Commission on Behavioral Health

Seclusion and/or Restraint Emergency Procedures for Children and Youth Denial of Rights v.12.24.2023

Print on gold paper. No names or HIPAA-identifiers.	Gender 🗌 Male 🔹 Female	Legal Status:
	Transgender (Trans Man)	
Date of Admission:	Transgender (Trans Women)	Parental Custody
Medical Record #:	☐Gender Non-Conforming ☐ Other	Child Welfare Custody
	U Other	State
	Height:	County:
	Weight:	Youth Parole Custody
(Required)	Age:	Co-Custody
Page Charle all that angle		
Race: Check all that apply American Indian/Alaskan Native	Asian	White (Caucasian)
Black American	Native Hawaiian/Pacific Islander	Other
Ethnicity: 🗌 Hispanic 🗌 Non-Hispanic 🗌 Unkn	own	
Programs/Facilities:		
DCFS/Adolescent Treatment Center	Desert Winds	Southern Hills
DCFS/Desert Willow	KW Legacy Ranch	UHS of Spring Mountain
DCFS/No. NV Children Services Enterprise Aurora Center for Healing	Reno Behavioral Hospital	UHS Sahara
Bamboo Sunrise	SAI Residential Treatment Center	□ Other □ Other
Desert Parkway	Sierra Sage	
Day of the week and shift:		
(<i>Required</i>) IS THIS CHILD/YOUTH CURRENTLY	ENROLLED IN SPECIALIZED FOSTER CARE	? TYes No
(For reporting purposes only)		
Discussed with physician: Yes No RN	Initials: Date/Time:	
Physician verbal/phone orders by Dr		
Physician Initials:		
Order noted by: Did RN extend order once up to the maximum allo	Date/Time:	
<u>CONTINUATION ORDER</u> : The RN evaluation and		e a face-to face-reassessment of the child/youth
current behavior that warrants the extension of the rest		- a face to face reassessment of the child youth
SECLUSION: Locked Unlocked		□ N/A
Placed in Seclusion: DATE: Released from Seclusion: DATE:	TIME: AM [PM
Released from Seclusion: DATE:	TIME: AM [PM Total time in minutes:
MECHANICAL RESTRAINT: Cuff/Belt L	egs Wrists 4-point 5-point Mitts	Geri Chair N/A
Other		
Placed in Restraint: DATE:	TIME: AM [] PM
Released from Restraint: DATE:	TIME: AN	$M \square PM$ Total time in minutes:
PHYSICAL RESTRAINT: CPAR- Escort Sta	lemented Type and Description:	g Supine (on back) \Box N/A
Lying Prone (on stomach) Other Hold Imp Placed in Restraint: DATE:	TIME:	РМ
Released from Restraint: DATE:] PM
Total Time in Minutes:	Number of Staff Involved in Restraining C	
CHEMICAL RESTRAINT: DATE:		
Medication Administered:		
Medication Administered: Medication Administered:		PO ☐ IM PO ☐ IM
Results After one Hour (Explain)	Dose	
Behavioral Descriptors of Events: (CHECK ALL T		
Attempted elopement	HAT APPLY)	
	HAT APPLY)	Pushes
Bites		Pushes Scratches
Bites Cuts	 Imminent harm to self Kicks Physical fighting 	Scratches Spits
□ Bites □ Cuts □ Hits	Imminent harm to self Kicks Physical fighting Property destruction	Scratches Spits Threatening gestures
 Bites Cuts Hits Imminent harm to others 	 Imminent harm to self Kicks Physical fighting 	Scratches Spits
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DCFS	ASSIGNED	FORM #
	/ COULT	

Is Child/Youth 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 Child/Youth During Procedure: Yes	No (If Yos, describe injury and any t	treatment		
injury to child/ found During Flocedure. Tes				
Staff Intervention Prior to Restraint/Seclusion (CH	ECK ALL THAT APPLY)			
Ventilation of Feelings	Environmental Change	Limit Setting		
Verbal Reassurance Verbal Redirection	 Praise/Empathy Statement 1:1 Interaction w/Staff 	 Rationale/Reality Statements Reduction in Stimuli 		
	Coupling Statements			
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?	Was there a Debriefing?			
Plan to prevent further events (Make Note of Any				
	-			
Names and Titles of Staff Involved:				
Name:		Title:		
Names and Titles of Witnesses:				
Name:		Title:		
Legally Responsible Individual/Parent/Guardian,	Custodian Notified 🛛 🗌 Yes 🗍 No			
legany responsible menvicual, ratent, Guardian,				
Name of Staff Member Providing Notification:		Date: Time: AM DAM		
Nursing Report: Findings and Treatment:				
Signature/Title:		Date:		
_		Date		
Physician's Report: Findings and Treatment:				
Signature/Title:		Date:		
Program Manager's (DCFS CPM I) Review: Findin	gs and Treatment:			
Signature/Title:		Date:		
DCFS Clinical Program Manager II's Review: Find				
0 0	0			
0				
Signature/Title:		Date:		
DCFS/Private Facility ADMINISTRATIVE	COMMISSION REVIEW: Comments-			
REVIEW: Comments-	Comments-			
DCFS Dep. Admin. / Facility Admin. Date:	Commissioner Date:	:		
NV Commissioner of Behavioral Health Comments:				