drained and scrubbed				
Was there a recent disinfectant "shock" treatment?				
Operating as designed and in good repair? **If no, describe issues.**				

APPENDIX D. OTHER WATER FEATURES

Note: Complete for decorative fountains, water walls, recreational misters, etc. This can also be modified for industrial use water. If SOPs and/or maintenance logs exist, request copies.

Water Feature Questions	Water Feature Descriptor/Location (e.g., lobby fountain, cabana misters)			
Indoor or outdoor?				
Source of water				
Operates continuously (C) or intermittently (I)				
Presence of a heat source? (e.g., incandescent lighting)				
Type of disinfectant used (include chemical name, formulation, and amount used)				
Current measured disinfectant level (e.g., free chlorine, bromine) (ppm)				
Current measured pH				
Is there a maintenance protocol?				
Date last cleaned				
Operating as designed and in good repair? **If no, describe issues.**				

APPENDIX E. RECENT OR ONGOING MAJOR CONSTRUCTION

1. Describe in general the extent of the construction: _____

   _____

   _____

   _____

2. Was temporary water service provided to the new construction area (i.e., separate meter)?

   ❑ YES ❑ NO

   If YES, describe: _____

   _____

3. Has jack-hammering or pile-driving been used during the construction process?

   ❑ YES ❑ NO

   If YES, list dates and locations: _____

   _____

4. Have there been disruptions or changes to the existing potable water system during the construction?

   ❑ YES ❑ NO

   If YES, describe: _____

   _____

5. Has the potable water changed in terms of taste or color during the construction process?

   ❑ YES ❑ NO

   If YES, describe the changes including when they started and ended: _____

   _____

6. Is there a standard operating procedure (SOP) for shutting down, isolating, and refilling/flushing for water service areas that have been subjected to repair and/or construction interruptions?

   ❑ YES ❑ NO

   If YES, briefly describe the steps used in the SOP (attach a copy if possible): _____

   _____

7. Was the potable water system flushed before occupying the new building space?

   ❑ YES ❑ NO

   If YES, what period of time passed between flushing and when the building was occupied? _____

   _____

8. Complete table on next page.

8. Complete the table below:

New Building/Wing Name or Remodeled Area	Date construction began	Estimated date of completion	Date water service began or restarted*	Relationship to existing potable water system Independent=I Extension of existing system=E	Stories and Square Feet Involved (# and Ft^2)	Uses (e.g., rooms, dining, recreation, utilities) For healthcare: Inpatient = I Outpatient = O Both = B Intensive Care = ICU Transplant = Tx	Date occupants began occupying new or remodeled building	Floors currently occupied

*If remodeling of existing structure, include water shut-down date and re-start date.

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Control #	Rev.	Title	Effective Date: 9/2017
CRR .014	03/2019	**Risk Management and Reporting Serious Incidents**	**Next Review Date:** 03/2021

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~~4.13.3 ~~-~~Nevada Revised Statue (NRS) 618.378.

~~4.13.5~~4.13.4 NRS 439.835

~~4.13.6~~4.13.5 HPP – 0020 Division Criminal Reporting Policy

4.13.6 DPBH Policy A 4.0 Emergency Notification

4.13.7 NRS 200.50935 Report of abuse, neglect, exploitation, isolation or abandonment of vulnerable person; voluntary and mandatory reports; investigation; penalty.

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~~4.13.7~~ NRS 433.5483 Use of Aversive Intervention

5.0 DEFINITIONS:

5.1 Avatar Incident Tracking Module (AITM)

~~5.1~~5.2 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 incidents is an are incidents that represents risk at the agency Level and do not have implications at a requiring higher level . Thesereporting 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 iares a serious incidents that may represent a high risk to the safety of consumers or staff or liability to the State including:.

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

5.2.2.2 Level II incidents Such incidents are reported to the DPBH 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.

5.2.3.1 Reportable Critical Incidents are dDefined 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.;

5.2.4 NRS 200.5092 Section 6: Older person" means a person who is 60 years of age or older.

5.2.5 NRS 200.5092 Section 8 "Vulnerable person" means a person 18 years of age or older who:

(a) Suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or

(b) Has one or more physical or mental limitations that restrict the ability of the person to perform the normal activities of daily living.

(Added to NRS by 1981, 1334; A 1983, 1359, 1652; 1995, 2250; 1997, 1348; 1999, 3517; 2003, 491; 2005, 1108; 2015, 804)

5.2.6 Mandated Reporter is a person required by law to report when they have reasonable cause to believe that a vulnerable person or a person 60 years of age or older is being abused, neglected or exploited.

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5.2.7 NRS 433.546 Corporal Punishment means the intentional infliction of physical pain, including without limitation, hitting, pinching or striking.

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5.2.8 NRS 433.5453 **Aversive intervention" defined.** "Aversive intervention" means any of the following actions if the action is used to punish a person with a disability or to eliminate, reduce or discourage maladaptive behavior of a person with a disability:

1. The use of noxious odors and tastes;
2. The use of water and other mists or sprays;
3. The use of blasts of air;
4. The use of corporal punishment;
5. The use of verbal and mental abuse;
6. The use of electric shock;
7. Requiring a person to perform exercise under forced conditions if the:

(a) Person is required to perform the exercise because the person exhibited a behavior that is related to his or her disability;
(b) Exercise is harmful to the health of the person because of his or her disability; or
(c) Nature of the person's disability prevents the person from engaging in the exercise;

8. Any intervention, technique or procedure that deprives a person of the use of one or more of his or her senses, regardless of the length of the deprivation, including, without limitation, the use of sensory screens; or
9. The deprivation of necessities needed to sustain the health of a person, regardless of the length of the deprivation, including, without limitation, the denial or unreasonable delay in the provision of:

(a) Food or liquid at a time when it is customarily served; or
(b) Medication.

(Added to NRS by 1999, 3229)

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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.

6.2.2 Progress notes must not include reference to the submission of a Serious Incident Report.

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

6.3 An Incident is categorized as Level I or Level II by the Agency Manager or designee and will be entered in the Avatar Incident Tracking Module accordingly.

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~~6.2.3~~

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

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

6.5.2 The SIR does not substitute for or relieve an employee of Mandated Reporter requirements.

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

~~6.7~~6.6 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~~6.7 Process for reporting Serious Incident events will be by using the Avatar~~VATAR~~ Incident Tracking Module (AITM).

6.7.1 All Serious Incident events will be reported by using AITM to include the designated reporting category.

~~6.8.1~~6.7.2 A detailed description of the event, including the names of witnesses, will be ~~entered into~~entered AITM no later than the end of the first working day after the incident occurs. ~~Recommend 48-72 hours~~.

~~6.8.2~~6.7.3 All follow-up notations, addendums and requests for closure will be completed in AITM.

~~6.8.3~~6.7.4 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 Avatar Incident Notes/ ~~SIR Investigations email account.~~

~~6.8.4~~6.7.5 All Serious Incident Events that are non-patient related (involving employees and/or non-patient person(s) (i.e. visitors, venders)) will be

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addressed by following proper risk management protocol and reported to direct supervisors or onsite program managers as soon as possible

~~6.9~~6.8 All DPBH Community Providers (~~SLAs~~CBLAs, group homes, etc.) will be required to report incidents within one (1) hour of their discovery to their state contracting agency.

~~6.10~~6.9 DPBH agencies will ensure that agency protocol and employee training for reporting SIRs are aligned.

~~6.11~~6.10 DPBH agencies will train all staff on the reporting and completion of SIR protocols.

~~6.12~~6.11 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~~6.12 Follow up reports of serious incidents are due within ten (10) days of the initial report using AITM

~~6.14~~6.13 Incidents are categorized as either Level I, Level II or Critical ~~Agency or Division~~. The determination regarding a~~n~~ incident is made by the Agency Director or their designee using the criteria provided in Attachment A.

~~6.15~~6.14 All work-related fatalities, and all work-related inpatient hospitalizations, all amputations and all losses of an eye within 24 hours, per "Employer Responsibilities" must be reported to the Occupational Safety and Health Administration. United States Department of Labor

~~6.16~~6.15 In the event of a non-patient, non-fatal employee injury or accident, employees and supervisor~~s~~ (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~~6.16 Procedures regarding types of incidents:

~~6.17.1~~6.16.1 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 Event and handled in accordance with CRR 1.13 Sentinel 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~~6.16.2 Death of a person currently open to community-based services or discharged from an inpatient facility ~~-~~within the last 30 days will be reported to Division Administration as an SIR.

~~6.17.3~~6.16.3 Reports of deaths also require the completion of additional questions regarding a death. Follow-up information is due within 30 days of the initial

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SIR report. ~~Refer to policy #A 5.2 Review of Clients Death for Mental Health Agencies.~~

6.16.4 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 (3) or more employees must be reported by the employer verbally~~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.

~~6.17.4~~ 6.16.4.1 The ~~appropriate~~ Agency Manager~~Director~~ or their designee will notify OSHA within eight (8) hours of.

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~~6.17.5~~6.16.5 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.

6.16.6 Agency Managers~~Director~~s 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.

~~6.17.6~~ 6.16.6.1 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.

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6.16.7 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.

~~6.17.7~~ 6.17.7.1 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.

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6.16.8 In the event of theft of State property, law enforcement must be notified immediately.

6.16.8.1 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.

~~6.17.8~~ 6.16.8.2 The DPBH HIPAA and Agency HIPAA Privacy officers must be notified.

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~~6.18~~6.17 Timeframes for Notification to Division of Level II Required Documentation

~~6.18.1~~6.17.1 Verbal Notification - Deaths (including suicide and homicide) occurring in a Division facility or Division-contracted 24-hour care

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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~~6.17.2 Avatar Inputting – Any patient serious incidents will be entered in Avatar within one (1) working day of the discovery of the serious incident. ~~Recommend 48–72 hours~~

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~~6.18.3~~6.17.3 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~~6.17.4 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 (1) 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

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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~~6.18 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 A 4.0 DPBH Emergency Communication DHHS Director's Office Critical Incident Report Form Attachment A

7.2 ~~CRR .014 Risk ManagmentManagement and Reporting Serious Incidents Attachment A~~B

EFFECTIVE DATE: 09/2017
DATE APPROVED BY DPBH ADMINISTRATOR: 09/2017, 11/18, 03/2019
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 09/2017, 11/18, 03/2019

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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

UPDATED

Control #	Rev. Date:	Title:	Effective Date: 7/1998
CRR 1.2	3/2019	PROHIBITION OF ABUSE OR NEGLECT OF CONSUMERS AND REPORTING REQUIREMENTS	Next Review Date: 3/2021

1.0 POLICY:

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

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

2.0 PURPOSE:

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

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

4.0 DEFINITIONS:

4.1 Mandated Reporter is a person required by law to report when they have reasonable cause to believe that a vulnerable person or a person 60 years of age or older is being abused, neglected or exploited.

4.2 Older Person NRS 200.5092 Section 6: Older person" means a person who is 60 years of age or older.

4.3 Vulnerable person NRS 200.5092 Section 8 "Vulnerable person" means a person 18 years of age or older who: (a) Suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or (b) Has one or more physical or mental limitations that restrict the ability of the person to perform the normal activities of daily living. (Added to NRS by 1981, 1334; A 1983, 1359, 1652; 1995, 2250; 1997, 1348; 1999, 3517; 2003, 491; 2005, 1108; 2015, 804)

4.4 NRS 433.546 Corporal Punishment means the intentional infliction of physical pain, including without limitation, hitting, pinching or striking.

4.5 NRS 433.5453 Aversive intervention" defined. "Aversive intervention" means any of the following actions if the action is used to punish a person with a disability or to eliminate, reduce or discourage maladaptive behavior of a person with a disability:

1. The use of noxious odors and tastes;

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2. The use of water and other mists or sprays;
3. The use of blasts of air;
4. The use of corporal punishment;
5. The use of verbal and mental abuse;
6. The use of electric shock;
7. Requiring a person to perform exercise under forced conditions if the:
(a) Person is required to perform the exercise because the person exhibited a behavior that is related to his or her disability;
(b) Exercise is harmful to the health of the person because of his or her disability; or
(c) Nature of the person's disability prevents the person from engaging in the exercise;
8. Any intervention, technique or procedure that deprives a person of the use of one or more of his or her senses, regardless of the length of the deprivation, including, without limitation, the use of sensory screens; or
9. The deprivation of necessities needed to sustain the health of a person, regardless of the length of the deprivation, including, without limitation, the denial or unreasonable delay in the provision of:
(a) Food or liquid at a time when it is customarily served; or
(b) Medication.

(Added to NRS by 1999, 3229)

~~4.1~~4.5 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~~4.5.1 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~~4.5.2 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~~4.5.3 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,

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mocking, swearing, ridiculing, yelling, or using words or gestures that frighten, humiliate, intimidate, threaten or insult the person.

~~4.1.4~~4.5.4 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.

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~~4.1.5~~4.5.5 Excessive Force: The use of excessive force when placing a consumer in physical restraints or in seclusion.

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~~4.1.6~~4.5.6 Restraint: The use of physical, chemical or mechanical restraints or use of seclusion in violation of state and/or federal law.

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~~4.1.7~~4.5.7 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.

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~~4.2~~4.6 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:

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~~4.2.1~~4.6.1 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.

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UPDATED

Control #	Rev. Date:	Title:	Effective Date: 7/1998
CRR 1.2	3/2019	PROHIBITION OF ABUSE OR NEGLECT OF CONSUMERS AND REPORTING REQUIREMENTS	Next Review Date: 3/2021

~~4.3~~4.7 Staff: is any Division of DPBH or contract service provider staff, employee, or volunteer, unless stated otherwise.

~~4.4~~4.8 Supervisor: is any Division of DPBH or contract service provider supervisor, unless stated otherwise.

5.0 REFERERNCES

~~5.1~~ Nevada Revised Statues (NRS): 200.5093, 433.464; 433.482; 433.484; 433.504; 433.524;

5.1 ~~433~~.554; 443A.360; 433A.460; 435.340;

5.2 ~~5.2~~ Division Policy #4.037, Professional Behavior of Division Employees.

5.3 DPBH Policy CRR.014 Risk Management and Reporting of Serious Incidents

6.0 PROCEDURE:

6.1 The Division of DPBH strictly prohibits abuse and neglect.

6.2 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.

6.3 Should an 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.

6.4 DPBH and contract staff shall receive training about abuse and neglect of consumers

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

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

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

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

6.5 All allegations of abuse and/or neglect shall be reported by following the requirements below, which will be repeated in Policy CRR1.4, Reporting Serious Incidents and Denials of Rights:

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

6.5.1.1 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;

6.5.2 The supervisor on receiving a report will:

6.5.2.1 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;

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

6.5.2.3 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

6.5.2.4 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).

6.5.2.5 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;

6.5.2.6 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

6.5.2.7 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.

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

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

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

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

6.5.3.4 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.

6.6 Reporting abuse and/or neglect is absolutely required.

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

6.6.2 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.

7.0 ATTACHMENTS:

7.1 A 4.0 DPBH Emergency Communication DHHS Director's Office Critical Incident Report Form Attachment 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: 07/17/98
REVIEWED / REVISED DATE: 02/99; 07/01; 03/05; 05/07; 09/10; 03/19
SUPERSEDES: Policy #2.003 Abuse or Neglect of Clients
APPROVED BY DPBH ADMINISTRATOR: 08/06/10, 03/19
APPROVED BY DPBH COMMISSION: 09/10; 3/2017; 03/19

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

CLINICAL SERVICES

TWO YEAR REVIEW – WITH CHANGES

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Control #	~~Rev.~~ Date:	Title:	Effective Date: 5/2017
CRR 1.3	5/2017	Seclusion/Restraint of Consumers	Next Review Date 5/2019

1.0 POLICY:

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

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

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

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

2.0 PURPOSE:

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

3.0 SCOPE:

Division of Public and Behavioral Health, Clinical Services Branch Agencies ~~agencies.~~

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4.0 DEFINITIONS:

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

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

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

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

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

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

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

4.2.3.1 CMS CoP 42 CFR 482.13 defines chemical restraint as a drug or medication when it is used as a restriction to manage the patient/client's behavior or restrict the patient/client's freedom of movement and is not a standard treatment or dosage for the patient/client's condition. Drugs that are used as part of a patient/client's standard medical or psychiatric treatment and are administered within the standard dosage for the patient/client's condition is not considered a chemical restraint.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.3 Philosophy of Care:

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

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

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

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

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

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

treatment or preventative interventions that would be most helpful and least traumatic for the client.

4.3.7 Use of the treatment plan and its components as a specific intervention tool. Treatment plans shall address client strengths, gender issues, history of trauma, age, and culture issues as well as staff and the client's identified alternatives to use in times of conflict, symptom escalation, and behavioral escalation.

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

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

4.3.10 Continuous performance improvement monitoring activities throughout the organization.

~~**4.44.3 Staff Training:**~~

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

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

~~**4.4.34.3.3** Training shall include:~~

~~**4.4.3.14.3.3.1** Division and Agency philosophy regarding restraint/seclusion;~~

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

~~**4.4.3.3** Emphasis on client safety during restraint/seclusion; and~~

~~**4.4.3.44.4.3.3** Development of skills and abilities to assess risk and trauma.~~

~~**4.4.44.4.3** Per NRS 433.5499, the mechanical restraint is applied by a member of the staff of the facility who is trained and qualified to apply mechanical restraint. Employees may not participate in physical or mechanical restraints of clients served without approved agency training.~~

~~**4.4.54.4.3** Retraining, recertification, and demonstration of competency must occur within timeframes established in Policy HR-2.5 CPART.~~

~~4.4.64.4.3 Staff who implement restraint must have current certification in a Division approved program which emphasizes prevention strategies.~~

~~4.4.6.34.4.3.3 Training shall include:~~

~~4.4.6.3.14.4.3.3.1 Best practices and philosophy of the use of seclusion and restraint;~~

~~4.4.6.3.24.4.3.3.1 Prevention strategies that focus on assisting clients to maintain~~

~~4.4.6.3.34.4.3.3.1 Emphasis on safety during restraint/seclusion;~~

~~4.4.6.3.44.4.3.3.1 Development of skills and abilities to assess risk and trauma; and~~

~~4.4.6.3.54.4.3.3.1 Training in the specific restraint(s) and de-escalation techniques.~~

~~4.54.4 Continuous Improvement Monitoring:~~

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

~~4.5.24.5.1 For inpatient/forensic facilities, the Agency Director and Medical Director are responsible for insuring that ongoing monitoring is maintained for clients placed in seclusion or restraints and documented accordingly.~~

5.0 REFERENCES

5.1 NRS 449A.242

6.0 RESTRAINT/SECLUSION

6.1 FOR NON – FORENSIC PSYCHIATRIC HOSPITALS.

6.1.1 Standards for Seclusion and Restraint:

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

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

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

~~6.1.1.1.2~~6.1.1.1.3 De-Escalation: The first attempts to avoid seclusion/restraint will focus on de-escalating the client.

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~~6.1.1.1.3~~6.1.1.1.4 Physicians who order these interventions shall be ~~specially~~ CPI trained and qualified to assess and monitor the client's safety and the significant medical and behavioral risk inherent in the interventions;

~~6.1.1.1.4~~6.1.1.1.5 Only agency approved crisis intervention ~~competent,~~ trained staff that have been credentialed or certified to perform these interventions will participate in implementation;

~~6.1.1.1.5~~6.1.1.1.6 The least restrictive restraint and/or seclusion method that is safe and effective will be administered;

~~6.1.1.1.6~~6.1.1.1.7 Clients placed in seclusion or restraint will be appropriately communicated with verbally and monitored at a minimum of required intervals;

6.1.1.1.8 A medical order authorizing the use of mechanical restraint is obtained for the medical staff before the application of restraint but not more than 15 minutes after the application of mechanical restraint. (NRS 449A.242)

6.1.1.1.9 Medical Staff who authorized the order must examine the patient not later than one (1) working day after the application of mechanical restraint.

~~6.1.1.1.7~~6.1.1.1.10 All seclusion or restraint orders will be limited to a specific ~~period of time~~period; however, interventions will be ended as soon as it becomes safe to do so, even if the time-limited order has not expired; and

~~6.1.1.1.8~~6.1.1.1.11 Clients who have been secluded or restrained, staff that have participated in these interventions, and appropriate other persons will participate in debriefings ~~in order to~~to review the episode and to plan for earlier.

~~6.1.1.1.9~~6.1.1.1.12 Notification: Upon admission, the service recipient and, with the service recipient's consent, their family/legal guardian shall be informed of the policies and procedures regarding the use of seclusion and restraint.

~~6.1.1.1.9.1~~6.1.1.1.12.1 With the service recipient's consent, as documented in the medical record, designated family members / legal guardians shall be informed of their opportunity to be notified of each occurrence of

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seclusion or restraint within the timeframe agreed to by the family and to participate in the client's debriefing as appropriate.

~~6.1.1.1.9.2~~6.1.1.1.12.2 If there is no family member/legal guardian available, upon consent of the service recipient, the office of Nevada Disability Advocacy & Law Center (NDALC) may be used.

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

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

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

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

~~**6.2.3**~~ 6.2.3.1 The client's face will always be maintained in view of staff to assure immediate identification of physical distress such as pain or breathing difficulties.

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

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

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

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

~~**6.2.7**~~

6.2.8 Any concerns will be referred to the physician by the registered nurse.

6.2.9 Staff will offer fluids, toileting and comfort measures every fifteen (15) minutes. Meals and snacks will be offered at regular times.

~~**6.2.9**~~ 6.2.10.1 Staff will assist the client with hand washing after toileting and before meals. Any exception to the above procedures must be clinically justified and noted in the medical record.

6.2.10 Range of motion and movement of limbs will be provided for at least ten (10) minutes at least every ~~two (2)~~ one (1) hour~~s~~.

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6.2.11 6.2.10.1 The client in mechanical restraint will be given the opportunity to move and exercise the parts of their body that are restrained at least 10 minutes per every 60 minutes of restraint. NRS 449A.242 This activity will be documented ~~Relief from mechanical restraint will occur as long as it is deemed to be safe.~~ 6.2.10.2 If client has not regained sufficient control to be considered safe, medical staff must be notified and this must be documented in the progress note.

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

6.2.10.4 A member of the staff of the facility lessens or discontinues the restraint every 15 minutes to determine whether the patient will stop or control his or her inappropriate behavior without the use of the restraint;

6.2.10.4.1 The record of the patient contains a notation that includes the time of day that the restraint was lessened or discontinued and the response of the patient and the response of the member of the staff who applied the mechanical restraint;

~~**6.2.10**~~

~~**6.2.11**~~**6.2.12** The seclusion and/or restraint will be terminated when the behaviors that necessitated the seclusion and/or restraint order are no longer in evidence and the behavioral release criteria are attained.

~~**6.2.12**~~**6.2.13** If the client is falling asleep or falls asleep, an immediate assessment of the client and the release criteria will be made. Clients who are sleeping in seclusion and/or restraint must be evaluated and removed from seclusion and/or restraint if they meet release criteria. A sleeping client continues to require face to face monitoring while in seclusion or restraint.

~~**6.2.13**~~**6.2.14** In any emergency requiring unit evacuation (including drills), the client shall be removed from seclusion and/or restraint, and staff will stay with the client on a minimum of 1:1 basis.

~~**6.2.14**~~**6.2.15** Precautions shall be taken to assure the protection of the client in restraints from being mistreated or harmed by other persons.

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

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

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

6.3.2.1 Client's verbalization of feelings;

6.3.2.2 Verbal reassurance/redirection given to client;

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6.3.2.3 1:1 interaction for the client with staff;

6.3.2.4 Reduction in stimuli;

6.3.2.5 Environmental changes for the client;

6.3.2.6 Limit setting;

6.3.2.7 Time Out offered to the client;

6.3.2.8 Medication offered to the client;

6.3.2.9 Antecedent behaviors or events which triggered the escalation;

6.3.2.10 Determining the point of conflict and deciding why the person cannot "win" or get his/her way.

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

6.4.1 Order to seclude and/or restrain:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.4.1.10.5 A description of interventions implemented to assist the client in marketing the release criteria.

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

6.4.1.11 Continuation of seclusion/restraint is determined by need:

6.4.1.11.1 The client must be continuously assessed monitored and re-evaluated as to the need for seclusion and/or restraint. This review and assessment will occur and be documented within one (1) hour following the initiation of seclusion and/or restraint and follow every two (2) hours, as well as any time there is a change in the client's physical status and at shift change by the RN

coming on duty. Each agency policy and procedures shall include the necessary factors to assess.

6.5 Release conditions for seclusion or restraint: Release criteria includes that the Client is no longer a danger to self or others, ~~person must be able to demonstrate calm behavior(s) and/or be able to state that they are calm.~~

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

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

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

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

6.9 Client and Staff Debriefing:

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

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

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

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

~~**6.10.1**~~ 6.10.1.1 For episodes in excess of twelve (12) hours, daily administrative review and clinical rationale to continue seclusion and/or restraint

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shall be provided by a non-treating psychiatrist or designee of the Medical Director.

6.10.2 Within 48 hours, a formal Ii~~i~~nterdisciplinary Treatment Plan Review will be held for all clients placed in seclusion or restraints. This shall be documented in the medical record.

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

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

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

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

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

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

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

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

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

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

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

6.12 RESTRAINT/SECLUSION PROCEDURES FOR FORENSIC PSYCHIATRIC HOPITALS: Restraints will be utilized under the same guidelines as non-forensic hospitals except for the utilization of safety searches when clinical indicated.

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

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

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

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

6.13 Physical/Mechanical Restraints:

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

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

6.14 Procedures to be followed during implementation:

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

6.14.2 Seclusion or restraint will be initiated only in identified emergency situations; Physicians who order these interventions shall be CPI specially trained and qualified to assess and monitor the client's safety and the significant medical and behavioral risk inherent in the interventions; privileged psychiatrist meet this criteriathis criterion.

6.14.3 A medical order authorizing the use of mechanical restraint is obtained for the medical staff before the application of restraint but not more than 15 minutes after the application of mechanical restraint. (NRS 449A.242)

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6.14.4 Medical Staff who authorized the order must examine the patient not later than one (1) working day after the application of mechanical restraint

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

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

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

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

6.15 Documentation:

6.15.1 Forensic staff, Nursing, and Physicians shall document seclusion and/or restraint according to agency policy and procedures.

6.5.1.2 Administrative documentation will be accomplished according to policy and procedures by the Agency Director, the Treatment Team Leader, the Clinical Coordinator, and the Medical Director.

6.16 Debriefing/Notifications:

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

6.16.1.1 Debriefing serves the purpose of allowing staff and clients to plan to avoid future events and trauma.

6.16.1.2 Debriefing will occur as soon as appropriate and possible, but no longer than one (1) business day following the incident.

6.16.1.3 If the client declines to participate in the debriefing, this will be documented in the medical record.

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6.16.1.4 Debriefing with the treatment team leader, or designee, will occur no more than one (1) business day following the event.

6.16.1.5 DPBH forensic hospitals shall develop and implement procedures to implement the provisions of this policy and to meet the requirements of state law with respect to seclusion and restraint of clients.

6.17 PROCEDURE:

6.17.1 Restraint: If restraint is used:

6.17.1.1 ~~**6.17.1.1**~~ Restraint shall be implemented in a manner designed to protect the client's safety, dignity and emotional well-being.

6.17.2 The client in mechanical restraint will be given the opportunity to move and exercise the parts of their body that are restrained at least 10 minutes per every 60 minutes of restraint. NRS 449A.242 This activity will be documented

6.17.2.1 If client has not regained sufficient control to be considered safe, medical staff must be notified and this must be documented in the progress note.

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

6.17.2.3 A member of the staff of the facility lessens or discontinues the restraint every 15 minutes to determine whether the patient will stop or control his or her inappropriate behavior without the use of the restraint;

6.17.2.3.1 The record of the patient contains documentation that includes the time of day that the restraint was lessened or discontinued, the response of the patient and the response of the member of the staff who applied the mechanical restraint;

6.17.2.1 ~~6.17.1.1.1~~ Restraint procedures must provide only the minimum amount of restriction necessary as a protective measure and shall only be applied until the client no longer poses a danger to self or others.

6.17.1.1.2 As determined by the client's treatment team, post-procedure debriefing and discussion shall occur that focuses on how future situations may be prevented or de-escalated by employing alternative preventive problem-solving measures.

~~6.17.2~~6.17.3 Usage, Tracking and Reporting:

6.17.2.1 Physical and Mechanical Restraints may be used, per NRS 433.5486-433.5499 inclusive), for the following reasons:

6.17.2.2 As a last resort, for protection of the person or others in an emergency:

6.17.2.3 The least restrictive restraint, such as a physical escort or basket-hold, shall be used prior to consideration of implementation of a more restrictive restraint procedure.

6.17.2.4 The restrain shall be employed for only the period of time necessary for the person to become calm

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6.17.2.5 Physical restraint may also be used to escort or carry a person to safety

6.17.2.6 Mechanical restraint may also be used to enable treatment of the medical needs of a person

~~6.17.3~~6.17.4 Physical guidance may be used to assist in completing a task or response where there is no or minimal resistance. The use of physical guidance is not considered a restraint procedure and does not require the completion of Denial of Rights paperwork.

~~6.17.3.1~~6.17.4.1 Mechanical supports used for the following purposes are not considered restraint and do not require the completion of Denial of Rights paperwork:

~~6.17.3.2~~6.17.4.2 Protect a person from injury because of lack of coordination or frequent loss of consciousness, and

~~6.17.3.3~~6.17.4.3 For the purpose of body alignment/ positioning as noted in a plan of treatment.

~~6.17.3.4~~6.17.4.4 Safety searches are to be used to prevent harm to the patient or others with implied consent by nonresistance.

6.18 Post-Restraint functions:

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

6.18.2 Staff shall provide documentation of this assessment in the electronic medical

6.18.3 record.

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

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

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

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6.19 Notification:

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

6.20 Staff Training Civil and Forensic:

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

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

6.20.2 Training shall include:

6.20.2.1 Division and Agency philosophy regarding restraint/seclusion;

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

~~**4.4.3.3** Emphasis on client safety during restraint/seclusion; and~~

~~**4.4.3.4** Development of skills and abilities to assess risk and trauma.~~

~~**4.4.4** Per NRS 433.5499, the mechanical restraint is applied by a member of the staff of the facility who is trained and qualified to apply mechanical restraint.~~

6.20.5.1 Employees may not participate in physical or mechanical restraints of clients served without approved agency training.

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

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

4.4.6.3 Training shall include:

4.4.6.3.1 Best practices and philosophy of the use of seclusion and restraint;

4.4.6.3.2 Prevention strategies that focus on assisting clients to maintain

4.4.6.3.3 Emphasis on safety during restraint/seclusion;

4.4.6.3.4 Development of skills and abilities to assess risk and trauma; and

4.4.6.3.5 Training in the specific restraint(s) and de-escalation techniques.

4.5 Continuous Improvement Monitoring:

4.5.1 The Agency Director and leadership staff of each agency shall maintain a performance improvement program designed to continuously review, monitor and

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analyze the use of restraint and/or seclusion working toward the goal of eliminating the need for these interventions.

4.5.2 For inpatient/forensic facilities, the Agency Director and Medical Director are responsible for insuring that ongoing monitoring is maintained for clients placed in seclusion or restraints and documented accordingly.

7.0 **Attachments:** N/A

8.0: **Implementation of Policy**

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

EFFECTIVE DATE: 4/30/98
REVIEWED / REVISED DATE: 12/21/98, 2/4/99, 2/17/00, 1/15/02, 3/11/03,8/01/04, 6/23/05, 11/7/07, 7/27/10, 08/23/11
SUPERSEDES: 2.005 SECLUSION/RESTRAINTS OF INDIVIDUALS
APPROVED BY MHDS ADMINISTRATOR: 7/27/10, 08/25/11
APPROVED BY MHDS COMMISSION: 1/30/98, 09/16/11

DATE APPROVED BY DPBH ADMINISTRATOR: 5/2017

DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 5/2017

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DPBH Seclusion/Restraint Physician Order

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Rationale for seclusion and/or restraint:

☐ Harmful to self ☐ Harmful to others

Methods used to avoid restraint and seclusion:

☐ ventilation of feelings ☐ verbal reassurance/redirection ☐ 1 -1 interaction with staff ☐ reduction in stimuli

☐ environmental change ☐ limit setting ☐ time out

☐ Consented Medication(s) given: name/dosage**:** _____ Time**:** _____ ☐ P.O. ☐ I.M.

☐ Non-consented medications given: **If checked, denial of rights initiated/in process** ☐ **Yes** ☐ **No**

If no, explain_____

name/dosage: _____Time: _____ ☐ P.O. ☐ I.M.

RN narrative: _____

_____

Patient's family or legal guardian notified of the seclusion or restraint event: ☐ **Yes** ☐ **No** ☐ Patient or Family waiver of notification:

Specific parameters: _____

Is the patient medically compromised? ☐ **Yes** ☐ **No** **If yes, check all that apply:**

☐ morbid obesity ☐ spinal injury ☐ known history of cardiac or respiratory disease

☐ recent vomiting ☐ pregnancy ☐ on seizure precautions ☐ other: _____

Physician's clinical assessment justifying use of seclusion or restraint:

_____

_____

Physician's behavioral criteria necessary for release:

_____

_____

PHYSICIAN ORDER:

Adults: ☐ **Seclude for up to 4 hours** ☐ **Restrain for up to 4 hours**

Patient placed in:

☐ **Manual restraint**: **Day of Week**_____ **Date:** _____ **Start Time:** _____ **End Time:** _____

☐ **Mechanical restraint**: **Day of Week**_____ **Date:** _____ **Start Time:** _____**End Time:** _____

☐ cuff/belt ☐ legs ☐ wrist ☐ 4-point ☐ 5-point ☐ mitts ☐ restraint chair ☐ spit hood

☐ **Seclusion: Day of Week**_____ **Date:** _____ **Start Time:** _____ **End Time:** _____

☐ **RN may extend order once to the maximum allowable hours with Physician notification** ☐ **Yes** ☐ **No**

CONTINUATION OF ORDER

The RN evaluation and documentation for continuation of orders must include a face-to-face reassessment of the patient's current behavior of the restraint/seclusion_____

_____

Discussed with physician: _____ _____ / _____

Print Physician name R.N. Signature Date/Time

Phone order by Dr. _____Date: _____ Time: _____

R.N. Signature/Printed Name: _____ Date: _____ Time: _____

Physician signature/Printed Name: _____Date: _____ Time: _____

_____SECLUSION AND RESTRAINT _____PHYSICIAN ORDER FORM	**PATIENT'S NAME:** _____ *label* MRN: _____

DPBH PHR 191 Rev:
4/2019

Control #	Rev. Date:	Title:	Effective Date: 08/2017
CRR 1.5	New	MANAGEMENT OF CIVIL INPATIENT ELOPEMENT EPISODES	Next Review Date: 08/2019

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

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

3.0 SCOPE: Clinical Services Branch

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

5.0 REFERENCES: N/A

6.0 PROCEDURE:

6.1 HOSPITALS:

6.1.1 Prevention of Elopement Episodes:

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

6.1.1.1.1 Initial assessment
6.1.1.1.2 Documentation of risk level
6.1.1.1.3 Communication of risk level
6.1.1.1.4 Frequency of reassessment
6.1.1.1.5 Triggers for reassessment
6.1.1.1.6 Prevention plans to be used depending on risk level

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

6.1.2 Reporting of Elopement Episodes:

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

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

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

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

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

7.0 REFERENCES:

7.1 Division Policy CRR .014 Risk Management and Reporting of Serious Incidents
7.2 Division Policy #4.048 DPBH Investigations Manual
7.3 Division Policy CRR 1.13 Sentinel Events
7.4 Nevada State Health Division: Sentinel Event Reporting Guidelines 2012

8.0 ATTACHMENTS: N/A

9.0 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: 09/2017
DATE APPROVED BY DPBH ADMINISTRATOR: 09/2017
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 09/2017

TWO YEAR REVIEW – NO CHANGES

Control #	Rev.	Title:	Effective Date: 08/2017
CRR 1.6	8/17	RESEARCH PROJECTS INVOLVING CONSUMERS	Next Review Date: 08/2019

1.0 **POLICY**:
It is the policy of the Division that when a program conducts or participates in research with human subjects, insures that there are appropriate human subjects' protections through IRB.

2.0 **PURPOSE**:
This policy is designed to ensure that rigorous review is made on the merits of each research project and of the potential effects of the research procedures on the consumer

3.0 **SCOPE**: DPBH Clinical Services Branch

4.0 **DEFINITIONS**:

4.1 Research is a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether they are conducted or supported under a program which is considered research for other purposes.

4.2 A human subject is a living individual about whom an investigator (whether professional or student) conducting research obtains Consumer a/k/a human subject participants: Data through intervention or interaction with the individual, or Identifiable private information.

5.0 **PROCEDURE**:

5.1 Research conducted using consumers is overseen by an Institutional Review Board (IRB) and is compliant with federal regulations (45 CFR 46).

5.1.1 A Review Board's purpose is to facilitate human subjects' research and to ensure the rights and welfare of human subjects are during their participation.

5.1.2 All Human Subjects Research must receive approval from an IRB. Therefore, if intended research meets the definitions of both research and human subjects, the IRB process must be completed.

5.1.2 If the research committee approves the research project, it must then be submitted for final approval to the Department of Health and Human Services Deputy Director's office for final approval by the Institutional Review Board.

5.1.3.1 The Consumer's right to privacy and confidentiality will be

addressed by the University's IRB pursuant to federal regulations.

5.1.3.2 No written or oral agreement entered into by the participant will include any language through which the program, its agents, or those responsible for conducting the research are released from liability for negligence.

5.1.3.3 The denial of consent to participate by any potential research subject will not be a cause for denying or altering the indicated services to that patient

5.2 Consumers will be allowed to withdraw consent and discontinue participation in the project at any time without affecting their status in the program or of the indicated services to that patient.

5.3 Investigators and others directly involved in research will adhere to the ethical standards of their respective professions concerning the conduct of research and should be guided by the regulations of the Department of health, Education, and Welfare on the protection of human subjects (Title 45, Part 46, 1978).

5.4 Upon completion of the research, the principal investigator, whether a member of the program staff or an outside research group will be responsible for communicating to the staff of the program, the purpose, nature, outcome, and possible practical or theoretical implications of the research.

5.5 Reports of all research projects will be maintained by the program.

6.0 REFERENCES: NA

7.0 ATTACHMENTS

7.1 CRR 1.6 Research Projects Involving Consumers Attachment A

8.0 IMPLEMENTATION:

Each agency will develop policies and procedures regarding the provisions of the

Department of Health and Human Services policy on Procedures for Research Involving Human Subject and Protocols and Guidelines adopted August 5, 1999, or will incorporate this policy into the agency policy and procedure manual.

EFFECTIVE DATE: 4/30/98

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

CLINICAL SERVICES

TWO YEAR REVIEW – NO CHANGES

Control #	Rev.	Title:	Effective Date: 08/2017
CRR 1.6	**8/17**	**RESEARCH PROJECTS INVOLVING CONSUMERS**	**Next Review Date: 08/2019**

DATE REVISED/REVIEWED: 8/23/99, 5/15/02; 7/3/07
SUPERSEDES: #2.009 – Research Projects Involving Consumers
APPROVED BY DPBH ADMINISTRATOR: 09/2017

Attachment A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CONSENT FOR EVALUATION AND TREATMENT

I, _____, consent to a treatment/evaluation plan at the Division of Public and Behavioral Health. I understand that the evaluation plan may include medication, interviews, psychological testing and rehabilitative services and that before the plans are put into effect, I have the right to be informed as to:

1. The nature and consequence of the evaluation/treatment plans.
2. The reasonable risks, benefits and purposes of the evaluation/treatment plans.
3. Any alternative evaluation/treatment plans or procedures available.
4. I DO/DO NOT (circle one) consent to the limited and supervised participation of students in the health professions (medical student, psychology interns, nursing students, social work interns, special education students, or other in related fields) in my evaluation and/or treatment with the understanding that a professional staff member will have responsibility for my treatment.

_____ _____

Consumer's Signature/Legal Guardian Signature Date

_____ _____

Witness Signature Date

TWO YEAR REVIEW – NO CHANGES

Control #	Rev.	Title:	Effective Date: 09/2017
CRR1.8	09/17	Civil Client Rights to Second Opinions	Next Review Date: 09/2019

1.0 **POLICY**:
It is the policy of the Clinical Service Branch that clients involuntarily admitted to a state psychiatric hospital have the right to request and receive a second evaluation by a psychiatrist or psychologist who does not have a contractual or business relation with the facility.

2.0 **PURPOSE**:
The purpose of a second opinion is to assist clients with making important decisions regarding diagnosis and other possible treatment options when admitted to a psychiatric hospital under certain conditions.

3.0 **SCOPE**: Clinical Services Branch

4.0 **DEFINITIONS**: n/a

5.0 **REFERENCES**: n/a

6.0 **PROCEDURES**:

6.1 The second opinion right applies to all involuntary court-ordered admissions, and to emergency admissions once the decision to file for involuntary admission is made.

6.1.1 It does not apply to the time period in which a person is held on an emergency admission before the decision to file for involuntary admission is made.

6.2 Clients have the right to request and receive a second evaluation from a psychiatrist or psychologist who does not have a contractual or business relationship with the facility when subject to a petition for involuntary admission to a mental facility.

6.3 The evaluation must:

6.3.1 include, without limitation, a recommendation of whether the consumer should be involuntarily committed to the facility, and

6.3.2 be paid for by the consumer if the insurance carrier of the consumer refuses to pay for the evaluation.

6.4 The consumer is to be notified of this right upon any type of involuntary admission to the facility.

6.4.1 The notification will be documented in the clinical record of the consumer.

6.5 The consumer will be further notified of this right upon being served with the petition for involuntary admission to the mental health facility.

6.6 Upon making the request for a second opinion, the consumer will be given:

6.6.1 A list of psychiatrists and psychologists who have a contractual or business relation with the facility.

6.6.2 Access to a current telephone directory and to a telephone for the purpose of engaging a psychiatrist or psychologist to perform the second evaluation;

6.6.3 The telephone number of the Nevada Disability Advocacy and Law Center, if the consumer asks for further assistance in locating an independent psychologist or psychiatrist for a second evaluation and opinion or demonstrates confusion with respect as to how he or she can access such an independent opinion.

6.6.4 The request for a second opinion, and the staff action performed in compliance with this policy will be noted in the consumer's clinical record.

6.7 If the consumer requests the information to be provided to a spouse or family member or friend to assist in obtaining a second opinion, the list of psychiatrists and psychologists who have a contractual or business relationship with the facility will be given to the person pursuant to the consumer's request.

6.8 A psychiatrist or psychologist who does not have a contractual or business relation with the facility shall have access to the consumer in the same fashion as a visitor, and upon the written consent of the consumer may review the consumer's clinical record and discuss the case with staff.

6.9 A copy of the second opinion will be provided to the facility. The mental health facility will document the day and time of receipt of the second opinion, and will forward it to the consumer's treating physician for a determination whether to obtain a third opinion to resolve any conflicting portions of the previous examinations.

Control #	Rev.	Title:	Effective Date: 09/2017
CRR1.8	09/17	Civil Client Rights to Second Opinions	Next Review Date: 09/2019

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION

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

Effective Date: 10/01/97
Date Revised: 10/01/99; 7/30/07
Date Reviewed: 3/10/05; 7/30/07
Date Approved by the MHDS Commission:
Date Approved by the DPBH Commission: 09/2017

TWO YEAR REVIEW – NO CHANGES

Control #	Rev. Date:	Title:	Effective Date: 10/16
CRR 1.13	10/16	SENTINEL EVENTS	Next Review Date: 10/18

1.0 Policy:

It is the policy of the Division of Public and Behavioral Health that all Division Mental Health Agencies will have a Sentinel Event protocol to manage, investigate and appropriately report Sentinel Events, as defined in this policy.

All Sentinel Events will be reported to the Division of Public and Behavioral Health Administrator/designee, the Statewide Psychiatric Medical Director, and the Agency Quality Assurance and Performance Improvement Manager by Agency Directors or their designee as defined in NRS 439.830.

The Division of Public and Behavioral Health is committed to improving the quality of care, throughout its service system. The occurrence of a Sentinel Event identifies an opportunity for improvement. A performance improvement/peer review process will be used in each occurrence of a Sentinel Event to assess the root cause of the event and identify opportunities for improvement.

2.0 Purpose:

The purpose of this policy is to describe the Division of Public and Behavioral Health Sentinel Event review and intervention process. This process is designed to focus attention on understanding the causes that underlie unexpected occurrences involving death or serious physical or psychological injury, or the risk of same, and to make the necessary organizational changes to:

2.1. Have positive impact in improving patient care, treatment and services and preventing unintended harm,
2.2. Focus attention on understanding the factors that contributed to the event, latent conditions and active failures and 3) reduce the probability of similar events occurring in the future.

3.0 Definitions:

Control #	Rev. Date:	Title:	Effective Date: 10/16
CRR 1.13	10/16	SENTINEL EVENTS	Next Review Date: 10/18

3.1. Sentinel Event is an unexpected occurrence involving the death of a person or serious physical or psychological injury, or the risk thereof when he/she is on state property or in residential services with 24 hour awake staff. Serious injury specifically includes but is not limited to loss of limb or function. Events are considered "sentinel" because the signal a need for an immediate investigation and response.

3.2. Patient Safety Officer as used in this policy references NRS. 439.815 means a person who is designated as such by a medical facility pursuant to NRS 439.870.

3.3. Root Cause Analysis is a formal process for identifying causal factors that contribute to an event associated with adverse outcomes or near miss/close call situations.

3.4. Reportable event is an event that occurs on state property or in residential services with 24 hour awake staff and results in:

3.4.1. Death or unanticipated death within 48 hours of discharge.
3.4.2. Suicide within 72 hours of discharge from an inpatient setting
3.4.3. Loss of limb or permanent loss of function.
3.4.4. Sexual assault.
3.4.5. Paralysis, coma or other major permanent loss of function associated with a medication error or other treatment intervention.
3.4.6. Consumer death or major permanent loss of function occurs during an elopement, i.e., unauthorized departure.
3.4.7. Any elopement of a person from a staffed around-the-clock care setting leading to death, permanent harm, or severe temporary harm to the patient.
3.4.8. Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor or vendor while onsite at the hospital.
3.4.9. Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care.

3.5. 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 or on the premises of the hospital, including oral, vaginal, or anal penetration or fondling of a patient's sex organ(s) by another individual's hand, sex organ or object. One or more of the following must be present to determine that it is a sentinel event:

3.5.1. Any staff witnessed sexual contact, as described above, occurred on the Premises.
3.5.2. Admission by the perpetrator that sexual contact, as described above, occurred on the premises.
3.5.3. Sufficient clinical evidence obtained by the hospital to support allegations of nonconsensual sexual contact.

3.6. Severe Temporary Harm is critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.

3.7. Adverse outcomes are outcomes that are directly related to the natural course of an illness or underlying condition are exempt from the reporting requirement.

4.0 Procedures:

4.1. When agency staff becomes aware of a Sentinel Event, as defined in this policy, they must notify their supervisor within one (1) hour of the event.

4.2. When agency staff become aware of incidents that could have resulted in any of the outcomes described in Section 3.3 and 3.3, they must notify their supervisor within one (1) hour of the event.

4.3. The Supervisor must notify the Agency Director/designee within one (1) hour of notification of the event.

4.4. The Agency Director/designee will notify the Administrator/designee of the Division of Public and Behavioral Health, and the Statewide Medical Director, and the Quality Assurance and Performance Improvement Manager of the event within one (1) hour of notification of the event.

4.5. Agency staff must complete a serious incident report before the end of shift.

4.5.1. The report must include the immediate care rendered to the individual; contributing factors involved; the nature of any injury.
4.5.2. If equipment or a medical device was involved, the name, model number, and serial number for the device.
4.5.3. This report will be given to the Agency Performance Improvement Coordinator within one (1) business day following the event.
4.5.4. The Incident Report shall be sent to Division, the Statewide Medical Director, and within one (1) working day.

4.6. Sentinel Events shall be investigated by a team appointed by the Agency Director. The team shall use the Division of Public and Behavioral Health Services review process or the Joint Commission Root Cause Analysis Model, depending on the accreditation of the agency. For Sentinel events meeting criteria for DPBH policy A.5.2 Performance Improvement: Review of Client Death for Mental Health Agencies; the structure, procedure and report will follow the Death Analysis /Root Cause Team analysis required process.

4.7. The Medical Director/designee shall appoint a Root Cause Analysis team within 24 hours which should include:

4.7.1. Facilitator/lead (supervisory level staff);
4.7.2. Staff who were involved with the care of the patient; and
4.7.3. Staff not involved in the care of the patient to include; nursing, mental health technician, social worker, psychiatrist, and other disciplines as appropriate.

4.8 The Medical Director/designee shall inform the patient or surrogate decision-maker about unanticipated outcomes of care, treatment and services that relate to

the Sentinel Event when the patient is not already aware of the occurrence or when further discussion is needed.

4.9 Agency Director/designee responsibilities within the first 24 hours of the event:

4.9.1 Ensure that staff is providing follow-up care/services to ensure the best possible outcomes for injured parties and staff members.
4.9.2 Ensure that all parties to the event (i.e., family members, staff members, providers, etc.) receive appropriate information.
4.9.3 Keep members of the facility leadership informed.
4.9.4 Follow regulatory reporting requirements, e.g., the Occupational Safety and Health Administration (OSHA) in the case of any employee death.
4.9.5 Consult with the Deputy Attorney General and other resources as needed.
4.9.6 Ensure that all pertinent documentation and data is collected and safely secured with the Patient Safety Officer or designee.
4.9.7 Instruct the Director of Health Information Services or Clinic Director for Rural Services to secure the medical record and all other evidence.
4.9.8 Maintain confidentiality surrounding the event and the patient.

4.10 Sentinel Event Team Responsibilities:

4.10.1 Within one (1) week of the event the sentinel event team will:

4.10.1.1 Meet as necessary, and interview those staff involved with and/or familiar with the event.
4.10.1.2 Obtain written statements.
4.10.1.3 Conduct a root cause analysis of the event that includes an analysis of all related processes and systems.
4.10.1.4 If the failure of a piece of equipment is involved in the incident, the Sentinel Event Team, through the Agency Patient Safety Officer, will submit the appropriate reports to the Food and Drug Administration, Bureau of Health Care Quality and Compliance within 10 (ten) days of the incident. The team will preserve the equipment in its last-

used state and have a qualified vendor review the equipment.

4.10.1.5 The Sentinel Event report will be sent to the Agency Medical Director and Agency Director for review within three (3) working days of the committee's findings.

4.10.2 The Agency Director will forward the root cause analysis to the Division of Public and Behavioral Health, Statewide Medical Director.

4.10.3 The Agency Director will present an overview of the root cause analysis to the Agency Leadership Committee for discussion and action. The overview will include at a minimum:

4.10.3.1 The Root Cause Analysis action plan that identifies strategies to reduce the risk of similar events occurring in the future. The plan must include:

4.10.3.1.1 Corrective actions to eliminate or control system hazards or vulnerabilities directly related to causal and contributory factors.

4.10.3.1.2 Responsibility for implementation

4.10.3.1.3 Timelines for completion

4.10.3.1.4 Strategies for evaluating effectiveness

4.10.3.1.5 Strategies to sustain change

4.10.3.2 The Agency Medical Director and/or Agency Director will approve or recommend changes to the action plan.

4.10.3.3 The Agency Director will assign the appropriate staff to initiate and complete each item on the action plan.

4.10.3.4 The Agency Quality Assurance and Performance Improvement manager will monitor completion of all areas identified for improvement and submit a final report to the Agency Director and Leadership team.

4.10.3.5 The Agency Director will submit evidence of the completed plan to the Administrator of the Division of Public and Behavioral Health, the State Medical Director.

4.10.4 The Sentinel Event report including all correspondence will be filed and secured in the Performance Improvement Office.

4.11 Mandatory Reporting of Sentinel Events

4.11.1 Except as otherwise provided:

4.11.1.1 A person who is employed by a medical facility shall, within 24 hours after becoming aware of a sentinel event that occurred at the medical facility, notify the facility Patient Safety Officer or designee of the sentinel event; and

4.11.1.2 The Patient Safety Officer or designee shall, within seven (7) days after receiving notification report the date, the time and a brief description of the sentinel event to:

4.11.1.2.1 The Division of Public and Behavioral Health; The representative designated pursuant to NRS 439.855, if that person is different from the Patient Safety Officer; and

4.11.1.2.2 The Joint Commission (as applicable) using the Quality Monitoring Sentinel Event Organization Self Report.

4.11.1.2.3 The DPBH Sentinel Event Registry (NRS 439.805)

4.11.2 If the Patient Safety Officer of a medical facility personally discovers or becomes aware, in the absence of notification by another employee, of a sentinel event that occurred at the medical facility, the Patient Safety Officer shall, within 14 days after discovering or becoming aware of the sentinel event, report the date, time and brief description of the sentinel event to:

4.11.2.1 The Division of Public and Behavioral Health ; and

4.11.2.2 The representative designated pursuant to NRS 439.855, if that person is different from the Patient Safety Officer.

4.11.2.3 The DPBH Sentinel Event Registry (NRS 439.805)

4.11.3 The Administrator of the Division of Public and Behavioral health shall prescribe the manner in which reports of sentinel events must be made pursuant to this section.

5.0 REFERENCES:

5.1 Nevada Revised Statute (NRS 439.800-890) Mandatory Reporting of Sentinel Events.

5.2 The Joint Commission, CAMH Accreditation Reporting Requirements Chapter current edition

5.3 The Joint Commission, CAMH Sentinel Events Chapter Update 2

5.4 The Joint Commission, CAMBHC Sentinel Events Chapter Update 2

5.5 State of Nevada Division of Public and Behavioral Health Records of Retention.

Effective Date: 11/17/03
Revised Date: 06/22/05; 10/31/07, 10/16
Approved by Commission on MHDS: 11/17/03

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

TWO YEAR REVIEW –WITH CHANGES

Control #	Rev. Date:	Title:	Effective Date: 09/17
CRR 2.1	09/17	CIVIL CONSUMER COMPLAINT AND GRIEVANCE PROCEDURE	Next Review Date: 09/19

1.0 POLICY:

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

2.0 PURPOSE:

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

3.0 SCOPE: DPBH Clinical Service Branch

4.0 DEFINITIONS:
N/A

5.0 REFERENCES:

5.1 Federal Health Insurance Portability and Accountability Act (HIPAA) https://www.hhs.gov/hipaa
~~4.1~~ 5.2 U.S. Department of Health and Human Services, Office for Civil Rights https://www.hhs.gov/ocr
5.2 Title VI of the Civil Rights Act of 1964
5.3 Section 504 of the Rehabilitation Act of 1973
5.4 Age Discrimination Act of 1975
5.5 Americans with Disabilities Act (ADA), Title I
5.6 NRS 201.255 Penalties
5.7 NAC 284, Rules for State Personnel Administration
5.8 Department of Human Resources: Prohibitions and Penalties
5.9 Joint Commission Manual; Conditions of Participation

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Control #	Rev. Date:	Title:	Effective Date: 09/17
CRR 2.1	09/17	CIVIL CONSUMER COMPLAINT AND GRIEVANCE PROCEDURE	Next Review Date: 09/19

5.10 CMS C.o.P. §482.13

5.11

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

6.1 Each agency shall have a complaint procedure for consumers, family, and stake holders. Per CFR 482.13(a) the procedure shall:

6.1.1 The process shall include promptly addressing complaints and other comments of consumers, their family, or stakeholders.

6.1.2 Ensure the notice of rights requirements are met.

6.1.3 Inform each client, or when appropriate, the client's representative (as allowed under State law), of the client's rights, in advance of furnishing or discontinuing client care whenever possible.

6.1.4 Establish a process for prompt resolution of client grievances and inform each client whom to contact to file a grievance.

6.1.5 The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a patient advocate.

6.1.6 The grievance process must include a mechanism for timely referral of client concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Assurance Performance Improvement Department.

6.1.7 Specify time frames for review of the grievance and the provision of a response.

6.1.8 The hospital should make sure that it is responding to the substance of each grievance while identifying, and resolving any deeper, systemic problems indicated by the grievance.

6.1.9 Provide the client with written notice of its decision that contains the name of the agency contact person, the steps taken on behalf of the client to investigate the grievance, the results of the grievance process, and the

~~5.1~~ date of completion.

~~5.2~~ 6.2 The process shall include a method to address complaints regarding protected health information (PHI), following requirements of the Health Insurance Portability and Accountability Act (HIPAA).

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Control #	Rev. Date:	Title:	Effective Date: 09/17
CRR 2.1	09/17	CIVIL CONSUMER COMPLAINT AND GRIEVANCE PROCEDURE	Next Review Date: 09/19

~~5.3~~ 6.3 The process shall include a method to address allegations of discrimination based on race, color, national origin, religion, gender, age, or disability.

~~5.4~~ 6.4 The process shall include a method to address allegations of discrimination based on race, color, national origin, religion, gender, age, or disability.

~~5.5~~ 6.5 The process shall include a method to evaluate suggestions and appropriately distribute the suggestions and compliments.

~~5.6~~ 6.6 ~~Consumers'~~Clients' use of the complaint process shall not interfere with their ability to file complaints with regulatory agencies, nor shall it result in agency or Division retaliation in any manner.

~~5.7~~6.7 ~~Consumers'~~Clients' use of the complaint process shall not result in a threat of or actual, current or future, denial, reduction, or cancellation of services.

~~6.8~~ The agency director shall identify the contact person(s) to receive and process these communications. This person's contact information shall be provided to all DPBH consumers upon admission to services, and ongoing within notices provided in an accessible manner.

6.9 All employees shall receive training and be familiar with the process. Employees shall assist clients to complete appropriate forms when they are unable to resolve the complaint or connect the client with the appropriate employee to resolve the complaint/grievance.

6.9.1.1 All employees have a participating responsibility to resolve or assist in the resolution of concerns before referring the individual or documenting a formal grievance.

6.9.1.2 All employees shall attempt to connect the grievant with the employee responsible for resolving the concern.

~~5.8~~ 6.10 Employees shall provide the name and telephone number of the Patient Advocate to individuals wishing to make a complaint and ensure the number is posted and available to the individual

~~5.9~~ 6.11 Each Division agency shall maintain records of complaints and other comments.

~~6.0~~7 ATTACHMENTS: N/A

~~**7.06 REFERENCES:**~~

~~7.16.7 Federal Health Insurance Portability and Accountability Act (HIPAA)~~

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~~https://www.hhs.gov/hipaa~~

~~7.26.7 U.S. Department of Health and Human Services, Office for Civil Rights~~

~~https://www.hhs.gov/ocr~~

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~~8.08~~ IMPLEMENTATION OF POLICY:

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

EFFECTIVE DATE: 04/15/03
REVIEWED / REVISED DATE: 07/09/07, 08/06/10, 09/17
SUPERSEDES: Policy #6.008 Client Complaint Procedures
APPROVED BY DPBH ADMINISTRATOR: 08/06/10, 09/2017
APPROVED BY DPBH COMMISSION: 09/17/10, 09/2017

NEW

Control #	Rev.	Title	Effective Date:
CRR 6.06	New	Caregiver's Authorization Affidavit	**Next Review Date**

1.0 POLICY:

DPBH Clinical Services provides caregivers of minor children who are not legal guardians, an avenue to seek mental health services for these minors.

2.0 PURPOSE:

To outline the process for DPBH Clinical Service Branch agencies that provide care for minor clients who are living with caregivers, the ability to provide mental health services.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 Caregiver's Authorization Affidavit – A document completed by a qualified relative (non-legal guardian) for the purpose of requesting mental health services for a minor child.

4.2 Qualified Relative – A spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix "grand" or "great" or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.

4.3 Emancipated 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.

5.0 REFERENCES:

5.1 NRS 129.080 Emancipated Minor
5.2 NRS 129.030 Consent for Examination and Treatment
5.3 CRR 6.05 Treating Personal Representative as an Individual

6.0 PROCEDURE:

6.1 On the initial visit, a legal responsible person may authorize care.

6.2 On-going visits, the minor may be seen with the authorization of a qualified relative.

6.3 The qualified relative must present a driver's license or identification card.

6.3.1 If they do not have this information, then another form of identification can be use such as social security number or Medicaid number.

6.4 Shall initiate the process of completing the Caregiver's Authorization Affidavit with the qualified relative when a request for services has been initiated for a minor child.

6.5 This completed form will be in the minor child's medical record.

6.6 Immediately upon the legal guardian becoming available the staff shall initiate the process assisting the guardian to complete all consents for treatment of the minor.

7.0 ATTACHMENTS:

7.1 Care Givers Authorization - Caregiver's Authorization Affidavit, Attachment A

8.0 IMPLEMENTATION OF POLICY:

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

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

Division of Public and Behavioral Health Clinical Services

CAREGIVER'S AUTHORIZATION AFFIDAVIT

Instructions: Completion of items 1-8 and the signing of the affidavit is sufficient to authorize assessment and treatment for behavioral health care. Please print clearly.

{ } I am requesting to authorize behavioral health care for a minor child.

The minor name below lives in my home and I am 18 years of age or older.

1. Name of minor: _____
2. Minor's DOB: _____
3. My name: (adult giving authorization) _____
4. My home address: _____

   _____
5. Relation to Minor: _____

   (See back of this form for a definition of "qualified relative")
6. Check one or both (for example, if one parent was advised and the other cannot be located):

   { } I have advised the parent(s) or other person(s) having legal custody of the minor of my intent to authorize medical care, and have received no objections.

   { } I am unable to contact the parent(s) or other person(s) having legal custody of the Minor at this time, to notify them of my intended authorization.
7. My DOB: _____
8. My driver's license or identification card number: _____

Warning: Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment, or both.

I declare under penalty of perjury that the foregoing is true and correct.

Date: _____

Signature: _____

Please Note:

- This declaration does not affect the right of the minor's parents or legal guardian regarding the care, custody, and control of the minor, and does not mean that the caregiver has legal custody of the minor.
- A person who relies on this affidavit has no obligation to make any further inquiry or investigation.
- This affidavit is valid for only one (1) year after the date on which it is executed.

IMPORTANT INFORMATION

TO CAREGIVERS:

1. "Qualified relative" for purposes of item #5. Means a spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix "grand" or "great" or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.

2. The law may require you, if you are not a relative or currently licensed foster parent, to obtain a foster home license in order to care for a minor. If you have any questions, please contact your local department of Social Services.

3. *If the minor stops living with you, you are required to notify any school, health care service plan to which you have given this affidavit.*

4. If you do not have the information requested in item #8 (driver's license, or identification card), provide another form of identification such as your social security number or Medicaid number.

TO THE HEALTH CARE PROVIDERS AND HEALTH CARE SERVICE PLANS:

1. No person who acts in good faith reliance upon a Caregiver's Authorization Affidavit to provide medical or dental care, without actual knowledge of facts contrary to those stated on the affidavit, is subject to criminal liability or to civil liability to any person, or is subject to professional disciplinary actions, for such reliance if the applicable portions of the form are completed.

2. This affidavit does <u>not</u> mean that the minor is automatically a dependent for heath care coverage purposes.

TWO YEAR REVIEW – NO CHANGES

Control #	Rev.	Title: Medicaid Mental Health Rehabilitative Services Billing And Charting / Documentation Requirements	Effective Date: 5/20/2010
F-1.1			Next Review Date:

1.0 POLICY:

The Division of Public and Behavioral Health and Developmental Services (DPBH), as well as Division agencies, will follow specific procedures to obtain Medicaid reimbursement for mental health rehabilitative treatment services as defined below.

2.0 PURPOSE:

This policy is to assist DPBH's mental health agencies with 1) meeting the documentation requirements set forth by the Centers for Medicare and Medicaid Services (CMS) and Division of Health Care Financing and Policy (DHCFP, for which Medicaid is the primary program) for mental health rehabilitation services, and 2) properly submitting claims and billing for mental health rehabilitation services.

3.0 SCOPE: DPBH Clinical Service Agencies

4.0 DEFINITIONS:

5.0 REFERENCES:

6.0 PROCEDURES:

6.1 Objectives of Mental Health Rehabilitation Treatment Services

6.1.1 The objectives of rehabilitation services are to provide treatment or rehabilitation in the following areas

6.1.1.1 Basic Skills Training;
6.1.1.2 Psychosocial Rehabilitation;
6.1.1.3 Program for Assertive Community Treatment (PACT);
6.1.1.4 Treatment Home Services; and
6.1.1.5 Clinical Case Management.

6.1.2 Definition and Standards

6.1.2.1 Rehabilitative Mental Health (RMH) Services must be recommended by a Qualified Mental Health Professional (QMHP)

within the scope of their practice under state law. RMH services are goal orientated outpatient interventions that target the maximum reduction of mental health and/or behavioral health impairments and strive to restore consumers to their best possible mental and/or behavioral health functioning. RMH services may be provided in a variety of community and/or professional settings. The objective is to reduce the duration and scope of care to the least intrusive level of mental and/or behavioral health care possible while sustaining the consumers' overall health. All RMH services must be directly and medically necessary.

6.1.2.2 Prior to providing RMH services, a QMHP must conduct a comprehensive assessment of a consumer's rehabilitation needs including the presence of a functional impairment in daily living and a mental and/or behavioral health diagnosis. The assessing QMHP must approve a written Rehabilitation Plan that includes a rehabilitation strategy sufficient in amount, duration, and scope to achieve established rehabilitation goals and objectives.

6.2 Recordkeeping/Documentation

6.2.1 **Medical Record/Chart -** For all consumers receiving mental health rehabilitation services, case records must include the following:

6.2.1.1 A copy of the rehabilitation treatment plan;
6.2.1.2 The name of the consumer;
6.2.1.3 The date of the rehabilitative services provided;
6.2.1.4 The nature, content, and units of the specific mental health rehabilitative services; and
6.2.1.5 The progress made toward functional improvement and attainment of the consumer's goals as identified in the rehabilitative plan and case record.

6.2.2 **Progress Notes -** Progress Notes must be completed at least monthly and any time there is a substantial change in the consumer's clinical status. They must contain:

6.2.2.1 Documentation of progress or lack of progress toward the Treatment Plan's goals and objectives;
6.2.2.2 Sufficient information to support the services provided;
6.2.2.3 Amount, scope, and duration of the service;
6.2.2.4 Provider of the service; and
6.2.2.5 A focus on how the services furnished are a) providing for the maximum reduction of mental disability and b) providing restoration to the consumer to their best possible functional level.

6.2.3 **Rehabilitative Plans**

6.2.3.1 A comprehensive, progressive, and individualized written Rehabilitation Plan must include all the prescribed RMH services: Basic Skills Training (BST), Program for Assertive Community Treatment (PACT), Day Treatment, Psychosocial Rehabilitation, and Crisis Intervention (CI). The Rehabilitation Plan must:

6.2.3.1.1 Include recovery goals, and provide for a process to involve the consumer, and family (if appropriate), in the overall management of care. The plan must document that the services have been determined to be rehabilitative services and will have a timeline based on the consumer's assessed needs and anticipated progress;
6.2.3.1.2 Involve the consumer, the consumer's family or other responsible consumers (if appropriate) in the reevaluation of the plan. The reevaluation of the plan must include a review of whether the established goals and objectives are being met and whether each of the services prescribed in the plans contributed to meeting the stated established goals and objectives;
6.2.3.1.3 Be reasonable and based on a consumer's diagnosed condition, ensuring that services are provided within the scope (therapeutic intent) of the rehabilitative services and would increase the likelihood that a consumer's

disability would be reduced and functional level restored.

6.2.3.2 As a minimum, Rehabilitative Plans must include the following headings:

6.2.3.2.1 Consumer's Full Name;
6.2.3.2.2 Consumer's 11-digit Medicaid Billing Number;
6.2.3.2.3 Intensity of Needs Determination;
6.2.3.2.4 SMI/SED Determination;
6.2.3.2.5 Measurable Goals and Objectives;
6.2.3.2.6 Prescribed Services:

6.2.3.2.6.1 Specific mental health services(s) to be provided;
6.2.3.2.6.2 The daily service duration and therapeutic scope for each service to be provided; and
6.2.3.2.6.3 The provider or providers that are anticipated to provide each service.

6.2.3.3 For more detailed information as to the Medicaid Rehabilitative Plan requirements, please consult the Medicaid Services Manual, Chapter 400, section 402.34.

6.2.4 **Eligible Consumers -** By statute, Mental Health Rehabilitation Treatment services are available for consumers who are seriously mentally Ill (SMI) and who:

6.2.4.1 Are 18 years or older;
6.2.4.2 Currently, or at any time during the past continuous 12 month period,, have had a diagnosable mental, behavioral or emotional disorder that meets the coding and definitional criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), excluding substance abuse or addictive disorders, and

irreversible dementias or mental retardation unless they co-occur with another DSM-IV diagnosed mental disorder;

6.2.4.3 Have a related functional impairment that substantially interferes with or limits one or more major life activities, such as social, psychological, occupational or educational, and may include limiting an adult from achieving or maintaining housing, employment, education, relationships or safety;

6.2.4.4 Are expected to benefit from treatment; and

6.2.4.5 Are recommended for services by a Qualified Mental Health Professional (QMHP) within the scope of their practice under state law.

6.2.5 **Standards for Provider Participation -** Facilities must be statutorily defined comprehensive mental health centers (NRS 433.144) and their affiliates.

6.2.5.1 Eligible providers are:

6.2.5.1.1 Licensed psychiatrists;
6.2.5.1.2 Licensed psychologists;
6.2.5.1.3 Licensed social workers;
6.2.5.1.4 Licensed RN's;
6.2.5.1.5 Psychiatric caseworkers, mental health technicians, peer supporters, and other paraprofessionals supervised by a licensed mental health professional; and
6.2.5.1.6 Approved contractors of the Division of DPBH.

6.2.5.2 Medicaid has classified providers into three main groups:

6.2.5.2.1 Qualified Mental Health Professionals (QMHP);
6.2.5.2.2 Qualified Mental Health Associates (QMHA); and
6.2.5.2.3 Qualified Behavioral Aides (QBAs).

6.3 **Mental Health Rehabilitative Treatment Claims Submission and Billing**

6.3.1 **Services (Medicaid's definitions as a requirement for billable services)**

6.3.1.1 **Basic Skills Training (BST):**
Individual - Procedure Code: H2014 (no modifier)
Group - Procedure Code: H2014 (modifier HQ)
Basic Skills Training (BST) Services are RMH interventions designed to reduce cognitive and behavioral impairments and restore consumers to their highest level of functioning. BST services help consumers acquire constructive cognitive and behavioral skills through positive reinforcement, modeling, operant conditioning, and other training techniques. BST services teach consumers a variety of life skills, and may include basic living and self-care skills, social skills, communication skills, parental training, organizational and time management skills, and transitional living skills.

6.3.1.2 **Psychosocial Rehabilitation (PSR)**
Individual - Procedure Code: H2017 (no modifier)
Group - Procedure Code: H2017 (modifier HQ)
Psychosocial Rehabilitative Services (PSR) are designed to reduce psychosocial dysfunction (e.g., interpersonal, cognitive, behavioral development, etc.) and restore consumers to their highest level of functioning. PSR services may include any combination of the following interventions – behavioral management, social competency, problem identification and resolution, effective communication, culturally relevant moral reasoning, emotional intimacy, self-sufficiency and identifying life goals.

6.3.1.3 **Program for Assertive Community Treatment (PACT)**
Individual or Group (No procedure code or modifier)

6.3.1.3.1 A multi-disciplinary team-based approach of the delivery of comprehensive and flexible treatment, support, and services within the community. The team must be composed of at least one QMHP and one other QMHP or QMHA. For DPBH agencies this means the team may be composed of the following providers:

Psychiatrist, Psychologist, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Psychiatric Counselor, Registered nurse, and Case Manager.

6.3.1.3.2 PACT is for consumers who have the most serious and intractable symptoms of a severe mental illness and who have the greatest difficulty with basic daily activities, keeping themselves safe, caring for their basic physical needs, or maintaining a safe and affordable place to live, and require interventions that have not been effectively addressed by traditional, less intensive services.

6.3.1.3.3 Services are available 24 hours a day, seven days per week. Team members may interact with a consumer with acute needs several times a day. As the consumer stabilizes, contacts decrease. This team approach is facilitated by the daily team meetings in which the team is briefly updated on each consumer. Activities for the day are organized and team members are available to one another throughout the day to provide consultation or assistance. This close monitoring allows the team to quickly adjust the nature and intensity of services in response to the consumer's changing needs. PACT is reimbursed as unbundled services.

6.3.1.4 **Crisis Intervention (CI) Services**
Individual – Procedure Code: H2011 (face-to-face)
H2011 (modifier GT) (telephone)
NNAMHS only use 96152 (face-to-face) and H2011 (telephone)
Group - Procedure Code: H2011 (face-to-face) and
H2011 (modifier GT) (telephone)
Crisis Intervention (CI) services are interventions that target situations where consumers are experiencing acute psychiatric and/or personal distress. The goal of CI services is to assess and stabilize situations through brief and intense interventions, and

provide appropriate mental and behavioral health service referrals. The objective of CI services is to reduce psychiatric and personal distress, restore consumers to their highest level of functioning, and prevent acute hospital admissions. CI services may be provided in a variety of settings including but not limited to psychiatric emergency departments, emergency rooms, homes, foster homes, schools and homeless shelters.

6.3.1.5 **Day Treatment**
Individual – Procedure Code: (currently not in use)
Group - Procedure Code: (currently not in use)

6.3.1.5.1 Day Treatment Services are designed to reduce emotional, cognitive, and behavioral problems and restore consumers to their highest level of functioning. Day Treatment Services provide consumers with opportunities to implement and expand upon what they learned / gained from other mental and/or behavioral health therapies and interventions in safe settings. The goal of Day Treatment Services is to prepare consumers for reintegration back into their home and community based settings.

6.3.1.5.2 Day Treatment Services includes a fluid combination of all RMH services, therefore, providers cannot bill separately for BST, Psychosocial Rehabilitation, and Crisis Intervention Services during the same time of day or day they bill for services.

6.3.1.6 **Medicaid Rehabilitative Mental Health Service Requirements**

6.3.1.6.1 For a complete listing of all Medicaid Rehabilitative Mental Health Service requirements including prior authorization requirements, please consult the Medicaid Services Manual, Chapter 400, which can be obtained from the following website link:

6.3.1.6.1.1 http://dhcfp.state.nv.us/MSM/CH0400/Ch%20400%20FINAL%202-9-10.pdf

6.3.2 **Billing-General**

6.3.2.1 In accordance with state law and public policy, consumers or responsible parties are financially responsible for the full cost of services rendered. No services will be denied consumers because of inability to pay. For consumers who claim inability to pay full cost of care, it is Division policy that the burden of proof to demonstrate inability to pay is the responsibility of the consumer served (or responsible parties).

6.3.3 **Medicaid Billing**

6.3.3.1 DPBH's Central Billing Office (CBO) bills for all mental health agencies' rehabilitative treatment services under their provider type 14 number. Services will be billed monthly in a professional format for daily and hourly rates utilizing the Medicaid devised procedure codes.

6.3.4 **Authorization for Services**

6.3.4.1 All mental health rehabilitative services require prior authorization, with the exception of CI services, which require post authorization.

6.3.4.2 To obtain authorizations for mental health services, DPBH agencies are required to submit First Health Services "Behavioral Health" Authorization Form (FH-11A). In return, First Health will issue the formal authorization to the DPBH agencies. (CI services require the use of the FH-11C form.)

6.3.5 **Complete Information on Billing**

6.3.5.1 Please consult DP Billing Policy #3.004, and the Medicaid Billing Guide, and the CMS 1500 Claim form instructions on the First Health Services Corporation website at:

6.3.5.1.1 http://nevada.fhsc.com/providers/manuals/manuals.asp

6.3.6 **Division Agency Procedures**

6.3.6.1 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.

EFFECTIVE DATE: 12/31/97
REVIEWED / REVISED DATE: 11/1/07, 06/01/06; 10/11/07; 5/20/2010
SUPERSEDES: #3.005 Medicaid Mental Health Rehabilitation Services Billing & Charting/ Documentation Requirements
APPROVED BY DPBH ADMINISTRATOR: 4/19/2010
APPROVED BY DPBH COMMISSION: 5/20/2010

SAMPLE ONLY

STATE OF NEVADA
DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES
SUPPORTED LIVING ARRANGEMENT PROGRAM

NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES
480 GALLETTI WAY
SPARKS, NV 89431-5574
(775) 688-2031

Dear **Participant:**
Thank you for your application to the Supported Living Arrangement Program. The Supported Living Arrangement Program is a program sponsored by the State of Nevada Division of Mental Health and Developmental Services. The program provides intermittent rental subsidies and supportive services to applicants who are in need of mental health services. Participants in the program must be willing to accept and cooperate with the support and mental health services.

I am pleased to inform you that your application has been approved. As part of your participation in the Supported Living Arrangement Program you will have a case manager at the Northern Nevada Adult Mental Health Services. Your case manager will be **Service Coordinator** and can be reached by phone at **688-xxxx.**

Also, as part of your participation in the program you will receive assistance in locating housing and other services. These services will be provided by **Service Coordinator,** your contact person at this agency, who can be reached by phone at **688-xxxx.**

The Supported Living Arrangement Program will provide financial assistance to assist you in paying rent for a **xx** bedroom apartment. The rent and the utilities for the apartment cannot exceed **$FMR** Based on the income that you reported in your application you must pay **$xxxx**/month toward the rent and utilities for the apartment. The amount may change if your income changes. Northern Nevada Adult Mental Health Services require that you report any changes in income to the Supported Living Arrangement Program within 10 days of the change in income.

Service Coordinator will contact you to assist you in finding an apartment and explain the program in more detail. If you do not hear from him/her in a day or two, please call him/her at **688-xxxx.** Welcome to the Supported Living Arrangement Program.

Sincerely,

_____ _____

(Date)

Residential Program Coordinator
Supported Living Arrangement Program

cc: NNAMHS Service Coordinator
Support Agency file

STATE OF NEVADA

BRIAN SANDOVAL
Governor

ROMAINE GILLILAND
Director

RICHARD WHITLEY, MS
Administrator

TRACEY D. GREEN, MD
Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
6161 West Charleston Blvd. Bldg. #1
Las Vegas, Nevada 89147

SAMPLE ONLY

May 27, 2010

To:

RE: State Supported Living Arrangement funds provided to you by Rural, NNAMHS, SNAMHS Clinics

Dear Ms/Mr. …..,

This letter is to inform you that Supported Living Arrangement (SLA) funds provided to you by Rural Clinics will end June 30, 2010. According to Rural Clinics policy 3.1007 the SLA program is a transitional residential program with a 24 month time limit. Our records indicate that you began receiving SLA funds in December of 2007 to assist you until mainstream resources could be obtained (Social Security benefits), you were able to gain employment skills training and/or become employed. June 30, 2010 you will have received SLA benefits for the 31st month, exceeding the time limit by 7 months.

In seeking treatment, it is necessary that you work with mental health staff on your goal of recovery by applying for mainstream resources and seeking employment and/or other types of resources to best fit your needs. Rural Clinics is not required to continue using limited state funds when other resources are available. Recovery from mental illness and individual self-sufficiency are obtainable goals but require your effort.

Since December of 2008 your Psychiatric Caseworker has worked continually with you for you to gain access to employment resources and education. On April 22, 2009 you agreed to apply for Social Security benefits; your application was later denied. January 2010 you agreed to attend Gamblers Anonymous once weekly for issues you face with gambling SLA funds leading to your inability to meet your basic needs. You stated that you attended two times in all without providing proof. You agreed to pursue Vocational Rehabilitation services on May 12, 2010. Our records indicate that you have canceled and/or no-showed eight scheduled appointments with your Psychiatric Caseworker in the past six months; 12/8/09, 12/10/09, 1/12/10, 1/25/10, 2/9/10, 3/18/10, 3/29/10 and 5/10/10.

You were notified in December 2009 and again on 2/19/2010 that your SLA funds would end with June 2010 and you were encouraged to pursue other resources. This letter is formal notification that Supported Living Arrangement funds will be terminated effective June 30, 2010. You have the right to appeal this decision. An appeal must be submitted within 30 days of the date of this letter via letter or email to:

Rural Services Administration
1665 Old Hot Springs Rd, Suite 157
Carson City, NV 89706
Attention:

Respectfully,

Center Director

SLA/SPC CONTRACT REQUEST FORM

Client's Name: _____ **Date:** **9/10/2019**

Service Coordinator: _____ **SS#** _____

SMI Diagnoses: _____

AVATAR #

Type of contract needed?
- ☑ NEW [No current contract]
- ☐ REPLACEMENT [Changes to current contract]
- ☐ RENEWAL [Extension to current contract; may include changes]
- ☐ ADDENDUM [One time costs; additions to current contract]

Start date for contract: _____

Address: _____

Currently Receives Food Stamps? ☐ Yes ☐ No Amount: _____

Payeeship Transferred to NNAMHS? ☐ Yes ☐ No Date of App: _____

Current Insurance? ☐ Yes ☐ No Type: _____

Income/Month : _____ Source(s): _____

Income after expenses/Month: _____

Savings (after expenses) in Pt. Accts: _____ Date: _____

Recurring Costs

	Monthly $	Std. Max. $
Rent:	$ -	$ 699.00
Utilities:	$ -	$ 150.00
Personal:	$ -	$ 178.19
Food:	$ -	$ 222.15
Phone:	$ -	$ 20.00
Travel:	$ -	$ 26.00
TOTAL:	$ -	

One Time Costs

Deposit	_____	$ 697.00
App. Fee	_____	$ 100.00
Other	_____	

Direct Services	Hrs per Month	Description of Support Needs
Self Care		
Basic Living		
Socialization		

Support Services	Hrs/Month
Awake	
Asleep	

Reason for Request: _____

Projected Monthly costs $0.00
Less monthly income $0.00
Total monthly cost $0.00

E-mail to Beckie Pinkston, Brian Burriss
Last Revision: 10/15/14

SLA - Intermittant
SLA - Provider Home
SPC
Board and Care
Day Tx.
One Time Cost

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

CLINICAL SERVICES

TWO YEAR REVIEW – WITH CHANGES

Control #	Rev.	Title: REQUIREMENT OF APPLICATION FOR HEALTH BENEFITS	Effective Date:
F-2.1			Next Review Date:

1.0. **POLICY:** It is the policy of the Division that all individuals applying for services from the Division will apply for Medicaid benefits when it appears that individuals meet basic screening requirements.

2.0. PURPOSE: The purpose of this policy is to ensure that all public mental health ~~and developmental services~~ that are eligible for reimbursement through Medicaid funds are claimed and to provide staff with basic screening requirements to make appropriate referrals for application to Medicaid.

3.0. SCOPE: DPBH clinical Service Branch Agencies ~~Mental Health and Developmental Services agencies. (Lakes Crossing Forensic Facility and Substance Abuse Prevention Treatment Agency are excluded.)~~

4.0. DEFINITIONS: NA

5.0. REFERENCES: NA

~~4.0.~~6.0. PROCEDURE:

~~4.1.~~6.1. Urgent or emergent services will not be delayed or denied as a result of failure to apply for benefits.

~~4.2.~~6.2. MHDS agency staff will assess each individual applying for services using the Basic Medicaid Screening Tool.

~~4.3.~~6.3. MHDS agencies will provide the following information to individuals seeking service:

~~4.3.1.~~6.3.1. Where and how to apply

~~4.3.2.~~6.3.2. The need to apply within 30 days of seeking MHDS services

~~4.3.3.~~6.3.3. Failure to apply may result in a delay or denial of MHDS services.

~~4.4.~~6.4. Each agency will develop a procedure to ensure that individuals seeking services have applied for benefits in accordance with the Basic Medicaid Screening Tool.

Harold Cook

~~ADMINISTRATOR~~

~~5.0.~~7.0. ATTACHMENT:

~~5.1.~~7.1. Basic Medicaid Screening Tool

EFFECTIVE DATE: 09/16/2011

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DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

CLINICAL SERVICES

TWO YEAR REVIEW –

WITH CHANGES

Control #	Rev.	Title: REQUIREMENT OF APPLICATION FOR HEALTH BENEFITS	Effective Date:
F-2.1			Next Review Date:

REVISED / REVIEWED DATE: N/A
SUPERSEDES: # N/A
APPROVED BY MHDS ADMINISTRATOR: 08/25/2011
APPROVED BY MHDS COMMISSION: 09/16/2011

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ATTACHMENT - A

Basic Medicaid Screening Tool

If a client **does not** have Medicaid, complete the following checklist:

*(If the client answers **YES** to any of these questions, refer the client to Nevada Welfare to apply for Medicaid)*

Does the individual receive Supplemental Security Income (SSI)?	☐Yes ☐No
Is the individual below age 19 and a dependent in a household with total household income at or below the poverty level with less than $2000 in resources?	☐Yes ☐No
Is the individual at least 65 years of age and living in a household with total household income at or below the poverty level with less than $2000 in resources?	☐Yes ☐No
Does the individual have Medicare coverage and is the total household income at or below 133% of the poverty level?	☐Yes ☐No
Is the individual under 65 years old and blind or disabled and living in a household with total household income at or below 133% of the poverty level?	☐Yes ☐No
Does the individual have a qualifying child in their household? (Newborn to age 18 and, if school age must be attending school)	☐Yes ☐No
Is the client pregnant with income at or below the poverty level?	☐Yes ☐No
Is the client a non-citizen and has/will be receiving emergency services?	☐Yes ☐No

Note: If the individual has recently been approved for Medicaid and has received services in the past 3 months, they may be eligible for payment of these services. Please refer them to Nevada Welfare to apply for Prior Medical Coverage.

Control #	Rev.	Title:	Effective Date:
F 2.3		MENTAL HEALTH COST REPORT DATE AND ALLOCATION METHODS	Next Review Date:

1.0 POLICY:

It is the policy of the Division of ~~Mental Health and Developmental Services~~ Public and Behavioral Health (~~MHDS~~DPBH) to gather cost-reporting data consistently, accurately and timely from the DPBH ~~MHDS~~ agencies. Allocation methods used will be defensible and consistent among DPBH~~MHDS~~ agencies.

2.0 PURPOSE:

Providing cost-reporting data in a consistent, accurate and timely manner will minimize errors and expedite the allocation process.

3.0 SCOPE:

Mental Health Agencies

3.1. Applicability:

3.1.1. The procedures set forth in this document will be used as a guideline to submit mental health financial information to Health Care Financing Administration Preview (HCFAP) for Medicaid administration cost reimbursement. The financial information submitted will be presented within a time frame that will allow filing of the cost report by statutory due dates without extensions.

3.2. Administrative Coordination:

3.2.1. Administrative Services Officers will meet regularly to ensure their cost reporting methods are consistent and accurate. Additionally, they will cooperate with central staff request for statistical information used for cost allocation methodologies.

Control #	Rev.	Title:	Effective Date:
F 2.3		MENTAL HEALTH COST REPORT DATE AND ALLOCATION METHODS	Next Review Date:

3.2.2. The various agencies will develop procedures and coordinate efforts to carry out the timely submission of uniform cost reporting financial information.

3.2.3. All cost reporting information, calculations and allocations will be documented and retained for subsequent review.

4.0 ATTACHMENTS:

N/A

5.0 Implementation of Policy:

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.

Rod White

~~ADMINISTRATOR~~

EFFECTIVE DATE: 09/30/2001

REVIEWED / REVISED DATE: 03/30/07, 05/25/2012

SUPERSEDES: Policy 3.016 Mental Health Cost Report Data and Allocation Methods

APPROVED BY MHDS ADMINISTRATOR: 05/25/2012

APPROVED BY MHDS COMMISSION: 05/18/01, 05/25/2012

Control #	Rev. Date:	Title:	Effective Date: 5/2012
F-2.4	~~(?)~~	CONTRACT PROCEDURES	Next Review Date: ~~(?)~~

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1.0 POLICY:

The mission of the ~~mental health and developmental services~~ agencies of the Division of Public and Behavioral Health is to serve the ~~developmental and~~ behavioral health needs of the individuals in the community 24 hours a day, seven days a week.

2.0 PURPOSE:

To facilitate this mission, agencies of the Division will frequently need to enter into contracts with a variety of entities for provision of ~~S~~services or procurement of materials and/or support activities that enable the effective operation of the Division.

3.0 SCOPE:

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Division Wide

4.0 DEFINITIONS: N/A

5.0 PROCEDURE:

5.1 Principles and Guidelines

5.1.1 Principles: Contract monitors and managers are required to develop and manage contracts and agreements for the Division's various agencies based on the following principles:

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5.1.1.1 All contracts and agreements entered into will be developed with sound practices for planning, construction and monitoring;

5.1.1.2 Ultimately serve the best interests of the consumer and their behavioral or developmental needs, and the interests of the agency in delivering these services to consumers;

5.1.1.3 Follow the established chain of contract development and approval, within the necessary timelines for submission; and

5.1.1.4 Contract packages and supporting documents will be prepared on the approved forms as determined by SAM Chapter 300, State Purchasing, the Department and the Division ASO IV, and will contain the necessary and prescribed language to ensure an uninterrupted approval flow.

5.1.2 Guideline: The following guidelines outline how Division and agency contract managers and monitors can better serve the contracting needs of their organizations.

5.1.2.1 Staff requirements: All agencies will designate an agency contract monitor and an agency contract monitor backup. Agencies will require that the designated contract monitors, managers and fiscal staff responsible for contract development, ~~,~~ monitoring, and approval will attend the required State Certif~~ication~~ied ~~for State~~ Contract Manager's course ~~class~~ given by State Purchasing ~~and Insurance for State Contracts class given by Risk Management,~~ to ensure uniformity of training and body of knowledge.

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5.1.2.2 Preparation: Contracts will be ~~developed~~ negotiated and prepared utilizing ~~the Contract Entry and Tracking System (CETS) established by the Budget and Purchasing Divisions. It is MHDS policy that all contracts shall be entered in the CETS system, with the exception of lease agreements which are managed by Building and Grounds.~~current State templates and policies and procedures from the DPBH Contract Unit.

5.1.2.3 Communication: Regular communication between agency Contract monitor and agency ASO, and the Division contract manager and Division ASO shall occur to keep parties informed of contract related issues.

5.1.2.4 Monitoring: Agencies will ensure the following monitoring activities occur for all approved contracts:

5.1.2.4.1 Ongoing vendor performance review ~~and related CETS entry at termination~~;
5.1.2.4.2 Ongoing receipt of current insurance certificates ~~and related CETS entry of updates~~;
5.1.2.4.3 Invoice and payment review, contract language; and
5.1.2.4.4 Contract expenditure and budget authority reconciliation.

5.1.2.5 Reporting: Agencies will identify the following items during the regularly scheduled Agency Operation Statement Meetings:

5.1.2.5.1 The need for new contracts;
5.1.2.5.2 A list of active contracts and significant issues;
5.1.2.5.3 Upcoming termination dates and action plans to avoid retroactive status; and

5.1.2.5.4 RFP or bidding updates.

~~5.1.2.5.4~~

5.2 Required and Necessary Contract Package Elements: Components of successful contracts in accordance with state law, Purchasing, Budget and Risk Management regulations (NRS 277, 433; SAM 300 and 1500), and Department and Division guidelines, contracts submitted to the ~~Central Office~~Contract Unit for review and processing shall contain the following elements:

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5.2.1 Supporting Documents: There shall be one (1) original of each of the supporting documents to the front of the contract package, this includes:

~~5.2.1.1 Department cover sheet ("DHHS Pink Sheet");~~

~~5.2.1.2 Division transmittal sheet outlining the general purpose of the contract;~~

~~5.2.1.3 Division contract checklist verifying all required elements have been met;~~

~~5.2.1.4~~5.2.1.1 Agency itemized calculation identifying how costs were derived ("Contract Cost Breakdown Sheet");

~~5.2.1.5 Copy of insurance certificates verifying the vendor has met the minimum insurance coverage requirements;~~

~~5.2.1.6~~5.2.1.2 Copy of the approved Solicitation Waiver or Professional Service Exemption Letter (if applicable);

~~5.2.1.7~~5.2.1.3 Retroactive Memorandum addressed to the Budget Office (if applicable); and

5.2.1.4 Additional correspondence or information as determined necessary.

~~5.2.1.8~~

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5.2.2 Contract Package: there shall be ~~five~~ one (~~5~~1) cop~~ies~~y of each contract package with all the necessary elements and original signatures for submission, this includes:

~~5.2.2.1 Contract summary sheet outlining details of the contract;~~

~~5.2.2.2~~5.2.2.1 Formal contract document~~s~~ with ~~original~~ vendor signature(s);

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~~5.2.2.3~~5.2.2.2 Attachment A~~A~~ (State ~~or~~ RFP or Scope of Work) showing the work and conditions under which the vendor will perform the contracted services;

~~5.2.2.4~~5.2.2.3 Attachment B~~B~~ (Insurance Schedule) identifying the minimum amounts of insurance coverage required;

~~5.2.2.5~~5.2.2.4 Attachment C~~C~~ (Confidentiality/Business Associate Addendum) showing that the vendor will abide by the necessary requirements to protect consumer health information that they may be exposed to or generate in the course of fulfilling their contracted duties and the privacy of those records in a HIPAA-compliant manner; and

~~5.2.2.6~~5.2.2.5 Additional attachments as determined necessary. Attachment labels A~~A~~-C~~C~~ may change depending on the importance of additional attachments.

~~5.2.2.7~~5.2.2.6 If required, package is forwarded to Budget Division for final review by Division's budget analyst and prepared for either clerk or full BOE-approval.

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: ~~0~~5/25/2012

DATE REVISED/REVIEWED: ~~New~~4/12/2019

SUPERSEDES: ~~New~~5/25/2012

DATE APPROVED BY ~~MHDS~~ DPBH ADMINISTRATOR: 05/25/2012

DATE APPROVED BY ~~MHDS~~ DPBH COMMISSION: 05/25/2012

TWO YEAR REVIEW – WITH CHANGES

Control #	Rev.	Title	Effective Date: 09/2017
FS 1.01	New	Forensic Services Security Camera System	Review Date: 09/2019

1.0 POLICY:

The Division of Public and Behavioral Health (DPBH) uses video recording equipment in its forensic facilities to ensure the safety and security of its clients and staff. Forensic facilities will use video camera system technology to monitor common areas, including observation and seclusion rooms, day rooms, corridors and hallways, visiting rooms, and/or group rooms.

2.0 PURPOSE:

This policy provides guidance regarding the use of video camera system technology in forensic settings and the maintenance and use of records generated by this technology.

3.0 SCOPE: DPBH Forensic Services

4.0 DEFINITIONS: N/A

5.0 REFERENCES: N/A

6.0 PROCEDURE:

The use of video camera system technology in forensic settings is not meant to supplant client supervision, rather it is intended to supplement and enhance safety and well-being for clients and staff.

6.1 The use of video camera system technology in forensic settings records images for security and administrative purposes. These recordings may be used to investigate abuse or neglect of clients served in forensic settings;

6.1.1 to be preserved for investigative purposes;

6.1.2 to report to law enforcement agencies; and

6.1.3 to be preserved in the incident report file.

6.2 Video camera system technology is not to be placed in individual rooms (except those designated for special observation), bathrooms, or shower areas.

6.3 The video camera system technology includes a recording feature with archival capacity.

6.3.1 Video is automatically retained for up to 14 days. This provides the opportunity to review images after a reportable incident, if/when a complaint is made, and/or for other clinical and administrative purposes, including training and quality improvement.

6.3.2 Copies of records from the archived data may be made and stored separately when authorized or when litigation or any other legal or disciplinary action is anticipated, pending, or ongoing. (Vault)

6.4 Access to video recordings will be limited to designated forensic staff members. Authorized staff members will have the capability to pull recordings upon request.

5.4.1 Other staff are prohibited from tampering with or disabling video camera system technology unless the staff member has been granted access by the Agency Director, Lieutenant, Sergeant, State Forensic Director, or Medical Director.

5.4.2 Any staff not assigned responsibility for maintaining the video camera system technology that is caught tampering with and/or disabling the video camera system may be disciplined, up to and including termination.

6.5 Access to viewing video camera system technology is limited to DPBH Deputy Administrator, Agency Director, and authorized staff.

6.5.1 Anyone requesting review of or access to video camera system records must obtain authorization from the DPBH Deputy Administrator and/or Agency Director. Requests must be made in writing.

6.6 Videos involving incidents of the following events will be retained until all related incidents or investigations are closed: escape and allegations of patient abuse/neglect by a staff member.

6.6.1 An Incident Report must be completed in these situations.

6.6.2 An email will be sent, in addition to the incident report, to the authorized staff requesting video be saved for any of these incidents or others were video could be beneficial.

6.7 Video recordings and incident reports will not be referenced in Avatar documentation and/or included in a patient chart.

6.8 Video recordings are considered to contain confidential information and are not to be viewed or shared with clients or staff members.

6.9 Staff that are within range of the video camera system have no expectation of privacy regarding any of their activities that are recorded.

6.10 All images and records may be used in investigations and/or complaints and with respect to disciplinary action.

6.11 Video recordings may be shared with law enforcement upon issuance of a subpoena.

7.0 REFERENCES: N/A

8.0 ATTACHMENTS: N/A

9.0 IMPLEMENTATION POLICY:

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

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

Control #	Rev.	Title	Effective Date: 09/17
FS 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 Division of Public and Behavioral Health (DPBH) that 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.

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 Services

4.0 **DEFINITIONS:** N/A

5.0 **REFERENCES:** N/A

6.0 PROCEDURE:

6.1 Upon admission to the Forensic Unit, clients will be assessed for escape risk by the intake clinician.
6.2 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.
6.3 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.
6.4 Treatment teams will review the client's watch/observation level and risk of escape during every treatment team meeting.
6.5 All Forensic Units are required to have at least two secure doors between the secure area of the facility and non-secure areas.
6.6 Clients are not allowed to be near the exit doors without staff presence.
6.7 Exit doors are always monitored by camera from the Control Room.
    6.7.1 Control Room staff will visually identify staff prior to opening a secure door.

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

6.9 Doors to courtyards require two forensic staff members to be present prior to opening.

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

- 6.10.1 Notify the nearest Police Department and State Capitol Police and provide the client's name, physical description, and last point of escapee contact.
- 6.10.2 Notify the Officer of the Day, Correctional Sergeant or designee and the Agency Director.
- 6.10.3 Confirm all doors are secure and complete a count of remaining clients.

6.11 Upon notification of an escape, the Agency Director or Designee will:

- 6.11.1 Notify the Administrator and Deputy Administrator immediately.
- 6.11.2 Notify the committing Criminal Court.
- 6.11.3 Notify the alleged victims, if applicable, as identified on the Arrest Report.
- 6.11.4 Complete a Critical Incident Report and a Serious Incident report.

6.12 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.

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

- 6.13.1 If a client attempts to elope, staff will make every effort to retain custody using approved methods.
- 6.13.2 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.
- 6.13.3 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.
- 6.13.4 A Serious Incident Report (SIR) must be completed.

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

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

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

7.0 ATTACHMENTS: N/A

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

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

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

NEW

Control #	Rev.	Title:	Effective Date:
FS 4.61	New	Privileging 461/NGRI Clients for off-site activities prior to a conditional release application.	**Next Review Date**

1.0 POLICY:
Forensic Services program will provide low risk, off campus activities for clients that are progressing toward conditional release.

2.0 PURPOSE:
To establish a process which collaboratively assesses the safety and appropriateness of treatment team recommendations for off-campus activities for clients committed to long-term inpatient treatment pursuant to NRS 178.461 and 175.539.

3.0 SCOPE: Foresnic Services

4.0 DEFINITIONS:
4.1 Conditional Release: release the person from commitment with conditions imposed by the court

5.0 REFERENCES:
5.1 NRS 178.463

6.0 PROCEDURE:
6.1 All activities considered should be low risk for the client and the community and should help the client develop skills which will help them progress towards achieving conditional release.
6.2 The treatment team will make a formal referral on the appropriate form(s) to the Agency Manager with a request to grant an off-unit activity to a long-term committed client.
6.3 The referral will include the following information:
6.3.1 All pertinent demographic information including the duration of hospitalization.
6.3.2 Medical Record Number
6.3.3 Diagnosis
6.3.4 Initial Charge
6.3.5 Course of treatment during hospitalization including violent behavior and aggression
6.3.6 Outline of requested activity including:
6.3.6.1 Location
6.3.6.2 Date program is to be implement

6.3.6.3 Purpose and summary of the activity
6.3.6.4 Forensic Specialist Safety Plan
6.3.6.5 Frequency
6.3.6.6 Potential benefits and risks

6.4 If the referral is acceptable to the Agency Manager, they may present the referral to the agency leadership team where there is no access to judicial review and approval.
6.4.1 If approved by the facility leadership team, a notification will be made to the court with the request of expansion of the client privileges.
6.4.2 If the court does not require an order to implement the plan, the following will occur:
6.4.2.1 The referral will be presented to the therapeutics committee at the sister forensic facility for additional review.
6.4.2.1 The receiving therapeutics committee will respond to the referral with any further questions, comments, concerns or suggestions.
6.4.2.2 Upon completion of the sister facility's review, the referral will be presented to the Statewide Forensic Program Director for additional review.
6.4.3 Once the plan has been vetted by those mentioned above, the treatment team will implement the planned off-campus activity incorporating the recommendations of the review process.
6.5 In locations where there is access to judicial review the plan will be presented to the court in which the client's case resides for review, approval and issuance of an order approving the activity.
6.6 Following completion of an approved client activity, an Avatar progress note will be written by the escorting staff outlining the activity, its outcome and any other pertinent details.
6.7 Any changes to the requested activity will require approval from the Agency Manager who will decide if further notification/review is required.

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY:
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.

TWO YEAR REVIEW – WITH CHANGES (POSITION TITLES UPDATED)

Control #	Rev.	Title	Effective Date: 03/01/2017
GOV 1.2	New	Practitioner Fit for Duty	**Next Review Date: 03/01/2019**

1.0 POLICY:

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

2.0 PURPOSE

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

3.0 SCOPE

This policy applies to all Division Medical Staff Practitioners.

4.0 DEFINITIONS:

N/A

5.0 REFERENCES: N/A

~~5.0~~ 6.0 PROCEDURE

~~5.1~~4.1 The Medical Staff orientation process provides education to the Medical Staff about illness and impairment recognition issues.

~~5.2~~4.2 The Division of Public and Behavioral Health shall establish a Practitioner Health subcommittee of the Medical Staff. The members will be selected by the Statewide Psychiatric Medical Director ~~Chief Medical Officer~~ from the

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nominations made by the Medical Staff. The Subcommittee shall meet as needed and shall document its activity.

5.34.3 The Practitioner Health Subcommittee shall accept self-referred practitioners as well as referrals from other department in the hospital relating to Medical Staff practitioners.

5.44.4 The Practitioner Health Subcommittee shall review the complaint, allegation, or concern, the circumstances of the situation related to fitness for duty. When the complaint is substantiated the medical Director will make referral for external diagnosis and treatment of the condition or concern if indicated. When external referral is not indicated, the Practitioner Health Subcommittee shall assign a member to work individually with the practitioner to address the issue.

5.54.5 When the complaint is unsubstantiated, the report will be closed and submitted to the Statewide Psychiatric Medical Director ~~Chief Medical Officer~~.

5.64.6 Every consideration for confidentiality will be considered in the Peer Review process.

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

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

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5.94.9 The Practitioner Health Subcommittee shall report to the Statewide Psychiatric Medical Director ~~Chief Medical Officer~~ on each referral.

5.104.10 If the practitioner's health jeopardizes patient safety, the Statewide Psychiatric Medical Director ~~Chief Medical Officer~~ shall initiate action per the Medial Staff Bylaws.

5.114.11 When a licensed independent practitioner fails to complete the required rehabilitation program, the subcommittee will notify the Statewide Psychiatric Medical Director ~~Chief Medical Officer~~.

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

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

~~6.0~~5.0 REFERENCES

~~6.1~~5.1 Joint Commission Manual. MS 11.01.01
~~6.2~~5.2 State of Nevada Risk Management Division, Employee Fitness for Duty Exam, Policy/Procedures
~~6.3~~5.3 UNSOM GME Fit for Duty policy/procedure

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Control #	Rev.	Title	Effective Date: 03/01/2017
GOV 1.2	New	Practitioner Fit for Duty	**Next Review Date: 03/01/2019**

~~7.0~~6.0 ATTACHMENTS: 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: 03/01/2017

DATE APPROVED BY DPBH ADMINISTRATOR: 03/01/2017

DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 03/17/2017

TWO YEAR REVIEW – WITH CHANGES (POSITION TITLES UPDATED)

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Control #	Rev.	Title	Effective Date: 03/01/2017
GOV 1.2	New	Practitioner Fit for Duty	**Next Review Date: 03/01/2019**

Control #	Rev.	Title:	Effective Date: 4/2003
HR 1.9 (5.029)	3/2017	WORKPLACE VIOLENCE~~IOLANCE~~ PREVENTION	Next Review Date: 3/2019

1.0 **POLICY**:

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

2.0 **PURPOSE**:

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

3.0 **SCOPE:**

Division of Public and Behavioral Health, Clinical Services Branch

~~3.0~~ **4.0 DEFINITIONS:**

4.1 Workplace: any location where an employee performs work -~~-~~related duties and can include, for example, parking lots, field locations,~~ and~~ consumer's homes and through the work email system or messaging systems.~~.~~

4.2 Medical Facility means a hospital as defined in NRS 449.012 or a psychiatric hospital as defined in NRS449.0165

4.3 Alarm means a mechanical or electronic communication system that does not rely on the vocalization of a person to alert others to an incident of workplace violence. (AB348)

4.4 Dangerous Weapon means an item capable of inflicting death or serious bodily Injury, regardless of whether the item was designed for that purpose. (AB 348)

4.5 Engineering Control means an aspect of a building or other designed space or device that removes a hazard from the workplace or creates a barrier between an employee or other provider of care and the hazard. (AB348)

4.5.1 Engineering Controls include one or more of the following:

4.5.1.1 Electronic Access controls to areas occupied by employees or other providers of care

4.5.1.2 Detectors of Weapons, whether installed or handheld.

4.5.1.3 Workstations enclosed with glass that is resistant to shattering.

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4.5.1.4 Deep Service counters
4.5.1.5 Separate rooms or areas for patients that pose a high risk of workplace violence.
4.5.1.6 Furniture affixed to the floor.
4.5.1.7 Opaque glass in rooms for patients that allows an employee or other provider of care to see the location of the patient before entering the room.
4.5.1.8 Closed circuit television monitoring and video recording.
4.5.1.9 Devised designed to aid the sight of an employee or other provide rof care.
4.5.1.10 Personal Alarm devices
4.5.1.11 Any other measure or devise that removes a hazard from the workplace or creates a barrier between an employee or other provider of care and a hazard.

4.6 Patient-Specific risk factor means a factor specific to a patient that may increase the likelihood or severity or an incident of workplace violence including :
4.5.1 The mental health of the patient;
4.5.2 The status of a patient's treatment and medication
4.5.3 A history of violent acts by the patient
4.5.4 The use of drugs or alcohol by the patient
4.5.5 Any other condition that causes a patient to experience confusion or disorientation fail to respond to instruction or to behave unpredictably.

4.6 Threat of Violence means a statement or conduct that:
4.6.1 Results in a reasonable person fearing for their own safety because of the likelihood of physical injury
4.6.2 Has no legitimate purpose

4.7 Work Practice Control means a procedure or rule that is used to reduce the risk of workplace violence, including without limitation:
4.7.1 Assigning and placing staff in a manner that reduces patient-specific risk factors.
4.7.2 Employing or contracting with security guards when applicable.
4.7.3 Providing training on methods to prevent workplace violence and respond to incidents of workplace violence.

4.8 Workplace violence means any act of violence or threat of violence except for a lawful act of self-defense or defense of another person including without limitation:
4.8.1 The use or threatened use of physical force against an employee or another provider of care, regardless of whether the employee or other provider of care is physically or psychologically injured.

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4.8.2 An incident involving the use or threatened use of a firearm or other dangerous weapon, regardless of whether the employee or other provider of care is physically or psychologically injured.

~~3.1~~

4.9 Acts of workplace violence include but are not limited to: causing or threatening to cause bodily injury, or ~~or~~ damage to the property of another person or substantial harm to the physical or mental health or safety of a person.

~~3.2~~

~~damage to the property of another person or substantial harm to the physical or mental health or safety of a person.~~

~~Acts of workplace violence~~ including ~~e~~but are not limited to:

4.9.1 striking, shoving ~~or~~ kicking another person

~~kicking another person;~~4.9.2 intentional physical injury;

4.9.3 intentional or reckless damage to another's property;

4.9.4 intimidating or menacing behavior;

4.9.5 abusive statements;

4.9.6 threats to cause harm or damage~~; and~~

4.9.7 reckless conduct that creates risk or threat of serious injury.

4.10 Threats include expressing intentions that would cause a reasonable person to feel frightened, intimidated or harassed

~~3.3~~

~~frightened, intimidated, or harassed~~.

4.11 Workplace bullying often involves an abuse or misuse of power. 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.

~~3.41.1 Acts of workplace violence include but are not limited to: striking, shoving or kicking another person; intentional physical injury; intentional or reckless damage to another's property; intimidating or menacing behavior; abusive statements; threats to cause harm or damage; and reckless conduct that creates risk or threat of serious injury.~~

4.12 "Security guard" per NRS 648.016 "Security guard" means a person employed as a watchman, guard, security consultant, patrol officer or in any other similar position.

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Control #	Rev.	Title:	Effective Date: 4/2003
HR 1.9 (5.029)	3/2017	WORKPLACE VIOLENCE~~IOLANCE~~ PREVENTION	Next Review Date: 3/2019

5.1 AB348
5.2 NRS 648.016
5.3 NRS 449.012 and .0165
5.4 NRS 449.242
5.5 DPBH Human Resources Office
5.6 Department of Health and Human Services Prohibitions and Penalties
5.6 Nevada Administrative Code.

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

6.1 Clinical Services Branch Medical Facilities shall establish a committee on workplace safety which will include:
6.1.1 Members of the staffing Committee
6.2.1 Members representing all major areas of the medical facility.
6.2 Medical Facilities shall develop a plan for the prevention of and response to workplace violence. The Plan must
6.2.1 Be in writing
6.2.2 Be in effect at all times
6.2.3 Be available to all staff and other providers of care at all times
6.2.4 Be specific for each unit, area and location maintained by the facility
6.2.5 Be developed in collaboration with the committee on workplace safety
6.3 The Workplace Violence Prevention and Response Plan must include:
6.3.1 All employees of the facility receive training:
6.3.1.1 On hire and then annually
6.3.1.2 Upon adoption of a new plan for the prevention of workplace violence.
6.3.1.3 Upon starting new job duties or assignments in a new location of the facility .
6.3.1.4 When a previously unrecognized hazard is identified or there is a material change in the facility requiring a change to the plan.
6.3.2 Training on Workplace violence will include:
6.3.2.1 Orientation to the plan and the manner that the facility plans to address incidents of workplace violence and the manner in which employees may participate in reviewing or revising

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the plan.

6.3.2.2 Orientation to the procedures on workplace violence

6.3.2.3 Recognizing situations that may result in workplace violence.

6.3.2.4 When and how to respond to and seek assistance in preventing or responding to workplace violence.

6.3.2.5 Reporting incidents of workplace violence to the medical facility and public safety agencies when appropriate.

6.3.2.6 Resources available to help cope with incidents of workplace violence including without limitation, a debriefing process and programs to assist an employee or other provider of care in recovering from the incident of workplace violence.

6.3.3 All employees or other providers of care who have direct contact with patients will have training on de-escalation techniques that:

6.3.3.1 Allows the employee or other provider of care to practice those techniques with other employees and other providers of care.

6.3.3.2 Practice sessions will include a debrief.

6.3.4 The facility shall collaborate with the committee on workplace safety in the development, review and revision of the training and any curricula, materials used in that training.

~~4.1~~5.6 General Provisions

~~4.1.1~~5.6.1 Workplace violence issues may arise from consumers, from random acts of individuals directed against the agency with or without apparent reason, from current or former employees, or from employees' personal relationships, such as a former spouse or a friend.

~~4.1.2~~5.6.2 Violence, threats, harassment, intimidation or other acts of aggression and disruptive behavior in the workplace will not be tolerated.

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~~4.1.3~~5.6.3 All reports of incidents will be seriously evaluated, and intervention will be initiated in accordance with the Division's Workplace Violence Prevention Program (Attachment I) and guidelines provided by the Risk Management Division (Attachment II).

~~4.2~~5.7 Employee Responsibilities

~~4.2.1~~5.7.1 Each employee's participation is needed to implement this policy effectively and maintain a safe working environment. It is expected that all employees will consistently treat other employees and all other persons contacted ~~in the course of~~during performing their job duties with dignity and respect.

~~4.2.2~~5.7.2 If you observe or experience an act of workplace violence, it is your responsibility to immediately report the incident to your supervisor or manager or a designated agency representative.

~~4.2.3~~5.7.3 If you are experiencing threats of violence from a domestic partner or other non-~~work related~~work-related relationship, you are encouraged to report this to your supervisor/manager or designated agency ~~representative~~representative, so a plan can be developed to minimize the risk to you and others during working hours.

~~4.3~~5.8 Agency Responsibilities

~~4.3.1~~5.8.1 Supervisors/managers/agency representatives who receive reports of workplace violence must initiate appropriate action in response to the ~~report, and~~report and ensure that the Workplace Violence Incident Report Form (Attachment III) is completed and forwarded to his/her supervisor.

~~4.3.2~~5.8.2 The agency director and division administrator are to receive copies no later than the next working day after the incident.

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~~4.3.3~~5.8.3 If there is a direct and imminent threat of violence, a supervisor should call 911 or other appropriate law enforcement entity and, if appropriate, evacuate the work area.

~~4.3.4~~5.8.4 If ~~a crisis situation~~a crisis arises, the highest agency official available at the time must be called into the situation to implement appropriate intervention. See Attachment II, Workplace Violence Prevention Program, for additional detail.

~~4.4~~5.9 Response to Acts of Violence

~~4.4.1~~5.9.1 If you are placed in a position of fear due to an act of aggression or violence, you should remain calm, remove yourself from the area (or excuse yourself from the phone call) as soon as possible and report the incident to the most accessible supervisory representative available.

~~4.4.2~~5.9.2 If you have advance knowledge of an encounter with a potentially aggressive individual, such as a meeting, notify your supervisor in advance so that preventive measures can be planned.

~~4.5~~5.10Consequences of Acts of Workplace Violence

~~4.5.1~~5.10.1 An individual who commits an act of workplace violence may be subject to disciplinary action (if an employee), may be removed from the premises, and/or subject to criminal penalties.

Effective Date: 4/18/03
Revised Date: 6/28/07
Approved by MHDS Commission: 4/18/03
Revised Date: 11/2016
Approved by the Commission on Behavioral Health 11/18/2016; 03/2017

~~5.0~~6 ATTACHMENTS

A. HR 1.9 (5.029) Workplace Violence Prevention ATTACHMENT 1

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B. HR 1.9 (5.029) Workplace Violence Prevention ATTACHMENT 2
C. HR 1.9 (5.029) Workplace Violence Prevention ATTACHMENT 3
D. HR 1.9 (5.029) Workplace Violence Prevention ATTACHMENT 4
E. HR 1.9 (5.029) Workplace Violence Prevention ATTACHMENT 5
F. HR 1.9 (5.029) Workplace Violence Prevention ATTACHMENT 6

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ATTACHMENT I

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

WORKPLACE VIOLENCE PREVENTION PROGRAM

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

1.0. TERMS

Acts of Workplace Violence

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

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

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

Workplace

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

Agency Threat Assessment Team

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

2.0. RESPONSIBILITIES OF ALL STAFF

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

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

3.0. AGENCY ADMINISTRATOR'S RESPONSIBILITIES

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

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

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

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

3.5. Appoint staff members to an agency assessment team.

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

4.0. EMPLOYEE'S RESPONSIBILITIES

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

4.2. An employee who is experiencing threats of violence that may carry over into the workplace from a domestic partner or other non-work-related relationship is also encouraged to report this to his/her supervisor, manager, or designated agency representative so a plan of action to minimize risk to the employee and others during working hours may be developed.

4.3. Notify his/her supervisor if he/she has prior knowledge of an encounter with a potentially aggressive individual expected to occur while in work status.

5.0. SUPERVISOR'S RESPONSIBILITIES

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

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

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

6.0. AGENCY ASSESSMENT TEAM'S RESPONSIBILITIES

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

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

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

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

7.0. INCIDENT REPORTING AND INVESTIGATION

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

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

As warranted by the incident, the agency administrator or his/her designee is responsible for reporting the incident to the Capitol Police or the local law enforcement agency, if they have not been called, and for providing written documentation of the incident. The law enforcement

Agency will conduct further investigation and coordination with other agencies as necessary.

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

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

8.0. ASSESSMENT AND PREVENTION ACTIVITIES

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

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

Review previous acts of workplace violence within the agency.

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

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

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

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

In addition, the team must survey employees, at least biennially, to identify the potential for acts of workplace violence and identify security measures which are in place (Sample Employee Security Survey – Attachment IV).

Based on the activities conducted, the agency assessment team will prepare written recommendations and provide those recommendations to the agency administrator for consideration.

9.0. TRAINING AND COMMUNICATION

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

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

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

10.0. FITNESS FOR DUTY EVALUATION

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

11.0. PROGRAM ASSISTANCE/AUDIT

The Risk Management Division is available to review and assist with the development of the workplace violence prevention program. Sample forms to use in program development are available at their website (**www.risk.state.nv.us**). The Risk Management Division will periodically audit division/agency programs.

ATTACHMENT II

State of Nevada
Guidelines for Responding to Employee Threats of Workplace Violence/Fitness for Duty Issues

Prepared by the Risk Management Division
"IMMEDIATE INTERVENTION"

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

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

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

- ♦ Place the employee on administrative leave (or in some cases sick leave) pending an investigation
- ♦ Notify the employee, verbally and in writing, that they are prohibited from coming to the worksite or other identified State property without prior approval and coordination with a designated agency representative

□□□ Contact the Attorney General's Office to initiate a criminal investigation
- ♦ Assemble a Threat Assessment Team, as noted above, to determine the best course of action

Indirect Threats, Stalking, Harassment, Bullying, Intimidation

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

to make a statement in regard to fitness for duty. Provide a copy of the employee's job description
-OR-

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

Bizarre, Inappropriate or Unsafe Behavior

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

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

Attorney General's Office- Investigation's Division	(775) 684-1150
Capitol Police - Chief	(775) 684-4542
Employee Assistance Program	(775) 684-0150 1-888 972-4732 (702) 486-2900 1-888 972-4732
Risk Management Division	(775) 687-3187
Critical Incident Stress De-Briefing	Contact the Risk Management Division

Guidelines for Responding to Threats of Workplace Violence/Fitness for Duty Issues
"IMMEDIATE INTERVENTION"

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

YES

Call 9-911 or other appropriate police entity

Notify affected employees – Give option to go home

If Appropriate – Evacuate work area – Place employees on Admin Leave

If possible, inform the offending person that they are prohibited from entering the workplace (If employee, place on Admin Leave)

Contact the Investigation Division of the Attorney General's Office

Assemble Threat Assessment Team

NO

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

YES

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

NO

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

YES

Confront and counsel the employee

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

Make formal referral to EAP

IS THIS???

An indirect threat, stalking, harassment, bullying, or intimidation?

OR

Bizarre, inappropriate, or unsafe behavior?

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

NO

No action necessary or try flow-chart again

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

ATTACHMENT III

WORKPLACE VIOLENCE Supplemental INCIDENT REPORT

DIVISION/AGENCY: _____ TODAY'S DATE: _____

ADDRESS/LOCATION WHERE INCIDENT OCCURRED:

_____

Office *Street Address* *City, State*

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

_____

Name *Title* *Telephone No.*

DATE AND TIME OF INCIDENT:_____A.M./P.M.

Date & Day of Week *Time*

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

_____

Name(s) *Title(s)*

PERSON(S) THE VIOLENCE WAS DIRECTED TOWARDS:

_____

Name(s) *Title(s)*

WAS THE PERSON INJURED? *(If so, describe)*

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

WHAT PRECIPITATED THE INCIDENT?

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

OTHER PERSON(S) WHO WITNESSED THE INCIDENT:

_____

Name(s) *Title(s)*

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

IF YES, TO WHOM WAS IT REPORTED AND WHEN?

ACTION BEING TAKEN BY ENTITY:

OTHER PERTINENT INFORMATION:

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

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

_____

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.

ATTACHMENT IV

EMPLOYEE SECURITY SURVEY
(Please Print)

NAME/TITLE: _____

DIVISION/AGENCY: _____

WORK LOCATION/ADDRESS: _____

1. Do you work alone in your building during working hours?

   If yes, is notification given to someone when you finish work?

2. Have you experienced any problems as a result of working alone?

   If yes, please describe the problem and explain whether it is problematic at only certain times (e.g., weekends, daylight savings time).

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

Issues of Concern	Experienced? (Y/N)	Observed (Y/N)	When?

4. Are there any areas/worksites where a violence-related incident would most likely occur? Please specify (*entrance, parking lot, private office, bathroom, field location, etc.).*

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

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

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

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

8. Other comments.

ATTACHMENT V

NRS REFERENCES

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

Attachment VI

HELP PREVENT WORKPLACE VIOLENCE

THE STATE OF NEVADA

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

Acts of workplace violence include incidents such as:

- Causing intentional physical injury
- Striking, kicking or shoving
- Intentional or reckless damage to another's property
- Menacing behavior
- Threats to cause harm or damage that would cause a reasonable person to feel frightened, intimidated or harassed.

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

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

_____ _____

Name Phone Number

If you need assistance to control anger or other behaviors, you may contact the State of Nevada Employee Assistance Program (EAP)

Northern Nevada: (775) 687-3869; (800) 397-3271 (Rural)
Southern Nevada: (702) 486-2929; 800 278-1889 (Rural)

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

DPBH 9/19

Control #	Rev.	Title	Effective Date: 1/1/2019
HR 1.35	New	DPBH Medical and Psychology Staff Offsite Work Activities	**Next Review Date:** 1/1/2021

1.0 POLICY:

DPBH requires time tracking of medical and psychology staff work hours including time worked at the off-site locations.

2.0 PURPOSE:

To establish guidelines for medical and psychology staff engagement in off-site work activities.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 Medical Staff: Medical Staff members include, physicians, advance practice registered nurses and physician's assistants who are licensed, credentialed and privileged to perform patient care duties within their scope of practice

4.2 Psychology Staff: Psychology Staff members include psychologists who are licensed , credentialed and privileged to perform patient care duties within their scope of practice.

4.3 Officer of the Day: A Senior Psychiatrist, Senior Physician or Pharmacist that perform on-call responsibilities to ensure 24-hour coverage in a psychiatric treatment facility (or forensic facilities and institutions) for additional payments.

5.0 REFERENCES:

AVATAR Patient Care Codes
NRS Medical Staff defined
NRS Medical Staff Cred and priviledges

6.0 PROCEDURE:

6.1 Medical and Psychology Staff are required to document work related activities as part of their on-site and off-site work responsibilities.

6.1.1 If an activity cannot be documented in AVATAR, staff shall be required to provide supplemental documentation specifying the nature.

6.1.2 Documentation should be specific to the type and duration of the activity.

Control #	Rev.	Title	Effective Date: 1/1/2019
HR 1.35	New	DPBH Medical and Psychology Staff Offsite Work Activities	**Next Review Date:** 1/1/2021

6.1.3 Additional documentation such as training certificates shall be required to document off-site activities.
6.1.4 Any off-site activities must be coded in AVATAR accurately with correlated documentation;

6.2 Agency Medical and Psychology Directors or designee in consultation with Agency Manager must determine approved off-site activities to maintain efficient work environment.

6.3 The Medical and Psychology Directors or designee in consultation with the Agency Manager must consider all aspects of medical and psychology staff clinical, administrative, and teaching responsibilities to maximize medical and psychology staff productivity and quality of patient care.

6.4 In general, the following types of work-related activities could be considered for off-site duties:

6.4.1. Student, resident, psychology assistants, and psychology intern supervision
6.4.2 Medical staff or psychology staff collaboration meetings;
6.4.3 Telephone communications for collateral interviews for psychology antreatment team physicians.
6.4.4 Officer of the day duties;
6.4.5 Review and completion of medical records;
6.4.6 Review and completion of evaluations;
6.4.7 State email communications;
6.4.8 Treatment team meetings when coordinating care with outpatient providers;
6.4.9 Review and completion of psychological testing;
6.4.10 Attendance at approved trainings and other educational meetings;
6.4.11 Participation in interagency committees;
6.4.12 Attendance of various committee hearings as representatives of the Agency or the DPBH;
6.4.13 Attendance of court hearings related to current or former DPBH patients;
6.4.14 Recruitment and retention activities;
6.4.15 Providing care at off-site locations as part of the Agency response to the community emergency needs.

Control #	Rev.	Title	Effective Date: 1/1/2019
HR 1.35	New	DPBH Medical and Psychology Staff Offsite Work Activities	**Next Review Date:** 1/1/2021

6.5 Medical and psychology staff who engage in off-site work as part of their work-related activities are required to provide an accurate account of their time and types of services performed.

6.5.1 This account must be documented by the Medical and Psychology Staff in the established time tracking system.

6.6 Each DPBH Clinical Service Branch Agency that employs medical and psychology staff will develop an internal process for tracking medical staff activities.

6.6.1 The Medical Director's office is responsible for monitoring medical staff off-site activities to ensure they are documented timely and appropriately.

6.6.2 The Psychology Director or designee is responsible for monitoring psychology staff
off-site activities to ensure they are documented timely and appropriately.

6.7 Medical Staff and Psychology staff that do not properly, accurately and timely document off-site work may
have their off-site work privileges revoked by the Medical Director, Psychology Director or Agency Administrator.

6.8 Approved off-site work activities can be canceled for any reason, at any time, without cause by the Medical Director, Psychology Director or designee, or Agency Manager.

6.8.1 Whenever feasible advance written notice will be provided prior to canceling approved off-site work activities, but this is not a requirement.

6.9 This procedure applies to all state employed DPBH Medical and Psychology staff

6.11 As a condition for maintaining credentials and medical staff privileges all Medical Staff Members and Psychology staff shall perform in compliance with Federal and State laws, Division and Agency policies, and established Medical Staff and Psychology Staff procedures.

7.0 ATTACHMENTS: N/A

Control #	Rev.	Title	Effective Date: 1/1/2019
HR 1.35	New	DPBH Medical and Psychology Staff Offsite Work Activities	**Next Review Date:** 1/1/2021

8.0 IMPLEMENTATION OF POLICY:

Training will be accomplished through PolicyTech within 30 days of hire date. Each Division agency shall implement this policy and may develop specific written protocols and procedures as necessary to do so effectively.

Control #	Rev.	Title	Effective Date: 1/1/2019
HR 1.35	New	DPBH Medical and Psychology Staff Offsite Work Activities	**Next Review Date:** 1/1/2021

Control #	Rev.	Title	Effective Date: 8/1/2019
HR 1.36	New	Medical Staff/Psychology Contractor Time tracking	**Next Review Date:** 8/2/2021

1.0 POLICY:

The Division of Public and Behavioral Health ensures proper documentation for contractors' billing is submitted and reviewed to verify that the documentation supports the rates and hours billed.

2.0 PURPOSE:

To provide a standardized process for reviewing documentation for contractors' billing before approval.

3.0 SCOPE: Statewide

4.0 DEFINITIONS:

4.1 Medical Staff: Medical Staff members include, physicians, advance practice registered nurses and physician's assistants who are licensed, credentialed and privileged to perform patient care duties within their scope of practice

4.2 Psychology Staff: Psychology Staff members include psychologists who are licensed , credentialed and privileged to perform patient care duties within their scope of practice.

4.3 Contractor: A non-employee of the state who as an individual or through an agency provides services

5.0 REFERENCES:

6.0 PROCEDURE:

6.1 The Division will utilize Avatar time tracking as a component of the billing accountability process.

6.1.1 This requires contractors to account for the number of hours they are required to work per their contract.

6.2 Payment will not be approved until the following process has been completed:

6.2.1 Contractors are required to sign in and sign out at an appointed location when entering and leaving the work premises.

Control #	Rev.	Title	Effective Date: 8/1/2019
HR 1.36	New	Medical Staff/Psychology Contractor Time tracking	**Next Review Date:** 8/2/2021

6.2.2 This sign in document is to be compared to the time entered into Avatar as well as the billed amount on the invoice.
6.2.3 Rates will be confirmed by current contract.
6.2.4 Internal Controls will verify available funding, correct coding and contract.
6.3 Should a discrepancy be found, the contractor will be contacted to clarify the discrepancy.
6.3.1 Approval for payment must not be granted unless the approver is satisfied that the billing invoice is accurately matched to the sign in sheet and Avatar notes.

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY:

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

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

NEW - EXPIDITED APPROVAL
BY ADMIINSTRATOR SHERYCH

Control #	Rev.	Title	Effective Date:
HR 1.37	New	Medical Staff and Psychology Contract Billing Rates	**Next Review Date**

1.0 POLICY:

The Division of Public and Behavioral Health will establish and maintain standardized rates for positions staffed by contractors.

2.0 PURPOSE:

To establish and maintain basic standardized rates for contractors that are employed by the State for services rendered within our inpatient hospitals and outpatient clinics.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 Medical Staff: Medical Staff members include, physicians, advance practice registered nurses and physician's assistants who are licensed, credentialed and privileged to perform patient care duties within their scope of practice

4.2 Psychology Staff: Psychology Staff members include psychologists who are licensed , credentialed and privileged to perform patient care duties within their scope of practice.

5.0 REFERENCES:

6.0 PROCEDURE:

6.1 Recommended standardized contract rates for psychiatrists:

6.1.1 $155/hour for board eligible;

6.1.2 $165/hour for board certified;

6.1.3 $175/hour for sub-specialty board certified, and

6.1.4 $185/hour for sub-specialty board certified psychiatrists who are acting in medical administration positions.

6.2 Recommended standardized contract rates for Advanced Practice Nurses (APRN):

6.2.1 $75/hour for non-psychiatric trained and boarded

6.2.2 Up to $85/hour for psychiatric trained and boarded

6.3 Recommended standardized contract rates for Psychologists:
- 6.3.1 $75/hour for psychologist
- 6.3.2 $85/hour for Neuropsychologist
- 6.3.3 Up to $125/hour Forensic Psychologist (certification for competency evaluations)

6.4 Rates for specialties may be adjusted to meet demand.
6.5 Rates will be reviewed every two years and adjusted as needed.
6.6 Contracted rates may include a management fee.
6.7 Final rates will be reviewed and approved by the Medical Directors, Agency Managers and Divison Administration.

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY:

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

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

NEW - EXPIDITED APPROVAL
BY ADMIINSTRATOR SHERYCH

Control #	Rev.	Title	Effective Date: 8/1/2019
HR 1.38	New	Medical Staff On-Call	**Next Review Date:** 08/01/2021

1.0 POLICY:

DPBH ensures proper processes are in place prior to approval of on-call, standby and Officer of the Day duties.

2.0 PURPOSE:

To establish guidelines for medical and other staff for on-call, standby and Officer of the Day duties.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 Medical Staff: Medical Staff members include, physicians, advance practice registered nurses and physician's assistants who are licensed, credentialed and privileged to perform patient care duties within their scope of practice

4.2 Call Back to work: an employee is called back to work during their scheduled time off without notification before end of work day.

4.3 Standby Status (On Call): a nonexempt employee in the classified service of the State and is directed to remain available for notification to work during specified hours and prepared to work if needed.

4.4 Officer of the Day: A Senior Psychiatrist, Senior Physician or Pharmacist that perform on-call responsibilities to ensure 24-hour coverage in a psychiatric treatment facility (or forensic facilities and institutions) for additional payments.

5.0 REFERENCES:

5.1 NRS 284.214

5.2 NAC 218

6.0 PROCEDURE:

6.1 DPBH may adopt a plan to authorize additional payments for employees to provide coverage.

6.1.1 Officer of the Day payments of up to $60 for a specified period on a weeknight and of up to $100 for a specified period on a weekend day for unclassified Senior Psychiatrists, Senior Physicians or Pharmacists

6.1.2 Duties for Officer of the Day must include without limitation, attending to clinical emergencies, evaluation of patients subject to seclusion and restraint and completing rounds during weekends and holidays. Pharmacists duties include without limitation, consultation with medical personnel and first dosage reviews.

6.1.3 Standby Status ceases and employee qualifies for straight time or overtime pay, whichever is applicable for the time worked.

6.1.4 Standby status of a nonexempt employee in the classified service receives additional pay at the rate of 5% of normal pay every hour on standby status.

6.1.5 All compensation status must be approved by supervisor and Agency Manager/designee

6.1.6 Documentation should be specific to the type and duration of the activity.

NEW

Control #	Rev.	Title:	Effective Date: 09/01/2019
IMRT 1.50	New	Inpatient Information Systems/Electronic Health Records Downtime/Medication Management	**Next Review Date:** 09/01/2021

1.0 POLICY:

DPBH will have established processes for business continuity of clinical services documentation in the event of planned and unplanned Information Systems/Electronic Health (Medical) Records and Medication Management (EHR/EMR) systems are down/no connectivity.

2.0 PURPOSE:

To document the strategies, personnel, procedures, dependencies and resources that the facilities' staff will use to continue business operations during any planned or unplanned interruption to Electronic medical records and the medication management system.

This document details assumptions for various scenarios and should be followed with only minor (if any) alterations required by each agency.

3.0 SCOPE: Clinical Services, DPBH

4.0 DEFINITIONS and ACRONYMS:

4.1 CPOE/EOE-Computerized Physician Order Entry/Electronic Order Entry
4.2 EHR/EMR-Electronic Health Record/Electronic Medical Record
4.3 eMAR- Electronic Medication Administration Record
4.4 HIS-Health Information Services
4.5 IS- Information System(s)
4.6 IT-Information Technology
4.7 LIS-Laboratory Information System
4.8 MPI-Master Patient Index
4.9 MMO – Medication Management Optimization

4.10 OIT Office of Information Technology
4.11 DPBH agencies: Rural Clinics, SNAMHS, Lakes Crossing and NNAMHS.
4.12 eOE- electronic Order Entry

5.0 REFERENCES:

6.0 PROCEDURE:

6.1 Each Agency will establish down time procedures
6.1.1 Each agency will assign Response and Recovery roles for each of their facilities, comprising the Business Continuity Team.
6.1.2 Response and Recovery Roles:

6.1.2.1 Team Leader	Leads the response or recovery effort following a disruptive incident and serves as the final decision maker for the response and recovery team.
6.1.2.2 Team Coordinator	Assists the team leader in managing the response or recovery effort including facilitating communications.
6.1.2.3 Team Administrator	Records meeting minutes, sets up meeting locations (including conference bridges), and helps administer the team's logistical needs and coordination with others.

6.2 DPBH clinical staff will utilize paper-based processes when official downtime or electronic ordering and documentation systems have been announced.
6.2.1 Upon restoration of normal system operations, paper records will be scanned into the EHR once the data has been entered into the system.
6.3 Scheduled downtime occurs for upgrades and maintenance to certain system components.
6.3.1 Scheduled downtime is requested and approved so that advance notice is given at a minimum 24 hours prior to scheduled downtime.
6.4 Unscheduled downtime occurs when unpredicted problems disable one (1) or more applications within the EHR system, network connectivity and/or IT infrastructure.
6.5 During either scheduled or unscheduled downtime, Agency Leadership and IT staff will

coordinate with their staff to enact the continuity plans set forth in this document.

6.6 Scheduled Downtime: There will be times when EHR, or components thereof, will have a planned downtime.

6.6.1 If the EHR system is going to be down and staff has advanced notice, there are several steps that must be observed before the system goes down and again, once the system becomes available for use.

6.6.2 Scheduled downtime 1-4 hours: EHR system is down for planned maintenance for a period of 1-4 hours and all other system/network components are functional.

6.6.2 Notification of scheduled downtimes will be communicated from OIT/Avatar team.

6.6.3 The OIT/Avatar Team will notify the Agency via e-mail when the situation has been addressed and the system is back.

6.6.3.1 State-wide, notification will be sent out via email.

6.6.4 Admission's Emergency downtime packets will be made available in each agency.

6.6.4.1 Client information will either be written by hand or pre-printed labels applied, if applicable.

6.6.4.2 New clients will be assigned a master patient index (MPI) Avatar number or other identification number from emergency downtime log.

6.6.4.3 Admission's staff will notify Dietary services each time a new patient is admitted with special dietary allergies, needs, or orders.

6.6.5 Upon notification that the system is back on-line, a designated person will enter admit information into the system for clients who were admitted to the agency during downtime.

6.6.5.1 All diagnoses, orders, alerts, allergies, and vitals will be entered into the system.

6.6.5.2 LOCUS, nurse assessments, treatment plan, AIMS, mental status, Psychosocial, progress notes, History and Physical, Discharge

Summaries, and Psych Evaluations may be scanned if downtime > 1 hour.

6.6.6 Clinical Staff: A paper version of the unit census or equivalent will be used during the downtime, making edits as needed.

6.6.6.1 Paper forms will be used with the client and for healthcare providers.

6.6.6.2 Forms are in packets called *Emergency Downtime Packet*/Avatar Down binders and are located on the nursing units.

6.6.6.3 Downtime forms are also available in a shared network drive location.

6.6.6.4 eMAR report will be run twice daily and printed as needed.

6.6.6.4.1 The eMAR report will be updated manually during downtime.

6.6.7 Upon notification that the system is back on-line, a designated person will enter the eMAR data as well as clinical information for each client into the EHR as soon as possible once the system is stable.

6.6.7.1 If downtime period lasts less than 24 hours, all hand-written forms will be transcribed into the EHR.

6.6.7.2 If downtime period lasts for more than 24 hours, all hand-written forms will be scanned into the HER, except for medications and time and date sensitive treatments.

6.6.8 Pharmacy Staff: The current non-eMAR Orders report will run according to schedule.

6.6.8.1 Print and distribute as needed during downtime.

6.6.8.2 Pull medications from the Pyxis machine to be administered during downtime according to the current orders.

6.6.8.3 Upon notification that the system is back on-line, a designated person will reconcile the medication inventory count.

6.6.9 Laboratory Staff**:** Process paper Lab Test Requisition orders

6.6.9.1 Critical Lab Results will be phoned in to Clinicians per agency protocol.

6.6.10 Upon notification that the system is back on-line, a designated person will reconcile paper lab test orders and results with eOE lab orders and results, and scan paper results generated during the downtime to the EHR.

6.7 Unscheduled Downtime: In the event of an unscheduled downtime event, staff will need

to be prepared to handle working without computerized technology and be able to transition to a paper process until the system is online.

6.7.1 Assumptions: This scenario assumes that the EHR system is unexpectedly down for a period of 15minutes or more and all other system/network components are functional.

6.7.2 Notification: When Avatar is down, and network is up, notification will be reported to the OIT Help Desk.

6.7.3 Once validation that an Avatar outage has occurred, the Avatar team will send a mass email to DPBH agencies.

6.7.4 When Avatar is down, and network is down, notification of unplanned downtime will be communicated by phone to Hospitals, Clinics and Pharmacy Administrators by DPBH OIT Management.

6.7.5 If the hospital experiences a system outage and has not been notified by OIT/Avatar Team, or HIS, the Agency Manager or designee should contact an IT representative during regular operating hours.

6.7.6 The OIT/Avatar Team will notify the agency via e-mail when the system is back on-line.

6.7.7 A notification that regular operations have resumed will be made in accordance to Agency Protocol.

6.7.7.1 This notification process will be adhered to during normal working hours which are as follows:
Monday – Friday: 7:00 am – 500 pm
Saturday – Sunday: 8:00 am – 5:00 pm

6.8 Admissions Staff: Upon notification from the OIT/Avatar Team/HIS or upon realization the system is down, admissions staff will adopt the downtime procedure processes and hard copy forms will be utilized.

6.9 Emergency downtime packets are available throughout clinical areas.

6.9.1 Client information will either be written by hand or pre-printed labels applied, if applicable.

6.9.2 For new clients, assign a master patient index (MPI) number or Facility Chart Number

(Avatar number) from the emergency downtime log located in Desktop Links or per protocol.

6.9.3 Notify Dietary services each time a new client is admitted, special diet, dietary allergies, and/or doctors' orders per protocol.

6.9.4 Upon notification that the system is back on-line, a designated person will enter admit information chronologically into the system for clients who were admitted to the agency during downtime.

6.10 Rural Clinics Outpatient Staff

6.10.1 Each Rural Clinic will maintain a binder with Master paper copies of all forms needed in the event of computer or AVATAR downtime.

6.10.2 A Master copy will also be kept on the computer desktop.

6.10.3 The Clinic Director or designee is responsible for updating forms as they are developed.

6.10.4 For outages less than 24 hours, information gathered will be entered into Avatar as soon as possible.

6.10.4.1 All handwritten notes need to be secured per HIPAA regulations until entered into the EHR (or Avatar).

6.10.5 For outages over 24 hours, notes may be scanned into AVATAR once it is available, with a note (for billing purposes) indicating downtime, and with handwritten note scanned into EHR (or Avatar).

6.10.6 For Sure Script electronic prescription entries, a paper MAR, or prescription Rx will be utilized and copied/faxed to the appropriate pharmacy, or called in.

6.10.6.1 The MAR/Rx will then be scanned into the chart.

6.10.7 Upon notification that the system is back on-line, a designated person will enter the MAR data as well as clinical information for each client as soon as possible after the system is stable.

6.10.8 If the downtime period lasts **less than** 24 hours, all hand-written forms will be transcribed into the EHR.

6.10.9 If the downtime period lasts for **more than** 24 hours, all hand-written forms will be scanned into the EHR.

6.10.10 To prevent confusion in the event of outages lasting **longer than a day**, each practitioner should print a copy of their following weeks' schedule on Friday.

6.11 Pharmacy Staff

6.11. 1 Upon notification that the system is back on-line, a designated person will reconcile the system inventory from the paper records.

6.13 Laboratory Staff

6.13.1 The Laboratory Information system will interface with Avatar Lab eOE to process inpatient lab test orders and results electronically.

6.13.2 Outpatient Lab Results will continue to be processed manually by the Lab.

6.13.3 Quest Diagnostics is the SNAMHS contracted Reference Laboratory.

6.13.3.1 Clinicians and Physicians will have access to Quest's Care360 application that allows them to review outpatient lab order status and results.

6.13.3.2 Lab tests sent to the reference laboratory will have their lab results returned in paper format and those results will be scanned into the EHR.

6.14 Follow Up

6.14.1 After the system is back on-line and all information has been collected, the loose filing will be entered into the EHR.

6.14.2 Records will be processed according to Agency Protocol.

6.14.3 Reports will be run on the information entered into the EHR and reconciled to the paper records according to Agency Protocol.

6.15 Third Party/Independent Server Downtime Scenarios: This section highlights server outages that would interrupt operations and how to go about getting those servers restored. These measures would be implemented in addition to and in concert with the Business Continuity Team enacting downtime procedures.

6.16 Avatar Outage

6.16.1 If the Avatar system is down, the Avatar Support team will contact Netsmart and proceed according to Netsmart's business continuity plan (Reference 6.1).

6.17 Pyxis Outage

6.17.1 If the Pyxis server is down, the Agency Avatar Support Team will contact Netsmart

and proceed according to Netsmart's business continuity plan (Reference 6.1).

6.17.2 If a single machine were to go down, utilize other machines in the hospital until that machine is operating again.

6.17.3 If all devices/system is down, nurses will utilize the after-hour med carts, conduct manual overrides or utilize the pharmacies.

6.18 RxConnect Outage

6.18.1 If the RxConnect server is down, the end user will contact the Avatar Support Team.

6.18.2 Agency Avatar Support Team will contact Netsmart and proceed according to Netsmart's business continuity plan (Reference 6.1).

6.18.3 During a time when Avatar is up and RxConnect is down, no patient information will flow from Avatar to the Pyxis machines, however existing orders will be in the Pyxis.

6.18.3.1 The Pyxis machine will go into Automatic Critical Override mode.

6.18.3.2 Nurses will be able to use the override and pull out needed medication.

6.18.3.3 For new orders, nurses will utilize the override feature in the Pyxis.

6.18.3.4 When downtime is over, the Pyxis machine will go out of critical override or the critical override can be manually turned off.

6.19 Laboratory Information System Outage

6.19.1 If the Laboratory Information System server is down, the Lab staff will contact Netsmart and proceed according to Netsmart's business continuity plan.

6.19.2 During a time when Avatar is up and the LIS is down, no patient information will flow from Avatar eOE to the LIS, any existing lab orders will be in the LIS, but no results will be sent from the LIS to Avatar Lab Results.

6.19.3 Upon notification that the system is back on-line, a designated person will reconcile paper lab orders and results with eOE lab orders and results in the LIS and scan paper lab results generated during the downtime to the EHR.

7.0 ATTACHMENTS:

7.1 IMRT 1.50 Information Systems Electronic Health Records Medication Management Downtime Matrix Attachment A

8.0 IMPLEMENTATION OF POLICY:

Control #	Rev.	Title:	Effective Date: 09/01/2019
IMRT 1.50	New	Inpatient Information Systems/Electronic Health Records Downtime/Medication Management	**Next Review Date:** 09/01/2021

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

 COMPUTERIZED PHYSICIAN ORDER ENTRY DOWNTIME MATRIX

Module	Business Function	Interim Process Implementation Timeframe	Disaster Recovery Process
myAvatar	Electronic Health Records (EHR)	Greater than one hour	• DPBH clinical staff will utilize paper-based processes when official downtime of electronic documentation systems is announced. • Upon restoration of normal system operations, paper records will be scanned into the EHR after the data has been manually entered into the system from the paper forms.
RxConnect	Pharmacy - Medication Order Review	Greater than one hour	• DPBH pharmacy staff will utilize paper-based processes when official downtime of electronic ordering/documentation systems is announced. • Upon restoration of normal system operations, paper records will be scanned into the EHR after the data is manually entered into the system from the paper forms.
RxConnect	Pharmacy – Medication Dispensing	Greater than one hour	• New patients will be temporarily entered the Pyxis Workstation by the nursing supervisor. • The pharmacy will set the Pyxis Workstations into Critical Override mode. • Nurses will be able to use the override and get out needed medication. • When the downtime is over, critical override can be manually turned off.
Electronic Order Entry (eOE)	Treatment and medication documentation for each client	Greater than one hour	• DPBH clinical staff will utilize paper-based processes when official downtime of electronic documentation systems is announced. • Upon restoration of normal system operations, paper records will be scanned into the EHR after the data has been manually entered into the system.
Electronic Medication Administration Record (eMAR)	Treatment and medication documentation for each client	Greater than one hour	• DPBH clinical staff will utilize paper-based processes when official downtime of electronic documentation systems is announced. • Upon restoration of normal system operations, paper records will be scanned into the EHR after the data has been manually entered into the system.

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Pyxis	Medication Dispensing	Greater than one hour	• If a single machine goes down (not functioning), utilize another Pyxis and call the service number on the down Pyxis. • If all IS systems are down, call the OIT helpdesk. • During off hours, use the phone tree\on-call list to call the pharmacist or follow your agency protocol.
Administration/ Scanning of Medication Dispensing	Medication Dispensing	Greater than one hour	• DPBH clinical staff will utilize paper-based processes when official downtime of electronic documentation systems, including scanning devices, is announced. • Upon restoration of normal system operations, paper records will be scanned into the EHR after the data is manually entered into the system.
Laboratory Information Systems (LIS) (*SNAMHS only*)	Lab test analysis and documentation	Greater than one hour	• DPBH clinical staff will utilize paper-based processes when official downtime of electronic documentation systems, including laboratory devices and systems, has been announced. • Upon restoration of normal system operations, paper records/forms will be scanned into the EHR after the data has been manually entered into the system, • *Critical lab values will be telephoned to nursing immediately.*

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Control #	Rev. Date:	Title:	Effective Date: 05/2008
IMRT 4.75 (4.075)		Website Maintenance Process	Next Review Date:

1.0 POLICY:

It shall be the policy of the Division of Public and Behavioral Health (DPBH) to ensure that DPBH website contains current, accurate and relevant information. The website shall not contain information considered to be proprietary, religious, political, or of a personal nature.

2.0 PURPOSE:

The purpose of this policy is to establish a system for the development and maintenance of the DPBH website and to provide information, communications, and resources to individuals accessing the internet with current information that is user-friendly and accessible.

3.0 SCOPE: Clinical Services

4.0 DEFINITIONS:

4.1 Website Author is the person authorized to make changes or add information to existing pages within the website.

4.2 Website Publisher is the person authorized to review the modifications made by the author. The publisher conducts a review of revised or new content to ensure Personal Health Information (PHI) is not on the website and to ensure website content meets state and federal laws and regulations for internet communications.

4.3 Website Requestor is the agency designee authorized to request new pages and/or modification to the website.

5.0 REFERENCES: N/A

Control #	Rev. Date:	Title:	Effective Date: 05/2008
IMRT 4.75 (4.075)		Website Maintenance Process	Next Review Date:

6.0 PROCEDURE:

6.1 Development of a new website page:

6.1.1 The requestor is required to complete and submit information for the new website page to the website author on an agency approved website maintenance form. The following initial information for a new page is required:

6.1.2 Modifications will be completed and posted to the website within 5 days of receiving the initial requet

6.1.3 Name, title, and agency of requestor

6.1.4 Date requestedTitle of pagePage name on menu; and

6.1.5 Order in which new page should be inserted onto website.

6.1.6 A new page will be completed and posted to the website within 10 days of receiving the initial request.

6.2 Modification of website pages:

6.2.1 Agencies are responsible for reviewing website content and updating information at least once a month.

6.2.2 The requestor is required to complete and submit revisions for the existing website page to the website author on an agency approved website maintenance form. The form should contain the following information:

6.3 General Requirements for all website changes:

6.3.1 Documents sent to the author for upload should be in PDF (Portable Document Format), which is very compact and can be viewed by any system/software.

6.3.2 When providing images for upload, provide a "description title" which will appear when hovering over the picture on the website. This information shold be provided on the agency approved website maintenance form.

6.3.3 Notices of public meetings should be posted to the website and no later than 9:00 am on the third working day before the meeting per NRS 241.020. A notice of public meeting posted on the website is supplemental to and is not a substitute for the minimum public notice requirements.

6.3.4 Agencies will track requests for website modifications, including the development of new pages by utilizing their approved website maintenance form

6.3.5 Agencies will check for broken links at least once a month

7.0 ATTACHMENTS:

Example of Website Maintenance form

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: 01/07/08
Revised/Review Date:
Approved by DPBH Administrator:
Approved by Commission: 05/30/08

WEBSITE MAINTENANCE REQUEST

Requestor Name: _____ Date: _____

Title: _____ Agency: _____

Phone/Fax: _____

Modification Description: **NEW** ☐ **UPLOAD** ☐ **CONTENT** ☐

FOR **NEW** WEB PAGES **ONLY**
1) TITLE OF PAGE: 2) _____
PAGE NAME ON MENU: _____
3) ORDER ON MENU: _____

DO NOT WRITE BELOW THIS LINE ~ WEB AUTHOR/PUBLISHER ONLY

Due Date: _____
Completed By: _____ Date: _____

~~Needs Attachments~~

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

NEW – MHDS-DPBH

Control #	Rev. Date:	Title:	Effective Date: 12/2013
SP 1.18		Enrollment and Benefits for Payment	Next Review Date:

1.0 POLICY:

It is the policy of the Division of Public and Behavioral Health that individuals applying for services from the Division will apply for all benefits for reimbursement for services in order to be assessed for payment on the Division's sliding fee scale. The Division will assist individuals who may be eligible for coverage through ACA through the, and Medicaid and/or other federally based benefits (e.g. SSI/SSDI) in the applying for these benefits.

2.0 PURPOSE:

The purpose of this activity is to ensure compliance with State regulations and maximize health benefits available to individuals through the expanded Medicaid programs. In addition, this policy is to ensure that all opportunities for reimbursement are appropriately pursued and claimed.

3.0 SCOPE:

This policy applies to all Statewide Divisions direct service agencies

4.0 DEFINITIONS:

Nevada Health Link ~~N/A~~
ACA - Affordable Care Act Coverage
CAC - Certified Application Counselor

5.0 REFERENCES: ~~REFERERNCES:~~

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:

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Control #	Rev. Date:	Title:	Effective Date: 12/2013
SP 1.18		Enrollment and Benefits for Payment	Next Review Date:

~~5.0~~6.0 PROCEDURE:

~~5.1~~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 individual who may be eligible for any benefits.

~~5.1.1~~6.1.1 Each behavioral health 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 of designee.

~~5.1.1.1~~6.1.1.1 CAC's will be made available across agencies to assist individuals and CAP staff as necessary.

~~5.1.1.2~~6.1.1.2 Each behavioral health site will have staff trained or access to staff trained by a CAC to assist individual with benefit applications. This staff will ensure all applications are completed and submitted or provided to Division of Welfare and Supportive Services (DWSS) as appropriate.

~~5.1.1.3~~6.1.1.3 Staff will refer individual with eligibility for Nevada.

~~5.2~~6.2 CAC or other staff will be assigned to the Division hospitals to assist individuals in applying for benefits.

~~5.2.1~~6.2.1 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 eligibility.

~~5.2.2~~6.2.2 All behavioral health agencies will assist these individuals with applying for benefits or provide the following information to individuals seeking services:

~~5.2.2.1~~6.2.2.1 Where and how to apply

~~5.2.2.2~~6.2.2.2 The need to apply within 30-days of seeking services

~~5.2.2.3~~6.2.2.3 Failure to apply may result in the individual being financially responsible for services.

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Control #	Rev. Date:	Title:	Effective Date: 12/2013
SP 1.18		Enrollment and Benefits for Payment	Next Review Date:

~~5.2.3~~6.2.3 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. Health Insurance plans to a designated CAC for assistance if necessary.

~~5.2.3.1~~6.2.3.1 ~~All sites will make every effort to contact these individuals by December 1, 2013 and if they wish to enroll, they will be assisted with enrollment before December 18, 2013.~~ Individuals will be assisted in completing and submitting an application for benefits. For those individuals who decline application 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 (see Attachment A) and written (see Attachment B) 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.

~~5.2.3.2~~6.2.3.2 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.

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~~5.2.3.2.1~~6.2.3.2.1 If the individual continues to decline application, the clinic director or designee will provide written notice (see Attachment C) 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.

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~~5.2.3.3~~6.2.3.3 Each site and all Division's Drop-In Centers will provide an opportunity for individuals to access information and assistance with applications for benefits.

~~5.2.3.3.1~~6.2.3.3.1 Paper applications will be available at all DPBH sites. 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.

~~5.2.3.4~~6.2.3.4 Division Service Coordinators 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.

~~5.3~~6.3 ACA Compliance:

~~5.3.1~~6.3.1 Each agency director will monitor the percentage of uninsured individuals opened to services on a monthly basis.

~~5.4~~6.4 The 270/271 transaction will be used to track the progress of individuals aided in applying for benefits towards successful enrollment for benefits.

~~5.4.1~~6.4.1 It is the responsibility of all individuals served to pursue and apply for all eligible benefits for reimbursement to the Division for services provided in order for the individual to be eligible for the Divisions sliding fee scale.

~~5.5~~6.5 Each agency will report to the central billing unit each month on all data on applications progress.

~~5.6~~6.6 Individuals' Role and Responsibility

~~5.6.1~~6.6.1 It is the responsibility of all individuals served to pursue and apply for all eligible benefits for reimbursement to the Division for services provided in order for the individual to be eligible for the Division's sliding fee scale.

~~5.7~~6.7 Urgent or emergent services will not be delayed or denied as a result of failure to apply for benefits.

7.0 ATTACHMENTS:

~~6.0~~ 7.1 SP 1.8 Enrollment and Benefits for Payment SNAP TANF Chart Attachment A

7.2 SP 1.8 Enrollment and Benefits for Payment Sliding Fee Scale NNAMHS

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~~Needs Attachments~~

Attachment B

~~6.1 Verbal Explanation of ACA/Medicaid Expansion Benefits~~

~~6.2 Written Explanation of ACA/Medicaid Expansion Benefits~~

~~6.3 Written Notice of Change in Eligibility for DPBH Sliding Fee Scale~~

~~6.4 Medicaid Screening Tool (get from Medicaide)~~

~~7.01.0 REFERERNCES:~~

~~7.11.1 Medicaid Services Manual (MSM), Chapter 100 – Medicaid Program~~

~~7.21.1 MSM, Chapter 400 – Mental Health and Alcohol/Substance Abuse Services~~

~~7.31.1 MSM 600 – Physician Services~~

~~7.41.1 MSM Chapter 2500 – Case Management:~~

8.0 IMPLEMENTATION OF POLICY:

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

Effective Date: 12/05/13
Approved by Administrator: 12/05/13
Approved by Commission:

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SNAP ALLOTMENTS (eff 10/1/18)					
MAXIMUM ALLOTMENT		MAXIMUM NET 100% OF PROVERTY	MAXIMUM GROSS 130% OF POVERTY	MAXIMUM GROSS 165% OF POVERTY	MAXIMUM GROSS 200% OF POVERTY FOR CAT ELIG DETERMINATION
HH1-	$192	$1,012	$1,316	$1,670	$2,024
HH2-	$353	$1,372	$1,784	$2,264	$2,744
HH3-	$505	$1,732	$2,252	$2,858	$3,464
HH4-	$642	$2,092	$2,720	$3,452	$4,184
HH5-	$762	$2,452	$3,188	$4,046	$4,904
HH6-	$914	$2,812	$3,656	$4,640	$5,624
HH7-	$1,011	$3,172	$4,124	$5,234	$6,344
HH8-	$1,155	$3,532	$4,592	$5,828	$7,064
	$144	$360	$468	$594	$720
MINIMUM SNAP ALLOTMENT FOR 1 OR 2 PERSON HH - $15.00					

SNAP DEDUCTIONS (eff 10/1/18)	
Standard Deduction	1-3=$164 4=$174 5=$204 6+=$234
Max Shelter Deduction	$ 552
Utility Allowances: SUA-$285 LUA-$252 IUA-$56	
Telephone Allowance (TUA)	$ 29
Homeless Shelter Allowance	$ 143
Max Child Care under 2	UNCAPPED USE ACTUALS
Dependent Care 2 and up	UNCAPPED USE ACTUALS

MEDICARE BENEFICIARY 2019 INCOME LIMITS (eff 4/1/19)		
GROUP	INDIVIDUAL	COUPLE
QMB	0-$1041.00	0-$1409.00
SLMB	$1041.01-$1249.00	$1409.01-$1691.00
QI1	$1249.01-$1405.00	$1691.01-$1902.00
QDWI	$1405.01-$2082.00	$1902.01-$2818.00

EFFECTIVE 04/01/2019

TANF NEEDS STANDARD					
	130% OF POVERTY (Eff. 4/1/2019)	100% NEED STANDARD (Eff.	PAYMENT ALLOWANCE (Eff. 4/1/2018)	TANF NNCT 275% Poverty (Eff.	NNCT PAYMENT ALLOWANCE (Eff.
1	$1,353	$781	$254	$2,862	$418
2	$1,832	$1,057	$320	$3,875	$478
3	$2,311	$1,333	$386	$4,888	$538
4	$2,790	$1,609	$452	$5,901	$598
5	$3,268	$1,886	$518	$6,914	$659
6	$3,747	$2,162	$584	$7,927	$719
7	$4,226	$2,438	$650	$8,940	$779
8	$4,705	$2,714	$716	$9,953	$839

2018 FEDERAL POVERTY LEVELS FOR MAGI MEDICAL (eff 04/01/2019)						
HH Size	AM Limit	AM Limit w/Medicare	122% FPL	138% FPL	165% FPL	205% FPL
HH1	$319	$368	$1,270	$1,436	$1,717	$2,134
HH2	$407	$473	$1,719	$1,945	$2,325	$2,889
HH3	$495	$577	$2,169	$2,453	$2,933	$3,644
HH4	$582	$681	$2,618	$2,961	$3,541	$4,399
HH5	$670	$786	$3,067	$3,470	$4,148	$5,154
HH6	$758	$891	$3,517	$3,978	$4,756	$5,909
HH7	$846	$996	$3,966	$4,486	$5,364	$6,664
HH8	$934	$1,101	$4,415	$4,994	$5,972	$7,419
ADD	$88	$105	$449	$508	$608	$755

KINSHIP CARE PAYMENT ALLOWANCE (EFF 04/01/2018)	
0 through 12 years of age	$401 for each child
13 years of age or older	$463 for each child
1 child household, child 0-12 $418	

NEVADA MENTAL HEALTH SERVICES

FINANCIAL ELIGIBILITY FOR SERVICES AND REDUCED FEES (SLIDING FEE AND BENEFIT SCALE) **EFFECTIVE 1/11/2019**

Minimum Based on 200% of Federal Poverty Level Guidelines (2019) Maximum Based on 300% of Federal Poverty Level Guidelines (2019)
Scale is applicable to all mental health services including inpatient, outpatient, medication clinic, service coordination and psychosocial rehabilitation.

1 FAMILY MEMBER

Combined Gross Family Income		SLIDING FEE SCALE % OF BILLED RATE
$0	$24,979	0%
$24,980	$26,367	10%
$26,368	$27,755	20%
$27,756	$29,142	30%
$29,143	$30,530	40%
$30,531	$31,918	50%
$31,919	$33,306	60%
$33,307	$34,693	70%
$34,694	$36,081	80%
$36,082	$37,469	90%
$37,470	& UP	100%

2 FAMILY MEMBERS

Combined Gross Family Income		SLIDING FEE SCALE % OF BILLED RATE
$0	$33,819	0%
$33,820	$35,698	10%
$35,699	$37,577	20%
$37,578	$39,456	30%
$39,457	$41,335	40%
$41,336	$43,213	50%
$43,214	$45,092	60%
$45,093	$46,971	70%
$46,972	$48,850	80%
$48,851	$50,729	90%
$50,730	& UP	100%

3 FAMILY MEMBERS

Combined Gross Family Income		SLIDING FEE SCALE % OF BILLED RATE
$0	$42,659	0%
$42,660	$45,029	10%
$45,030	$47,399	20%
$47,400	$49,769	30%
$49,770	$52,139	40%
$52,140	$54,509	50%
$54,510	$56,879	60%
$56,880	$59,249	70%
$59,250	$61,619	80%
$61,620	$63,989	90%
$63,990	& UP	100%

4 FAMILY MEMBERS

Combined Gross Family Income		SLIDING FEE SCALE % OF BILLED RATE
$0	$51,499	0%
$51,500	$54,360	10%
$54,361	$57,221	20%
$57,222	$60,082	30%
$60,083	$62,943	40%
$62,944	$65,805	50%
$65,806	$68,666	60%
$68,667	$71,527	70%
$71,528	$74,388	80%
$74,389	$77,249	90%
$77,250	& UP	100%

5 FAMILY MEMBERS

Combined Gross Family Income		SLIDING FEE SCALE % OF BILLED RATE
$0	$60,339	0%
$60,340	$63,691	10%
$63,692	$67,043	20%
$67,044	$70,396	30%
$70,397	$73,748	40%
$73,749	$77,100	50%
$77,101	$80,452	60%
$80,453	$83,805	70%
$83,806	$87,157	80%
$87,158	$90,509	90%
$90,510	& UP	100%

6 FAMILY MEMBERS

Combined Gross Family Income		SLIDING FEE SCALE % OF BILLED RATE
$0	$69,179	0%
$69,180	$73,022	10%
$73,023	$76,866	20%
$76,867	$80,709	30%
$80,710	$84,552	40%
$84,553	$88,396	50%
$88,397	$92,239	60%
$92,240	$96,082	70%
$96,083	$99,926	80%
$99,927	$103,769	90%
$103,770	& UP	100%

7 FAMILY MEMBERS

Combined Gross Family Income		SLIDING FEE SCALE % OF BILLED RATE
$0	$78,019	0%
$78,020	$82,353	10%
$82,354	$86,688	20%
$86,689	$91,022	30%
$91,023	$95,357	40%
$95,358	$99,691	50%
$99,692	$104,026	60%
$104,027	$108,360	70%
$108,361	$112,695	80%
$112,696	$117,029	90%
$117,030	& UP	100%

8 FAMILY MEMBERS

Combined Gross Family Income		SLIDING FEE SCALE % OF BILLED RATE
$0	$86,859	0%
$86,860	$91,685	10%
$91,686	$96,510	20%
$96,511	$101,336	30%
$101,337	$106,161	40%
$106,162	$110,987	50%
$110,988	$115,812	60%
$115,813	$120,638	70%
$120,639	$125,463	80%
$125,464	$130,289	90%
$130,290	& UP	100%

Control #	Rev.	Title	Effective Date: 01/2000
SP 4.05 ~~4.005~~	07/2007	Discharge of Consumers from Civil ~~Division~~ Inpatient Facilities	Next Review Date

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1.0 POLICY:

Prior to discharge from a Civil~~Division~~ inpatient facility, the treatment team shall determine whether the consumer meets discharge criteria and shall provide an individualized aftercare plan for the consumer.

2.0 PURPOSE:

The purpose of this policy is to maximize the consumer's progress and adjustment to daily life after discharge from a civil inpatient~~Division~~ facility.

3.0 SCOPE:

Division Wide

4.0 DEFINITIONS: N/A

5.0 REFERENCES: N/A

6.0 PROCEDURE:

~~**6.0**~~

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~~**6.1 Conditions for Consumer Discharge from a Division Facility under NRS Chapter 178, Incompetent to Stand Trial, Evaluation of Competency:**~~

6.1.1 ~~Consumers committed to the division's forensic facility, Lake's Crossing Center (LCC), shall not be discharged unless a court order, signed by a district or municipal judge, is received authorizing the discharge. These consumers can only be discharged to the custody of the appropriate law enforcement agency.~~

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~~**6.1.2** Should a consumer committed under NRS 178 be adjudicated as incompetent with no probability of attaining competency and charges dismissed, the consumer shall not be discharged or recommitted under an involuntary civil commitment to another division facility unless a court order, dismissing the charges and signed by the appropriate district judge is received.~~

~~6.1.3~~6.1.2 ~~Prior to commencing an involuntary civil commitment of a consumer adjudicated incompetent with no probability of attaining competency, LCC officials shall contact and consult with the Deputy Attorney General assigned to the Division~~.

~~**6.1.4** Consumers committed under NRS Chapter 178 as incompetent to stand trial and charged with a capital offense, i.e., murder, etc., and found incompetent to stand trial with no possibility of attaining competency in the foreseeable future and are involuntarily committed to the division shall not be discharged from LCC to a less restrictive environment unless the division administrator has granted written approval.~~

6.2 Consumer discharge from a division facility under NRS 433A, Conditional Release:

6.2.1 The provisions of this law apply only to persons under civil commitments for involuntary court-ordered admissions. When a person is under a civil commitment by virtue of an involuntary court-ordered admission to a mental health facility, the maximum duration of that commitment order is six (6) months. The committemnt order may be extended if needed.

~~6.2.2~~ If a person continues to need to be under a civil commitment at the expiration of the 6-month period, a new petition for court ordered admission must be filed, and a hearing must be held prior to the end of ~~6.2.2~~ the 6-month period.

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6.2.3 If, following an order for civil commitment, a person becomes ready for discharge from the mental health facility within that 6-month period, then the team responsible for discharge planning must decide whether the discharge from the hospitalization should be conditional or unconditional.

6.2.4 If it is decided that a person should be unconditionally released from a facility, then notice must be given to the court and the district attorney.

6.2.5 Once a person is unconditionally released, the civil commitment order will become null and void.

6.2.6 If the discharge planning team believes the person should be conditionally released from the mental health facility, then it must provide a Notice of Conditional Release to the court and the district attorney. On the form, the maximum duration of that release must be noted.

6.2.7 Conditional release may last only for the maximum extent of the underlying civil commitment. The consumer must also be provided a copy of the Notice.

6.2.8 Rural Clinics will be notified of conditional releases of consumers returning to rural communities.

6.2.9 The criteria and procedure for bringing a person back from conditional release is set forth in NRS 433A.380(5):

6.2.9.1 A member of the consumer's treatment team, who is professionally qualified in the field of psychiatric mental health, will determine that the person is presently mentally ill and a danger to himself or to others pursuant to the criteria of NRS 433A.115.

6.2.9.2 This member of the treatment team will discuss the matter with a psychiatrist. If they determine that conditional release is no longer appropriate because the person presents a clear and present danger to self or others, they have three (3) options:

6.2.9.2.1 If the decompensation is gradual, they may request an order from the administrative officer of the mental health facility, ordering the person to return to the hospital in three (3) days.

6.2.9.2.2 A copy of the~~is~~ administrative order must be given to the person.

6.2.9.2.3 If ~~for any reason~~ the person starts to improve, or complies with the medication regimen such that their behaviors no longer pose a clear and present danger to self or others, it should be duly noted in the chart, let the ~~mental health facility~~ receiving agencyknow, let the court know, and the process may stop there.

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~~6.2.9.2.1~~6.2.9.2.4 If the person returns voluntarily to the mental health facility, provide notice of the same to the court, and the matter will be reviewed at the next court hearing date.

~~6.2.9.2.2~~6.2.9.2.5 In cases involving imminent threat of danger to self or others a Legal 2000 should be initiated immediately.

~~6.2.9.2.3~~6.2.9.2.6 If a person is ordered to return from conditional leave and does not, the administrative officer of the mental health facility may issue an order to law enforcement to return a person to the mental health facility.

6.2.10 Persons being returned to a mental health facility from conditional release do not require medical clearance before being readmitted to the mental health facility.

6.2.11 If a person is intoxicated they must be detoxed prior to admission. Similarly, any obvious physical conditions needing treatment should be addressed prior to admission.

6.2.12 The committing court will review the return from conditional leave. The attached forms are to be used:

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6.2.12.1 Notice of conditional release attachment B~~.~~

6.2.12.2 Notice of unconditional release attachment A~~.~~

~~6.2.12.2~~

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6.2.12.3 Notice of order to return from conditional release and of hearing attachment ??~~.~~

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6.2.12.4 Administrative order to return from conditional releas~~e.~~Attachment D

6.3 Consumer discharge from a division facility under NRS 433A.150 & NRS 433A.310:

6.3.1 When a consumer with charges pending is to be released from a 72-hour emergency admission, pursuant to NRS 433A.150, the discharge must be reviewed and approved by the agency administrator.

6.3.2 If a local, state or federal law enforcement agency requests notification of a consumer's discharge from an inpatient residential setting in order to pursue criminal charges, the agency shall cooperate.

6.3.3 The law enforcement agency's request must be in writing on the "Request for Notification by Law Enforcement Agency" form.

6.3.4 Written confirmation of the notification to law enforcement must follow telephone contact.

6.3.5 Written confirmation must include identification of the consumer discharged, the staff member making contact, and the law enforcement officer contacted and the date.

6.4 Consumers with mental illness shall not be discharged without an individualized aftercare plan that incorporates conditions that will maximize the consumer's progress and adjustment to daily life.

~~**6.4**~~ 6.4.1 If the discharge is conditional leave NRS 433A.380, a "Notice of Conditional Leave" form must be completed, including the conditions of aftercare.

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6.5 Should the court object to a consumer discharge or transfer to a less restrictive treatment, the agency administrator shall contact the division administrator. The division administrator, attorney general, and agency administrator shall determine the proper course of action.

6.6 All discharges that require out-of-state placement are to be reviewed and approved by the Agency Director prior to placement.

6.7 Consumers with mental illness who have been identified as having a history of violent behavior(s) shall not be discharged without a risk assessment inventory pursuant to Division Policy #3.002 having been conducted.:

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7.0 ATTACHMENTS:

7.1 ?? Request for Notification by Law Enforcement Agency

7.2 Notice of Conditional Leave

7.4 Pending

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~~7.0~~ 7.3 Order to REturn from Conditional Release

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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.

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Control #	Rev.	Title	Effective Date: 01/2000
SP 4.05	07/2007	Discharge of Consumers from Civil	
~~4.005~~		~~Division~~ Inpatient Facilities	Next Review Date

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Code No.
CATHERINE CORTEZ MASTO
Attorney General
CINDY A. PYZEL or LISA BROWN
Senior Deputy Attorney General
Nevada Bar #0996
100 N. Carson Street
Carson City, NV 89701
(775) 684-1136

IN THE _____ JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA
IN AND FOR _____ COUNTY
FAMILY DIVISION

In the Matter of the Examination of:	)	Case No.
	)	Dept. No.
An Allegedly Mentally Ill Person.	)	
	)	NOTICE OF
	)	UNCONDITIONAL RELEASE

TO: District Court Judge
TO: District Attorney

_____Client_____ was involuntarily committed to the Nevada Mental Health Institute (hereafter "NMHI") on __date __ by the _____ Judicial District Court, _____County Nevada for a period of six (6) months, ending on __date__.

Pursuant to NRS 433A.390, it has been determined that this client will be unconditionally Released before the end of the six month period specified in NRS 433A.310.

This notice is being provided to you at least 10 days before the actual release date.

DATED this _____ day of _____, _____.

Agency Director

Code No.
FRANKIE SUE DEL PAPA
Attorney General
CYNTHIA A. PYZEL or LISA BROWN
Senior Deputy Attorney General
Nevada Bar #0996
100 N. Carson Street
Carson City, NV 89701
(775) 684-1136

IN THE _____ JUDICIAL DISTRIC COURT OF THE STATE OF NEVADA
IN AND FOR THE _____ COUNTY
FAMILY DIVISION

In the Matter of the Examination of:	)	Case No.
	)	Dept. No
An Allegedly Mentally Ill Person.	)	
	)	NOTICE OF
	)	CONDITIONAL RELEASE

TO: District Court Judge
TO: District Attorney
TO: Client
TO: Client's Attorney

Client was involuntarily committed to the _____ on _date_ by the _____ Judicial District Court, _____ County, Nevada for a period of six (6) months, ending on _date_. Pursuant to NRS 433A.380 it has been determined by the Medical Director of _____ that a conditional release is in the best interest of this client and will not be detrimental to the public welfare. This conditional release is effective until the period commitment expires.

DATED this _____ day of _____, _____.

Agency Director

ADMINISTRATIVE ORDER TO
RETURN FROM CONDITIONAL RELEASE

TO: Any Peace Officer of the State of Nevada
TO: "Client" and Client's Attorney

__Client____ (hereafter "client") was involuntarily committed to the _____ ___ on date by the _____ Judicial District Court, _____ County, Nevada for a period of six (6) months, ending on __date___. The client was placed on conditional release after it was determined by the Medical Director of _____ that it was in the best interest of Client and would not be detrimental to the public welfare. The conditional release is effective for the period up to and including __date___.

Now, pursuant to NRS 433A.310, a psychiatrist and a member of the client's treatment team who is professionally qualified in the field of psychiatric mental health have determined that the conditional release is no longer appropriate because the client currently presents a clear and present danger of harm to himself/herself or others.

I am the Administrative Officer of _____ and pursuant to the authority granted to me by NRS 433A.380 and NRS 433A.370, I am hereby ordering the return of this client to _____, located at _____, phone number _____ and am requesting that any peace officer, pursuant to NRS 433A.370, apprehend, take into custody and deliver this client to this facility.

DATED this _____ day of _____, _____.

Agency Director

Control #	Rev.	Title	Effective Date:
SP 4.07		**Notifications of Victims and Police of Potential Violent Acts by Consumers**	**02/27/1998**
			Next Review Date 02/21/1999

1.0 POLICY:

It is the policy of the division to notify intended victims of potential violent acts against them by consumers and to cooperate with law enforcement agencies by notifying them of the possible violent acts of consumers and consumers who have gone AWOL.

2.0 PURPOSE:

The purpose is to provide for the safety of intended victims of potential violent acts by division consumers, when it comes to the attention of the division.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 **Escape or Absence Without Leave**: (AWOL) Per NRS 433A.370 a person who is involuntarily detained pursuant to NRS 433A.145 to 433A.300, inclusive, escapes from any division facility, or when a judicially admitted consumer has not returned to a division facility from conditional release after the administrative officer of the facility has ordered the consumer to do so.

5.0 REFERENCES:

5.1 NRS 433A.145

6.0 PROCEDURE:

6.1 If a client expresses an intention to physically harm a specific victim, both the intended victim and local law enforcement shall be notified as soon as possible.

6.1.1 Any staff member who hears or overhears a consumer state that he intends to harm a specific person shall immediately report the event to his or her supervisor, who will determine whether the threat requires immediate action or can be reviewed administratively without endangering the intended victim.

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6.1.2 If it is determined that any delay will likely endanger an intended victim, the supervisor will immediately notify the agency administrator, or designee, who will notify local enforcement in the area where the intended victim is located and contact the district attorney's office for direction on contacting the intended victim.

6.1.3 The agency administrator, or designee, shall immediately notify the division administrator.

6.1.4 If it is unlikely that a delay will endanger the intended victim, the supervisor shall meet with the agency director or designee to decide, based on the information, whether a true threat exists.

6.1.4.1 This decision, if possible, will be made in consultation with the agency's deputy attorney general.

6.1.4.2 If it is decided a threat does exist, the agency administrator or designee shall proceed to notify local law enforcement in the area where the intended victim is located and contact the district attorney's office for direction on contacting the intended victim.

~~6.1.5~~ If a potential victim is notified, the agency administrator shall initiate a denial of rights form which will be submitted to the Commission on Behavioral Health. ~~for Mental Health and Developmental Services.~~

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

7.0 ATTACHMENTS: N/A

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

Effective Date: 02/27/98

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Control #	Rev.	Title	Effective Date:
SP 4.07		**Notifications of Victims and Police of Potential Violent Acts by Consumers**	**02/27/1998**
			Next Review Date 02/21/1999

Review Date: 02/27/99

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Control #	Rev.	Title	Effective Date: ~~09/2017~~
~~FS 1.01~~ SP 4.08	New	~~Forensic Services~~ Civil Security Camera System	Review Date: ~~09/2019~~

1.0 POLICY:

The Division of Public and Behavioral Health (DPBH) uses video recording equipment in its ~~forensic~~ facilities to ~~ensure~~ increase the safety and security of its clients and staff. ~~Forensic facilities~~ Agencies ~~will~~ may use video camera system technology to monitor common areas, including observation and seclusion rooms, day rooms, corridors and hallways, visiting rooms, and/or group rooms.

2.0 PURPOSE:

This policy provides guidance regarding the use of video camera system technology ~~in forensic settings~~ and the maintenance and use of records generated by this technology.

3.0 SCOPE: Division Wide

4.0 DEFINITIONS: N/A

5.0 PROCEDURE:

The use of video camera system technology ~~in forensic settings~~ is not meant to supplant client supervision, rather it is intended to supplement and enhance safety and well-being for clients and staff.

5.1 The use of video camera system technology ~~in forensic settings~~ records images for security and administrative purposes. These recordings may be used to investigate abuse or neglect of clients served ~~in forensic settings~~;

5.1.1 to be preserved for investigative purposes;

5.1.2 to report to law enforcement agencies; and

5.1.3 to be preserved in the incident report file.

5.2 Video camera system technology is not to be placed in individual rooms (except those designated for special observation), bathrooms, or shower areas.

5.3 The video camera system technology includes a recording feature with archival capacity.

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Control #	Rev.	Title	Effective Date: ~~09/2017~~
~~FS 1.01~~ SP 4.08	New	~~Forensic Services~~ Civil Security Camera System	Review Date: ~~09/2019~~

5.3.1 Video is automatically retained for up to 14 days. This provides the opportunity to review images after a reportable incident, if/when a complaint is made, and/or for other clinical and administrative purposes, including training and quality improvement.

5.3.2 Copies of records from the archived data may be made and stored separately when authorized or when litigation or any other legal or disciplinary action is anticipated, pending, or ongoing.

5.4 Access to video recordings will be limited to designated ~~forensic~~ staff members. Authorized staff members will have the capability to pull recordings upon request.

5.4.1 Other staff are prohibited from tampering with or disabling video camera system technology unless the staff member has been granted access by the Agency Director, ~~Lieutenant, Sergeant, State Forensic Director,~~ or Medical Director.

5.4.2 Any staff not assigned responsibility for maintaining the video camera system technology that is caught tampering with and/or disabling the video camera system may be disciplined, up to and including termination.

5.5 Access to viewing video camera system technology is limited to DPBH Deputy Administrator, Agency Director, and authorized staff.

5.5.1 Anyone requesting review of or access to video camera system records must obtain authorization from the DPBH Clinical Services Deputy Administrator and/or Agency Director.

~~5.5.1~~5.5.2 Requests must be made in writing.

5.6 Videos involving incidents of the following events will be retained until all related incidents or investigations are closed: escape and allegations of patient abuse/neglect by a staff member.

5.6.1 An Incident Report must be completed in these situations.

5.6.2 An email will be sent, in addition to the incident report, to the authorized staff requesting video be saved for any of these incidents or others whenre video could be beneficial.

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Control #	Rev.	Title	Effective Date: ~~09/2017~~
~~FS 1.01~~ SP 4.08	New	~~Forensic Services~~ Civil Security Camera System	Review Date: ~~09/2019~~

5.7 Video recordings and incident reports will not be referenced in Avatar documentation and/or included in a patient chart.

5.8 Video recordings are considered to contain confidential information and are not to be viewed or shared with clients or staff members.

5.9 Staff that are within range of the video camera system have no expectation of privacy regarding any of their activities that are recorded.

5.10 All images and records may be used in investigations and/or complaints and with respect to disciplinary action.

5.11 Video recordings may be shared with law enforcement upon issuance of a subpoena.

6.0 REFERENCES: N/A

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION POLICY:

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

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

Control #	Rev.	Title	Effective Date: 12/1997
SP 4.12	~~03/2019~~	Intradivision Transfers	Next Review Date: 03/2019

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 requires division agencies to cooperate with one another 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:

To facilitate ~~a~~ expedient, efficient and consistent client transfers between DPBH Agencies.

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 or their designee must approve the transfer.

6.3 A client, or his/her parent or guardian, must give informed, written consent to a transfer.

6.3.1 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 approved by the Division Administrator or their designee.

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

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.

6.5.1 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.

6.5.2 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.

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.

EFFECTIVE DATE: 12/31/97
DATE APPROVED BY DPBH ADMINISTRATOR: 03/2019
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 03/2019

Control #	Rev.	Title	Effective Date: 12/1997
SP 4.12	~~03/2019~~	Intradivision Transfers	Next Review Date: 03/2019

Control #	Rev. Date:	Title:	Effective Date: 08/2002
SP 4.~~0~~44	06/2007	Waiting Lists for Civil Mental Health Agencies ~~& Developmental Services Agencies~~	Next Review Date:

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1.0 POLICY:

It is the policy of the Division of Public and Behavioral Health, only when necessary, to employ a waiting list for service programs when such programs temporarily cannot accept new consumers.

2.0 PURPOSE:

A waiting list shall be fair, regularly reviewed, and utilized so as to ensure the most rapid service available to consumers.

It is the intent of the division to assure all individuals receive care in a timely fashion. For those individuals referred to fulfill the requirements of a court order, the agency is diligent in its efforts to serve individuals immediately, refer individuals to available community resources or advise the court issuing the order of the agency's inability to fulfill the court order due to a lack of available resources.

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~~Forensic prohibited from having wait lists~~.

Commented [ER1]: Court ordered outpatient programs are prohibited from waiting lists.

Commented [ER2]: For OP restoration, MHC, misdo diversion and AOT, the court cannot court someone into a program only to be placed on the waiting list. If they are court ordered in, than that means that they have to be served.

Commented [TG3]: One question…..is this based on an interlocal agreement?? Rural does have some clients who are referred by the court but we don't necessary guarantee we have a clinician unless we have an interlocal agreement/contract.

Commented [PR4]: This would be good to know. We would have to create a waitlist if our service coordinators were over capacity.

3.0 SCOPE:

Clinical Services Branch~~Division Wide~~

4.0 DEFINITIONS:

4.1 For those persons whose first scheduled treatment session falls during the reporting month, report by program, the number of persons who have waited 15 or more days from the agency acceptance (intake) date or screening date to the first treatment session. This will include both persons who attended the treatment session and those who do not.

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4.2 Calculation: DPBH ~~agencies~~ will report monthly (Caseload Report) the number of persons who meet the above wait list definition.

4.3 DPBH will report quarterly (Performance Indicators) the wait time in days using the following categories: 0-14, 15-30, 31-60, >60.~~:~~

5.0 REFERERNCES:

~~4.3~~ Division Data Dictionary

~~5.0~~6.0 PROCEDURE:

~~5.16.1 Waiting List #1 (Agency): The number of persons, as of the last day of the month, who will have waited 15 or more days from initial contact application for services to scheduled intake (persons are not enrolled in agency and are not receiving any services). Waiting period is measured from referred date to the date of intake or services. This will include persons who attended the treatment session and those who did not.~~

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Commented [ER5]: Suggest leaving it just as DPBH since this is pulled by OPHIE for CLEO

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Commented [ER6]: I would suggest taking off 0-14 and 15-30

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~~5.2~~6.2 ~~Waiting List #II (Program): For those persons whose first scheduled treatment session falls during the reporting month, report by program, the number of persons who have waited 15 or more days from the agency acceptance (intake) date or screening date to the first treatment session. This will include persons who attended the treatment session and those who did not.~~

~~5.3~~6.3 Waiting lists shall be utilized only when existing resources pose a temporary inability of the agency or individual program to serve additional clientele.

~~5.4 Consumers shall be added to the waiting list in order to contact with the agency.~~

Commented [TG7]: In order of contact? Is this comment the same as 5.5?

Commented [ER8]: I agree it is the same as 5.5

~~5.5~~6.4 Consumers shall be assigned to agency or program services in ascending order (from earliest date of placement on the waiting list to most recent date).

~~5.6~~6.5 Based on unique clinical need, the agency director may approve assignment of consumers awaiting services to active service based on determined needs, and risk which may be independent of chronological order of entry to the list.

~~5.7~~6.6 All persons on the waiting list ~~shall~~ may be contacted at least every 30-days for purposes of determining current need, willingness to accept service and to advise consumers of their status on the waiting list.

Commented [TG9]: Can we say may be contacted at least every 30 days? We want high risk clients to be contacted more often than 30 days.

Commented [ER10]: I am good with that suggestion

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~~5.8~~6.7 These monthly contacts shall be documented by a designated program staff.

~~5.9~~6.8 In the event no current phone number is available or no contact is achieved with the consumer within five (5) days of a message or following two (2) phone call attempts, a letter shall be sent via first class mail to the individual at the last known address. The letter shall indicate to the consumer that unless they respond to the agency within ten (10) working days they will be dropped from the waiting list.

~~5.10~~6.9 Consumer(s) on the agency or program waiting list shall be contacted immediately and offered the awaited services when "vacancies" or caseload decreases below capacity.

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~~5.11~~6.10 Any consumer on a waiting list for more than 89 days shall be immediately reviewed for needs by the agency director or designated department head, which shall determine appropriate action.

~~6.0 ATTACHMENTS:~~

7.0 ATTACHMENTS:

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~~N/A~~

~~7.0 REFERERNCES:~~

7.1 ~~Division Data Dictionary:~~

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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Effective Date: 08/23/02
Date Revised: 04/10/03, 05/09/03, 06/29/07
Approved by Administrator:
Approved by Commission: 08/23/02

NEW

Control #	Rev.	Title:	Effective Date:
S 5.3	**New**	Community Based Living Arrangements Assessment and Compliance Reporting	**Next Review Date:**

1.0 POLICY:

DPBH will ensure that Community-Based Living Arrangement providers remain compliant with Division of Public and Behavioral Health, State, and Federal laws and regulations to provide safe and flexible housing arrangements for DPBH Clients.

2.0 PURPOSE:

To outline the process staff will follow when reporting State and Federal Law violations found in Community-Based Living Arrangement sites to HCQC and the Office of the Labor Commission.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 Community Based Living Arrangement (CBLA) - These are flexible, individualized services provided in the home to persons with mental illness or related conditions.

4.2 CBLA services are designed to have clients live in the community with support from a Service Coordinator and/or provider to work with clients to develop needed skills to maximize independence.

4.3 CBLA Provider – A state-contracted certified provider approved by SNAMHS, NNAMHS or OTHER DPBH programs to provide CBLA services

4.4 Service Coordinator Or Clinician – Any Employee or Contractor acting on behalf of DPBH to assess the client's clinical or targeted case management needs.

4.5 The Bureau of Health Care Quality and Compliance (HCQC)

4.6 Minor Child or children is legally defined as an infant or a person under the age of legal competence which in most states is 18.

5.0 REFERENCES:

5.1 NNAMHS Protocol OP-CBLA-1901

5.2 FairLaborStandardsAct
https://www.dol.gov/whd/flsa/jointemployment2019/index.htm

5.3 West's Encyclopedia of American Law, edition 2

NEW

Control #	Rev.	Title:	Effective Date:
S 5.3	**New**	Community Based Living Arrangements Assessment and Compliance Reporting	**Next Review Date:**

6.0 PROCEDURE:

6.1 DPBH Agency Quality Assurance Teams, Service Coordinators and others will conduct home visits of all contracted HCQC certified CBLA provider homes to determine compliance with Division of Public and Behavioral Health, State, and Federal laws and regulations.

6.2 DPBH Staff are required to report violations to HCQC and the Labor Commissioner if applicable.

6.3 CBLA Provider Homes will be reported to HCQC for a minimum of the following:

- 6.3.1 Unsanitary Conditions
- 6.3.2 Abuse and Neglect
- 6.3.3 Personal Health and Safety Hazards
- 6.3.4 Fire Safety Hazards
- 6.3.5 Inadequate Medication Management Practices
- 6.3.6 Utility management problems and failures
- 6.3.7 Caregivers do not speak the language of the majority of the residents
- 6.3.8 Minor Child/ren Living in the home
- 6.3.9 Unhealthy and Unsafe Living Conditions

6.4 Agency Managers will alert the Labor Commission when a provider is suspected of violating Labor Laws such as:

- 6.4.1 *Paying sub-minimum wages
- 6.4.2 Not paying required overtime
- 6.4.3 Not ensuring a safe workplace
- 6.4.4 Failure to keep accurate records pf hours worked and wages paid
- 6.4.5 *Failure to pay ,inimum wages for allhours worked
- 6.4.6 Workplace discrimination

6.5 Reporting Instructions:

- 6.5.1 The Agency Administrator will contact HCQC via:
  - 6.5.1.1 The complaint Intake Line (702-668-3250)
  - 6.5.1.2 Online Intake Form http://dpbh.nv.gov/Reg/HealthFacilities/dta/Complaints/HCQC-Complaint-Form/

NEW

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S 5.3	**New**	Community Based Living Arrangements Assessment and Compliance Reporting	**Next Review Date:**

6.5.1.3 Email – HCQCComplaint@health.nv.gov

6.5.2 Office of Labor Commission Reporting:
6.5.2.1 Office 775-684-1890
6.5.2.2 Online – Labor.nv.gov
6.5.2.3 Email – Shannonchambers@labor.nv.gov or lmartinez@labor.nv.gov

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.