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

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Programs/Facilities:

☐ DCFS/DWTC Acute-Adolescent (AAP)	☐ DCFS/PRTF Oasis East 12	☐ Reno Behavioral Healthcare
☐ DCFS/DWTC RTC	☐ DCFS/PRTF Oasis West 12	☐ Seven Hills Behavioral Institute
☐ DCFS/PRTF Enterprise FLH 1	☐ DCFS/PRTF Oasis 13	Southern Hills Hospital Pavilion
☐ DCFS/PRTF Enterprise FLH 2	☐ DCFS/PRTF Oasis 14	☐ Spring Mountain Treatment Center
☐ DCFS/PRTF Enterprise FLH 3	☐ Desert Parkway Behavioral Healthcare	☐ West Hills Hospital/Adolescent
☐ DCFS/PRTF Enterprise FLH 4	☐ Montevista Hospital/Acute	☐ West Hills Hospital/Pediatric
☐ DCFS/PRTF North (formerly ATC)	☐ Montevista/Adolescent Residential	☐ Willow Springs Treatment Center
☐ DCFS/PRTF Oasis West 11	☐ Never Give Up 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	☐ Imminent harm to self	☐ Pushes
☐ Bites	☐ Kicks	☐ Scratches
☐ Cuts	☐ Physical fighting	☐ Spits
☐ Hits	☐ Property destruction	☐ Threatening gestures
☐ Imminent harm to others	☐ Punches	☐ 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: