Changes to Seclusion and/or Restraint Emergency Procedures Form

Page 1

- *Add* "/or" to title of form
- *Add* "Print on gold paper. No names or HIPAA-identifiers." to first box
- *Change* "Patient/Client #:" to "Medical Record #:"
- *Add* "(Required)" under the line for Medical Record #
- *Add* "Transgender" and "Other" to Gender
- *Add* "State" and "County:" under Legal Status/Child Welfare Custody
- *Add* "Co-Custody" under Legal Status
- *Add* "Southern Hills Hospital Pavilion" to list of Facilities
- *Delete* "Children and Adolescents ages 9-17:" and "Children under age 9:" boxes
- *Add* "Day of the week and shift:"
- *Add* "(Required) IS THIS CHILD/YOUTH CURRENTLY ENROLLED IN SPECIALIZED FOSTER CARE? Yes/No (For reporting purposes only)"
- Under CONTINUATION ORDER, *change* "patient/client's" to "child/youth"
- Under PHYSICIAL RESTRAINT/Number of Staff Involved, *change* "Patient" to "Child/Youth"

Page 2

- *Change* "Is Patient Medically Compromised" to "Is Child/Youth Medically Compromised"
- *Change* "Injury to Patient/Client" to "Injury to Child/Youth"
- *Change* "Does the patient/client have a Personal Safety Plan?" to "Does the Child/Youth have a Personal Safety Plan (Safety Assessment and Crisis Plan)?"
- *Add* "Legally Responsible Individual/" before "Parent/Guardian/Custodian Notified"

NEW

Commission on Behavioral Health
Seclusion and/or Restraint Emergency Procedures for Children and Youth
Denial of Rights v.01.08.2020

Print on gold paper. No names or HIPAA-identifiers. Date of Admission: _____ Medical Record #: _____ *(Required)*	Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other Height: _____ Weight: _____ Age: _____	Legal Status: ☐ Parental Custody ☐ Child Welfare Custody ☐ State ☐ County: _____ ☐ Youth Parole Custody ☐ Co-Custody

Race: *Check all that apply*

☐ American Indian/Alaskan Native ☐ Black American	☐ Asian ☐ Native Hawaiian/Pacific Islander	☐ White (Caucasian) ☐ Other _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Programs/Facilities:

☐ DCFS/DWTC Acute-Adolescent (AAP) ☐ DCFS/DWTC RTC ☐ DCFS/PRTF Enterprise FLH 1 ☐ DCFS/PRTF Enterprise FLH 2 ☐ DCFS/PRTF Enterprise FLH 3 ☐ DCFS/PRTF Enterprise FLH 4 ☐ DCFS/PRTF North (formerly ATC) ☐ DCFS/PRTF Oasis West 11	☐ DCFS/PRTF Oasis East 12 ☐ DCFS/PRTF Oasis West 12 ☐ DCFS/PRTF Oasis 13 ☐ DCFS/PRTF Oasis 14 ☐ Desert Parkway Behavioral Healthcare ☐ Montevista Hospital/Acute ☐ Montevista/Adolescent Residential ☐ Never Give Up Treatment Center	☐ Reno Behavioral Healthcare ☐ Seven Hills Behavioral Institute ☐ Southern Hills Hospital Pavilion ☐ Spring Mountain Treatment Center ☐ West Hills Hospital/Adolescent ☐ West Hills Hospital/Pediatric ☐ Willow Springs Treatment Center ☐ Other _____

Day of the week and shift:

(*Required*) IS THIS CHILD/YOUTH CURRENTLY ENROLLED IN SPECIALIZED FOSTER CARE? ☐ Yes ☐ No
(For reporting purposes only)

Discussed with physician: ☐ Yes ☐ No RN Initials: _____ Date/Time: _____
Physician verbal/phone orders by Dr. _____ Date/Time: _____
Physician Initials: _____ Date/Time: _____
Order noted by: _____ Date/Time: _____
Did RN extend order once up to the maximum allowable hours? ☐ Yes ☐ No
CONTINUATION ORDER: *The RN evaluation and documentation for continuation orders must include a face-to face-reassessment of the child/youth current behavior that warrants the extension of the restraint/seclusion.*

SECLUSION: ☐ Locked ☐ Unlocked ☐ N/A
Placed in Seclusion: DATE: _____ TIME: _____ ☐ AM ☐ PM
Released from Seclusion: DATE: _____ TIME: _____ ☐ AM ☐ PM Total time in minutes: _____

MECHANICAL RESTRAINT: ☐ Cuff/Belt ☐ Legs ☐ Wrists ☐ 4-point ☐ 5-point ☐ Mitts ☐ Geri Chair ☐ N/A
☐ Other _____
Placed in Restraint: DATE: _____ TIME: _____ ☐ AM ☐ PM
Released from Restraint: DATE: _____ TIME: _____ ☐ AM ☐ PM Total time in minutes: _____

PHYSICAL RESTRAINT: CPAR- ☐ Escort ☐ Standing Wrap/Basket Hold ☐ Seated ☐ Lying Supine (on back) ☐ N/A
☐ Lying Prone (on stomach) ☐ Other Hold Implemented, Type and Description: _____
Placed in Restraint: DATE: _____ TIME: _____ ☐ AM ☐ PM
Released from Restraint: DATE: _____ TIME: _____ ☐ AM ☐ PM
Total Time in Minutes: _____ Number of Staff Involved in Restraining Child/Youth: _____

CHEMICAL RESTRAINT: DATE: _____ TIME: _____ ☐ AM ☐ PM ☐ N/A
Medication Administered: _____ Dose: _____ ☐ PO ☐ IM
Medication Administered: _____ Dose: _____ ☐ PO ☐ IM
Medication Administered: _____ Dose: _____ ☐ PO ☐ IM
Results After one Hour (Explain) _____

Behavioral Descriptors of Events: (CHECK ALL THAT APPLY)

☐ Attempted elopement ☐ Bites ☐ Cuts ☐ Hits ☐ Imminent harm to others	☐ Imminent harm to self ☐ Kicks ☐ Physical fighting ☐ Property destruction ☐ Punches	☐ Pushes ☐ Scratches ☐ Spits ☐ Threatening gestures ☐ Throwing objects at another

Descriptive Narrative of Behaviors:

Is Child/Youth Medically Compromised: ☐ Yes ☐ No (CHECK ALL THAT APPLY)

☐ Known Hx of Cardiac or Respiratory Disease ☐ Morbid Obesity ☐ Seizure Precautions	☐ Pregnancy ☐ Recent Vomiting	☐ Spinal Injury ☐ Other

Injury to Child/Youth During Procedure: ☐ Yes ☐ No (If Yes, describe injury and any treatment)

Staff Intervention Prior to Restraint/Seclusion (CHECK ALL THAT APPLY)

☐ Ventilation of Feelings ☐ Verbal Reassurance ☐ Verbal Redirection ☐ Timeout	☐ Environmental Change ☐ Praise/Empathy Statement ☐ 1:1 Interaction w/Staff ☐ Coupling Statements	☐ Limit Setting ☐ Rationale/Reality Statements ☐ Reduction in Stimuli

Describe Interventions Prior to Procedure:

Does the Child/Youth have a Personal Safety Plan (Safety Assessment and Crisis Plan)? ☐ Yes ☐ No

Was the Plan followed? ☐ Yes ☐ No Was there a Debriefing? ☐ Yes ☐ No

Plan to prevent further events (Make Note of Any Changes to the Positive/Individual Behavior Plan, and attach Plan):

Names and Titles of Staff Involved: _____ _____
Name: Title:

Names and Titles of Witnesses: _____ _____
Name: Title:

Legally Responsible Individual/Parent/Guardian/Custodian Notified ☐ Yes ☐ No

Name of Staff Member Providing Notification: _____ Date:_____ Time:_____ ☐ AM ☐ PM

Nursing Report: Findings and Treatment:

Signature/Title:_____ Date:_____

Physician's Report: Findings and Treatment:

Signature/Title:_____ Date:_____

Program Manager's (DCFS CPM I) Review: Findings and Treatment:

Signature/Title:_____ Date:_____

DCFS Clinical Program Manager II's Review: Findings and Treatment

Signature/Title:_____ Date:_____

DCFS/Private Facility ADMINISTRATIVE REVIEW: Comments- DCFS Dep. Admin. /Facility Admin. Date:	DCFS ADMINISTRATOR REVIEW: Comments- Administrator Date:	DAG/COMMISSION REVIEW: DAG Date: Commissioner Date:

NV Commissioner of Behavioral Health Comments:

OLD

Commission on Behavioral Health
Seclusion and Restraint Emergency Procedures for Children and Youth
Denial of Rights

Date of Admission: _____	**Gender:** ☐ Male ☐ Female	**Legal Status:**
Patient/Client#: _____	**Height:** _____	☐ Parental Custody
Age: _____	**Weight:** _____	☐ Child Welfare Custody
		☐ Youth Parole Custody

Race:

☐ American Indian/Alaskan Native	☐ Asian	☐ White (Caucasian)
☐ African American	☐ Native Hawaiian/Other Pacific Islander	☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Programs/Facilities:

☐ DCFS/ATC	☐ DCFS/OCTH East 12	☐ Reno Behavioral Healthcare
☐ DCFS/DWTC Acute-Adolescent (AAP)	☐ DCFS/OCTH West 12	☐ Seven Hills Behavioral Institute
☐ DCFS/DWTC RTC	☐ DCFS/OCTH 13	☐ Spring Mountain Treatment Center
☐ DCFS/FLH 1	☐ DCFS/OCTH 14	☐ West Hills Hospital/Adolescent
☐ DCFS/FLH 2	☐ Desert Parkway Behavioral Healthcare	☐ West Hills Hospital/Pediatric
☐ DCFS/FLH 3	☐ Montevista Hospital/Acute	☐ Willow Springs Treatment Center
☐ DCFS/FLH 4	☐ Montevista/Adolescent Residential	☐ Other _____
☐ DCFS/OCTH West 11	☐ Never Give Up Treatment Center	

Children and Adolescents ages 9-17:	**Children under age 9:**
☐ Restrained for up to 2 hours	☐ Restrained for up to 1 hour
☐ Secluded for up to 2 hours	☐ Secluded for up to 1 hour
☐ Secluded and Restrained for up to 2 hours	☐ Secluded and Restrained for up to 1 hour

Discussed with physician: ☐ Yes ☐ No RN Initials: _____ Date/Time: _____
Physician verbal/phone orders by Dr. _____ Date/Time: _____
Physician Initials: _____ Date/Time: _____
Order noted by: _____ Date/Time: _____
Did RN extend order once up to the maximum allowable hours? ☐Yes ☐ No
CONTINUATION ORDER: ***The RN evaluation and documentation for continuation orders must include a face-to face-reassessment of the patient/client's current behavior that warrants the extension of the restraint/seclusion.***

SECLUSION: ☐ Locked ☐ Unlocked ☐ N/A
Placed in Seclusion: DATE:_____ TIME:_____ ☐ AM ☐ PM
Released from Seclusion: DATE:_____ TIME:_____ ☐ AM ☐ PM
Total Time in Minutes: _____

MECHANICAL RESTRAINT: ☐ Cuff/Belt ☐ Legs ☐ Wrists ☐ 4-point ☐ 5-point ☐ Mitts ☐ Geri Chair ☐ N/A
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☐ Lying Prone (on stomach) ☐ Other Hold Implemented, Type and Description: _____
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Released from Restraint: DATE:_____ TIME:_____ ☐ AM ☐ PM
Total Time in Minutes: _____ **Number of Staff Involved in Restraining Patient:** _____

CHEMICAL RESTRAINT: DATE:_____ TIME:_____ ☐ AM ☐ PM ☐ N/A
Medication Administered: _____ Dose: _____ ☐ PO ☐ IM
Medication Administered: _____ Dose: _____ ☐ PO ☐ IM
Medication Administered: _____ Dose: _____ ☐ PO ☐ IM
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Descriptive Narrative of Behaviors:

Is Patient Medically Compromised: ☐ Yes ☐ No (CHECK ALL THAT APPLY)

☐ Known Hx of Cardiac or Respiratory Disease	☐ Pregnancy	☐ Spinal Injury
☐ Morbid Obesity	☐ Recent Vomiting	☐ Other
☐ Seizure Precautions		

Injury to Patient/Client During Procedure: ☐ Yes ☐ No (If Yes, Please describe injury and any treatment)

Staff Intervention Prior to Restraint/Seclusion (CHECK ALL THAT APPLY)

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☐ Verbal Reassurance	☐ Praise/Empathy Statement	☐ Rationale/Reality Statements
☐ Verbal Redirection	☐ 1:1 Interaction w/Staff	☐ Reduction in Stimuli
☐ Timeout	☐ Coupling Statements	

Describe Interventions Prior to Procedure:

Does the patient/client have a Personal Safety Plan? ☐ Yes ☐ No Was the Plan followed? ☐ Yes ☐ No

Was there a Debriefing? ☐ Yes ☐ No

Plan to prevent further events (Make Note of Any Changes to the Positive/Individual Behavior Plan, and attach Plan):

Names and Titles of Staff Involved: _____ _____
Name: Title:

Names and Titles of Witnesses: _____ _____
Name: Title:

Parent/Guardian/Custodian Notified ☐ Yes ☐ No

Name of Staff Member Providing Notification: _____ Date:_____ Time:_____ ☐ AM ☐ PM

Nursing Report: Findings and Treatment:

Signature/Title:_____ Date:_____

Physician's Report: Findings and Treatment:

Signature/Title:_____ Date:_____

Program Manager's (DCFS CPM I) Review: Findings and Treatment:

Signature/Title:_____ Date:_____

DCFS Clinical Program Manager II's Review: Findings and Treatment

Signature/Title:_____ Date:_____

DCFS/Private Facility ADMINISTRATIVE REVIEW: Comments-	DCFS ADMINISTRATOR REVIEW: Comments-	DAG/COMMISSION REVIEW:
		DAG Date:
DCFS Dep. Admin./Facility Admin. Date:	Administrator Date:	Commissioner Date:

NV Commissioner of Behavioral Health Comments: