Control #	Rev. Date:	Title:	Effective Date: 03/2000
2.013	11/2007	Civil Rights Grievance Procedures	Next Review Date:

1.0 POLICY:

It is the policy of the Division of Public and Behavioral Health to not discriminate in provision of services, or hiring and employment practices, on the basis of race, age, color, creed, sex, sexual orientation, religion, disability (including AIDS and related conditions), or national origin. DPBH has an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. These policies state, in part, that no person will, solely by reason of his/her race, age, color, creed, sex, sexual orientation, religion, disability (including AIDS and related conditions), or national origin be excluded from participating in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial participation.

2.0 PURPOSE:

To ensure equitable provision of services regardless of protected class statuses, and to provide federally required means for persons to file a complaint and receive a response at the Division level.

3.0 SCOPE:

Division Wide

4.0 DEFINITIONS:

5.0 REFERENCES:

6.0 PROCEDURE:

Control #	Rev. Date:	Title:	Effective Date: 03/2000
2.013	11/2007	Civil Rights Grievance Procedures	Next Review Date:

6.1 Any person who believes he/she has been subjected to discrimination on the basis of race, age, color, creed, sex, sexual orientation, religion, disability (including AIDS and related conditions), or national origin may file a grievance under this procedure. It is unlawful for DPBH to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance

6.2 Grievances must be submitted to Central Office Personnel Officer, Civil Rights Coordinator (at DPBH 4126 Technology Way, Suite 201, Carson City, NV 89706, 775/684-5943) within thirty (30) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.

6.3 A complaint must be in writing and contain the name and address of the person filing it ("the grievant"). The complaint must state the action alleged to be discriminatory and the relief sought.

6.4 The Civil rights Coordinator, or designee, will conduct an investigation of the complaint to determine its validity. The investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Civil Rights Coordinator will maintain the files and records for DPBH relating to such grievances.

6.5 The civil Rights Coordinator will issue a written decision on the grievance no later than 30-days after its filing.

6.6 DPBH Administrator will issue a written decision in response to the appeal no later than 30-days after its filing.

The availability of this grievance procedure does not preclude a person from filing a complaint of discrimination on the basis of race, age, color, creed, sex, sexual orientation, religion, disability (including AIDS and related conditions), or national origin with the Office for Civil Rights (OCR), 50 United Nations Plaza, Room, 322, San Francisco, CA 94102; (415) 437-8310 (voice) or (415) 437-8311 (TDD). Note: If the complaint is made by an employee, the OCR has said it will be referred to the relevant office of EEOC. The Division's primary document describing employee discrimination complaints is its policy 5.027, Non-Discrimination in Employment.

6.7 If the grievance is based on a disability, DPBH will make appropriate arrangements to assure that persons with disabilities can participate in or make use of this grievance process the same as persons who do not have disabilities. Such arrangements may include, but not be limited to, the provision of interpreters for the deaf, providing taped cassettes for the blind, or assuring a barrier-free location for the proceedings. DPBH Civil Rights Coordinator will be responsible for providing such arrangements.

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.

Control #	Rev. Date:	Title:	Effective Date: 03/2000
2.013	11/2007	Civil Rights Grievance Procedures	Next Review Date:

Effective Date: 03/01/00

Revised/Review Date: 11/06/07

Approved by Commission:

Control #	Rev. Date:	Title:	Effective Date: 03/2000
2.013	11/2007	Civil Rights Grievance Procedures	Next Review Date:

Control #	Rev.	Title	Effective Date: 01/2000
4.005	07/2007	Discharge of Consumers from Division Inpatient Facilities	Next Review Date

1.0 POLICY:

Prior to discharge from a 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 Division facility.

3.0 SCOPE:

Division Wide

4.0 DEFINITIONS:

5.0 REFERENCES:

6.0 PROCEDURE:

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.

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 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 6 months.

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 6-month period.

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.

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 3 days. A copy of this administrative order must be given to the person. 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 know, let the court know, and the process may stop there. 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 In cases involving imminent threat of danger to self or others a Legal 2000 should be initiated immediately.

6.2.9.2.3 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:

6.2.12.1 Notice of conditional release.

6.2.12.2 Notice of unconditional release.

6.2.12.3 Notice of order to return from conditional release and of hearing.

6.2.12.4 Administrative order to return from conditional release.

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. If the discharge is conditional leave NRS 433A.380, a "Notice of Conditional Leave" form must be completed, including the conditions of aftercare.

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.:

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.

Control #	Rev.	Title	Effective Date: 01/2000
4.005	07/2007	Discharge of Consumers from Division Inpatient Facilities	Next Review Date

Policy: It shall be the policy of the division to account for the whereabouts of all inpatient/ICFMR consumers at all times and that all consumers on special watches are closely monitored.

. Purpose: The Division will ensure consumers are properly supervised to protect and promote for the safety of the consumer, staff and the community.

Procedure:

I. Each inpatient/ICFMR facility shall conduct and document routine headcounts of all consumers. Procedures shall be developed to account for any consumer who leaves the unit for any reason, including time and reason of departure, call-in times, and return times.

II. Any consumer assessed to be a risk to self or others, an elopement risk, a threat to property, and/or to have medical problems of a serious nature shall be placed on special watches and closely monitored. Documentation of such watch and monitoring shall be both on a special watch sheet and the consumer's medical record.

III. Each inpatient/ICFMR facility shall develop coverage policies for outside courtyards to ensure proper supervision of courtyards to prevent injury or elopement.

IV. Ea.ch inpatient/ICFMR facility shall develop transport policies to ensure that consumers escorted from the facility for any reason are supervised at a level to protect public safety and safeguard the consumer.

V. Each inpatient/ICFMR facility shall develop procedures to prevent the importation of contraband, including alcohol, nonprescription medication, weapons, etc., into the facility. The procedure should include steps to be followed should importation or attempted importation of contraband be discovered.

VI. Each inpatient/ICFMR facility shall develop procedures for tracking and accounting for consumer property and that consumer rights pertaining to personal property are maintained.

VII. Each inpatient/ICFMR shall formulate policies and procedures to implement the provisions of this policy.

Administrator

Effective Date: 12/31/97
Date Revised: · 7/30/07
Date Reviewed: 12/31/99, 3/10/05; 7/30/07
Date Approved by MHDS Commission:

LAKE'S CROSSING CENTER

POLICY: #7.000 POLICY ON EMPLOYEE SAFETY

POLICY: It is the policy of Lake's Crossing Center that the first consideration in the performance of work shall be the safety of employees. All reasonable methods, procedures and equipment necessary to achieve this goal will be used.

PROCEDURES:

1. A Safety Coordinator will be appointed by the agency director for a term of one year. The Safety Coordinator shall chair the Safety Committee and oversee safety activity and training within the facility. In addition, he will:

   A) Conduct monthly facility inspections.

   B) Review inspection reports submitted by Area Supervisors.

   C) Initiate corrective action on recommendations of the Safety Committee.

   D) Maintain a bulletin board and safety posters.

2. A Safety Committee, composed of representatives from management and line staff, shall meet monthly to:

   A) Review accident/injury reports and discuss corrective actions.

   B) Discuss and report on unfinished business of the previous meeting.

   C) Review and discuss any "Hazardous Condition Reports submitted since the last meeting.

   D) Maintain appropriate records of activities.

   E) Actively participate in safety and health instruction programs and evaluate the effectiveness of these programs.

   D) Plan improvements to existing safety and health rules, procedures and regulations.

3. The facility shall be divided into "Areas of Supervision" for purposes of safety inspections and responsibility (see attachment A). Each area supervisor shall conduct monthly inspections of his area using the "Safety Inspection Checklist" (see attachment B). If the area supervisor discovers any unsafe situation, he must initiate a "Hazardous Condition Report" (see attachment C) and submit it to the Safety Coordinator within one working day.

4. Training sessions in safety issues for all staff will, be conducted at least six (6) times per calendar year. Training will consist of lecture video, handouts, and, on occasion, guest speakers. Training will be documented on the employee's training jacket by the Training Coordinator.

5. Staff are encouraged to report any hazardous condition to the Safety Coordinator using a "Hazardous Condition Report" form.

6. New employee orientation will be done by the Safety Coordinator using the “New Employee Orientation” form (see attachment D) before the new employee is scheduled for any floor coverage.

7. All injuries are to be reported immediately and the Administrative Assistant II is responsible for completing a C-3 form.

8. Any injuries will be investigated by the staff member’s immediate supervisor, using the “Supervisor’s Report of Accident” form. The “Supervisor’s Report of Accident” must be completed and sent to the Safety Coordinator within three (3) working days of the date of the accident.

9. Any “near miss” is to be reported to the supervisor on duty and a C-1 form is to be completed by the employee or the Administrative Assistant II.

10. Any violation of safety practices shall be documented on a “Safety Violation” form (see attachment F). Disciplinary action shall proceed in accordance with the Division of MHDS’ “Prohibitions and Penalties.”

_____
Elizabeth W. Neighbors, Ph.D.
Director

_____
Department Head

Effective Date: 7/1/1994
Revision Date: 6/1/2001
Reviewed: 5/03
Review Date: 5/05

ATTACHMENT A

Lake's Crossing Center Safety Committee

Areas of Supervision:	Staff Responsible
Front office area to include: Lounge, bathrooms, conference room public areas (exclude maintenance closed)	
Secure Areas: Chart room, east salley port maintenance shop and office med records, boiler room, vehicle court yard, control room, control room bathroom, telephone room	
Classroom, classroom storage, arts and crafts room, canteen MPR, MPR courtyard, MPR bath-rooms,	
Kitchen, including sharps room, mop room, bathroom. Blue wing excluding med room and nursing office, blue wing courtyard	
Med room, nursing office, Crowfoot's office, storage area	
Rust Wing: laundry room, offices, storage closets, rust courtyard	
Brown Wing: clothing room, offices, storage closets and	
Visiting area, west salley port, Green MPR, Green ISO Green offices, Green Wing living area,	
Barbershop, Green wing Laundry room	

LAKE'S CROSSING CENTER
POLICY #7.000 POLICY ON EMPLOYEE SAFETY

POLICY: It is the policy of Lake's Crossing Center that the first consideration in the performance of work shall be the safety of employees. All reasonable methods, procedures and equipment necessary to achieve this goal will be used.

PROCEDURES:

1. A Safety Coordinator will be appointed by the Agency Director for a term of one year. The Safety Coordinator shall chair the Safety Committee and oversee safety activity and training within the facility. In addition, he will:
    a. Conduct monthly facility inspections.
    b. Review inspection reports submitted by Area Supervisors.
    c. Initiate corrective action on recommendations of the Safety Committee.
    d. Maintain a bulletin board and safety posters.

2. A Safety Committee composed of representatives from management and line staff, shall meet monthly to:
    a. Review accident/injury reports and discuss corrective actions.
    b. Discuss and report on unfinished business of the previous meeting.
    c. Review and discuss any "Hazardous Condition Reports" submitted since the last meeting.
    d. Maintain appropriate records of activities.
    e. Plan improvements to existing safety and health rules, procedures and regulations.

3. The facility shall be divided into "Areas of Supervision" for purposes of safety inspections and responsibility (see Attachment A). Each area supervisor shall conduct monthly inspections of his area using the "Safety Inspection Checklist" (see Attachment B). If the area supervisor discovers any unsafe situation, he must initiate a "Hazardous Condition Report" (see Attachment C) and submit it to the Safety Coordinator within one (1) working day.

4. Training sessions in safety issues for all staff will be conducted at least six (6) times per calendar year. Training will consist of lecture videos, handouts, and on occasion, guest speakers. Training will be documented on the employee's training jacket by the Training Coordinator.

5. Staff are encouraged to report any hazardous condition to the Safety Coordinator using a "Hazardous Condition Report" form.

6. New employee orientation will be done by the Safety Coordinator using the "New Employee Orientation" form (see Attachment D) before the new employee is scheduled for any floor coverage.

7. All injuries are to be reported immediately and the Administrative Assistant II is responsible for completing a C-3 form.

8. Any injuries will be investigated by the staff member's immediate supervisor, using the "Supervisor's Report of Accident" form (see Attachment E). The "Supervisor's Report of Accident" must be completed and sent to the Safety Coordinator within three (3) working days of the date of the accident.

9. Any "near miss" is to be reported to the supervisor on duty and a C-1 form is to be completed by the employee or the Administrative Assistant II.

10. Any violation of safety practices shall be documented on a "Safety Violation" form (see Attachment F). Disciplinary action shall proceed in accordance with the Division of MHDS "Prohibitions and Penalties."

_____
Elizabeth W. Neighbors, Ph.D., ABPP

_____
Department Head

Effective Date: 7/1/1994
Revision Date: 6/1/2001
Reviewed: 1/31/2006
Review Date: 1/31/2008

ATTACHMENT A

Areas of Supervision:

Front office area to include:

- Lounge
- Bathrooms,
- Conference room
- Public areas (exclude maintenance closed)

Staff Responsible:_____

Secure Areas:

- Chart room
- East salley port
- Maintenance shop and office
- Medical Records
- Boiler room
- Vehicle court yard
- Control room
- Control room bathroom
- Telephone room

Staff Responsible:_____

- Classroom
- Classroom storage
- Arts and crafts room
- Canteen
- MPR
- MPR courtyard
- MPR bathrooms

Staff Responsible:_____

- Kitchen (including sharps room
- Mop room
- Bathroom
- Blue wing (excluding med room and nursing office)
- Blue wing courtyard

Staff Responsible:_____

Attachment A (continued)

- Med room
- Nursing Office
- Storage area

Staff Responsible:_____

Rust Wing:

- Laundry room
- Offices
- Storage closets
- Rust courtyard

Staff Responsible:_____

- Visiting area
- West salley port
- Green MPR
- Green ISO
- Green offices
- Green Wing living area

Staff Responsible:_____

- Barbershop
- Green wing laundry room

Control #	Rev.	Title	Effective Date: 09/2017
A 4.1	New	Mail Room and Mail Safety	Next Review Date: 09/2019

1.0 POLICY:

To provide guidelines for safe screening and handling of all incoming packages and letters, whether delivered via the United States Postal Service (USPS), third party couriers (FedEx, UPS, DHL) special messengers, interoffice mail or guest and visitors.

2.0 PURPOSE:

To provide mail center manager**s**, supervisors, staff and security personnel a framework for mitigating risk when handling mail and packages received. Mail security and screening protects employees, clients, facilities, business functions and guests.

3.0 SCOPE: DPBH

4.0 DEFINITIONS:

4.1 **Personal Protective Equipment (PPE)** protective clothing, helmets, goggles, masks (inclusive of N95) or other garments or equipment designed to protect the wearer's body from injury or infection. The hazards addressed by protective equipment may include physical, electrical, heat, chemicals, biohazards, and gaseous or airborne particulate matter.

4.2 **CBRNE** - Chemical, Biological, Radiological, Nuclear or Explosive Substances

4.2.1 **Chemical** – is a specialized weapon that uses **chemicals** formulated to inflict death or harm on humans. Examples of chemical threats include nerve agents, blood agents, pulmonary agents, blister agents, industrial chemicals and irritants. Chemical threats can be solid, liquid or gaseous/vapor.

4.2.2 **Biological** - also called bio-agent, biological threat agent, biological warfare agent, biological weapon, or bioweapon—is a bacterium, virus, protozoan, parasite, or fungus that can be used purposefully as a weapon in bioterrorism or biological warfare (BW).

4.2.3 **Radiological** - or radiological dispersion device (RDD) is any **weapon** that is designed to spread radioactive material with the intent to kill and cause disruption.

4.2.4 **Nuclear** - a bomb or missile that uses nuclear energy to cause an explosion.

4.2.5 **Explosive** - weapons that affect an area around the point of detonation, usually through the effects of blast and fragmentation.

4.2 **Dangerous Items** – items that can cut, shock or harm an individual when the letter or package is opened.

4.3 **Illegal or Contraband Items** – illegal drugs, guns, knives, swords or other potentially dangerous substances or weapons.

4.4 **Hoax** – a suspicious mail item that is designed to present the appearance of a dangerous substance or other threat but do not actually contain the actual substance necessary to cause harm.

4.5 **White Powder Envelope or Package**– Any white powdery substance that creates the appearance of anthrax, a dangerous biological substance or toxin.

4.6 **Threats** – suspicious mail may contain threatening language on the envelop or inside the envelope's contents. The threat intends to inflict pain, injury, damage or other hostile action on someone or something.

4.7 **Mailroom** – a point of receipt, sorting and distribution of mail and packages.

4.8 **Types of Mail and Package Deliveries**

4.8.1 **U.S. Postal Service (USPS)** agency responsible for general delivery of a full range of items.

4.8.1.2 **U.S. Postal Service Accountable Mail Certified and Registered Mail**. Includes the deliverer and recipient signature and is assigned a unique tracking number.

4.8.2 **Express Couriers** provide pickup and delivery of express mail and packages. Security features include end to end tracking and limited security screening. Terrorist have begun using global express couriers for delivery of explosive packages.

4.8.3 **Interoffice Mail** – Mail created and delivered entirely within a system,

building, or campus environment. Interoffice mail cannot be assumed safe and must be considered a potential source of suspicious mail. Disgruntled employees, visitors and others can introduce suspicious mail directly into the internal mail sorting process.

5.0 PROCEDURE

5.1 Basic Mail Security Procedures:

- 5.1.1 All mail including packages must be delivered through a central location in each agency; preferably a designated mail center or room.
- 5.1.2 Ensure that all mail delivery personnel from the postal service and other package delivery and supply vendors are clearly identified and log in.
- 5.1.3 Provide a designated parking area for delivery of mail, packages and supplies.
- 5.1.4 Staff handling and sorting mail should wear gloves and wash their hands or use hand sanitizer immediately after completion of the task.
- 5.1.5 Personal Protective Equipment (PPE) should be available in every mail center or room location.
- 5.1.6 Basic PPE – gloves, gowns and masks should be donned before handling suspicious mail.
  - 5.1.6.1 Suspicious mail indicators include the following but must be considered within the context of the organization and its population:
    - 5.1.6.1.1 Powdery substance on the outside of the package.
    - 5.1.6.1.2 Is an unexpected delivery
    - 5.1.6.1.3 Has excessive postage, is hand written or contains a poorly typed address, incorrect title, or just a title with no name, misspells of common words.
    - 5.1.6.1.4 Is addressed to someone no longer with the organization or is otherwise outdated.
    - 5.1.6.1.5 Has no return address or one that cannot be verified as legitimate.
    - 5.1.6.1.6 Unusual weight for its size or is lopsided or oddly shaped.
    - 5.1.6.1.7 Has an unusual amount of tape on it.
    - 5.1.6.1.8 Is marked with restrictive endorsements.
    - 5.1.6.1.9 Has strange odors, stains or protruding wires.

5.1.7 Close off the room including the ventilation system (if possible)
5.1.8 Call an Overhead Code as appropriate: example Code Bravo, Code 45, Code 77; Call 911 and notify Capitol Police.
5.1.9 Report immediately through your chain of command to activate the emergency notification process (DPBH Policy A.4 DPBH Emergency Notification).
5.1.10 Notify other agencies in immediate proximity as appropriate.
5.1.11 Notify the DPBH Statewide and Regional Emergency Operations Managers.
5.1.12 Update HAvBED and put agency status on Internal Disaster.
5.1.13 Notify the U.S.P.S Post Master.
5.1.14 Don't open any parcel until it is verified as safe.
5.1.15 If you receive a suspicious letter or package: handle with care, do not shake, bump, open, smell, touch or taste it.
- 5.1.15.1 Isolate it immediately – treat it as suspect.
- 5.1.15.2 If possible isolate it in a separate room that can be closed off and is away from personnel and staff traffic. If possible isolate the air ducts to and from the room or area.
- 5.1.15.3 If it has powdery or other substances leaking from the package, do not clean up and avoid further contact.
- 5.1.15.4 Calmly and immediately move away from the envelope or package and inform others in the area to leave.
- 5.1.15.5 Do not walk around and show others or invite others to come in and look.
- 5.1.15.6 If your clothes are contaminated, do not brush vigorously as this may disperse powder into the air. Remain in place and wait for directions from first responders.
- 5.1.15.7 Do not touch your eyes, nose, mouth, hair or any other part of your body.
- 5.1.15.8 If possible and without contaminating other ares, wash your hands with soap and water or hand sanitizing gel or wipe.

5.1.16.1 Make a list of all people who had contact with the powder or were in the area when the powder was released.

Control #	Rev.	Title	Effective Date: 09/2017
A 4.1	New	Mail Room and Mail Safety	Next Review Date: 09/2019

6.0 TRAINING

6.1 Suspicious Mail Training:
- 6.1.1 All staff will be trained on hire and annually
  - 6.1.1.1 Training will include emergency response procedures.
- 6.1.2 Mail Center staff will be trained on hire and twice per year.

7.0 REFERENCES:

- 6.0.1 Maintaining Mail Safety and Security on A Budget: White Paper, Pitney Bowes, 2009
- 6.0.2 Handling Powdery Substances
- 6.0.3 Best Practices for Mail Screening and Handling Processes: A Guide for the Public and private Sectors, September 2012, 1st Edition, US Department of Homeland Security and the Interagency Security Committee.

8.0 ATTACHMENTS

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: 9/2017
DATE APPROVED BY DPBH ADMINISTRATOR: 9/2017
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 9/2017

Control #	Rev.	Title	Effective Date: 09/2017
A 4.1	New	Mail Room and Mail Safety	Next Review Date: 09/2019

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

1.0 POLICY:

The Department of Public and Behavioral Health (DPBH) ensures proper communications during emergent events, while protecting and promoting the safety and confidentiality of those involved

2.0 PURPOSE:

This policy establishes guidelines for proper communications during emergent events to the Director of DPBH with the use of telecommunications, electronic communications, and personal electronic devices. Each agency will incorporate this policy into their agency protocol. This policy is not intended to replace existing policies related to significant/serious incident reports but rather to establish a quick reporting mechanism to key staff at the time the event is unfolding.

3.0 SCOPE: Division Wide

4.0 DEFINITIONS:

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

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

5.0 PROCEDURE:

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

5.1.1 The appropriate agency code will be called, over the intercom system, when an incident occurs. Agency approved codes will be used for this notification.

5.1.2 Notification of the incident will be made immediately to the operator and/or Forensic Control Room staff by phone or in person.

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

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

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

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

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

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

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

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

5.1.9.1 Notification should occur through multiple redundant communication mechanisms such as Nxt Communicator, Email, Text messaging, Over Head Paging and Voice to voice to ensure rapid and inclusive awareness of the situation.

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

6.0 REFERENCES

6.1 DPBH Policy CRR 1.4 Reporting of Serious Incidents

6.2 DPBH Policy A6.1 Psychological First Aid Counselor Response

6.3 DPBH Policy A6.3 Clinical Services Disaster Requirement Plan

6.4 DPBH Comprehensive Emergency Management Plan

6.5 DPBH CRR1.5 Management of Elopement Inpatient Services

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

Control #	Rev. Date:	Title:	Effective Date: 1/06
A 4.61 (4.061)	9/2019	UTILIZATION MANAGEMENT	Next Review Date: 09/2021

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.

Control #	Rev. Date:	Title:	Effective Date: 1/06
A 4.61 (4.061)	9/2019	UTILIZATION MANAGEMENT	Next Review Date: 09/2021

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)	9/2019	UTILIZATION MANAGEMENT	Next Review Date: 09/2021

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: 09/2019
Date Approved by DPBH Commission: 1/20/06, 3/18/10, 09/2019

Control #	Rev. Date:	Title:	Effective Date: 10/16
A 5.2	10/18	REVIEW OF CLIENT DEATH FOR ADULT MENTAL HEALTH AGENCIES	Next Review Date: 10/20

1.0 POLICY:
It is the policy of the Division to review certain cases in which people receiving services expire. Clients who expire while receiving services in hospital inpatient units will be reviewed according to DPBH CRR 1.3 Sentinel Events.

2.0 PURPOSE:
The purpose of this review is to assess the care provided and make recommendations for improvements to care systems thereby reducing risk for others receiving services. Recommendations stemming from these reviews will be used to promote quality care at all agencies.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS: N/A

5.0 REFERENCES:
5.1 DPBH Policy CRR .014 Risk Management and Reporting Serious Incidents
5.2 DPBH CRR 1.14 Root Cause Analysis and attachments
5.3 DPBH CRR 1.13 Sentinel Events

6.0 PROCEDURE

6.1 In order to most efficiently use the resources of the State of Nevada, review activities are adjusted according to the circumstances of the death and the extent of services the person was receiving.

6.1.1 Any death while the person who died was currently receiving round the clock services from a Division Adult Mental Health agency or a suicide within 72 hours of discharge from such a setting is subject to Policy 1.13 Sentinel Events.

6.1.2 Outpatient clients who commit suicide or die in circumstances that are unclear will be analyzed using a root cause analysis type process.

6.1.3 Outpatient clients who commit suicide in a state facility or on state property will be reported to the Sentinel Event Registry.

6.1.4 Outpatients who die accidentally, by natural causes, from disease process or accidents unrelated to their mental illness will be reviewed by a designated staff person and referred to the more extensive root cause process only if deemed necessary by the Agency Director, State Psychiatric Medical Director, or Division Administration.

Immediate action upon receipt of notification of death:

6.1.5 Immediately, and in no event later that one (1) hour after receipt of notification of a death, the Agency Director or designee will secure and/or direct to be secured the client's complete, original clinical records to the custody of the Director of Health Information Services or applicable staff designated by the agency Director.

6.1.6 A Serious Incident Report (SIR) will be completed, per Division P CRR .014 Reporting of Serious Incidents. The following information will be included in the SIR:

6.1.6.1 What is the reported time, date and reported/apparent cause of death?

6.1.6.2 Note if the coroner was contacted, if the information is available.

6.1.6.3 Where was the client found, if the information is available?

6.1.6.4 Who found the client, if the information is available?

6.1.6.5 Was there a history of suicide or assaultive symptoms? Give analysis of care specific to suicide or assaultive symptomatology for the last six months.

6.1.6.6 If the client missed appointments during the past six months, was appropriate follow-up done?

6.1.6.7 Give a summary of the client's contact with the Agency with special emphasis to services provided within the last six months if the information is available.

6.1.6.8 Were any medical conditions present? If so, describe contacts with the medical provider during the last six months of care relative to the condition.

6.1.6.9 Describe interaction between Division programs and all non-Division community-based programs for the past six (6) months.

6.1.6.10 Was grief counseling offered to the family? If not, give reasons.

6.1.7 The Agency Director, the Agency Quality Assurance Performance Improvement Manager or the Agency Medical Director or their designees may refer the case for root cause analysis.

6.1.8 Upon notification of death, the Agency Director of Health Information Services or appropriate staff will request a copy of the death certificate, Coroner's report, and toxicology report.

6.1.8.1 Upon receipt these reports will become a part of the permanent medical record

6.1.9 The Agency Director may request that an agency debriefing team hold a debriefing meeting with the treating clinical staff team.

6.1.9.1 The purpose of this meeting is to provide emotional support to staff, not to investigate the death.

6.1.9.2 The coordinator of the debriefing will report to the Agency Director the time and date of the debriefing and the number of people participating.

6.2 All incidents of client suicides and unusual client deaths that meet the requirements of a Sentinel Event will be referred by the Division Deputy Administrator to the Commission on Behavioral Health for review.

6.3 The review, report and action provided pursuant to this policy is a performance improvement function of the Division agencies, undertaken to help assure appropriate quality services to Division clients. As such, the performance improvement privilege attached to the actions of the committee, Clinical Supervisors, Agency Directors, and Division Administrators, all documents, notes, conversations or discussions by the committee reviewed or made in the course of its exercise of its function are privileged and not subject to disclosure.

Control #	Rev. Date:	Title:	Effective Date: 10/16
A 5.2	10/18	REVIEW OF CLIENT DEATH FOR ADULT MENTAL HEALTH AGENCIES	Next Review Date: 10/20

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: 12/31/97
DATE REVISED: 11/27/02, 1/28/03, 7/07/03, 11/18/03, 5/28/07, 10/16, 09/18

Control #	Rev. Date:	Title:	Effective Date: 10/16
A 5.3 (4.039)	10/16	QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT	Next Review Date: 10/18

1.0 POLICY:

The Division of Public and Behavioral Health (DPBH) Clinical Services Branch shall maintain a statewide, comprehensive and integrated quality assurance and performance improvement (QAPI) program. Responsibility for oversight and coordination of QAPI initiatives and processes at the Division, Agency and Program levels lies with the DPBH Clinical Services QAPI Department under the leadership of the Statewide QAPI Manager. The QAPI Department is driven by the following values: (a) a non-static, dynamic concept of quality; (b) efficiency in resource allocation; (c) consumer driven and directed services; (d) staff empowerment in organizational improvement activities; (e) valuing DPBH staff and their contributions; (f) diversity and cultural competency; (g) positive reinforcement; and (h) adherence to the DPBH Strategic Plan.

2.0 PURPOSE:

QAPI uses data-driven, proactive approach to improving the quality of care and services in DPBH inpatient and outpatient behavioral health care facilities and services. The activities of QAPI involve members at all levels of the organization to identify opportunities for improvement, address gaps in systems or processes, develop and implement an improvement or corrective plan, and continuously monitor the effectiveness of interventions.

The mission of the DBPH Clinical Services QAPI Department is “to create an organizational focus on continuous performance improvement, patient safety and staff development in all functional areas to assist adults with mental illness improve their quality of life.”

The quality assurance (QA) components of QAPI focus on assisting the Division in meeting or exceeding regulatory standards as set forth by State CMS (HCQC), The Joint Commission (TJC), and the Centers for Medicare and Medicaid Services (CMS). The performance improvement (PI) components of QAPI move beyond the expectations of external regulatory entities to promote Division-wide continuous improvement in the efficiency, effectiveness and availability of resources aimed at meeting the needs of and protecting, promoting and improving the lives of consumers who seek our services.

PI is a continuous, positive, process-oriented endeavor that provides educational and technical support to leadership and staff at Division, Agency and Program levels.

3.0 SCOPE:

All DPBH entities within the Clinical Services branch including (1) Southern Nevada Adult Mental Health Services-SNAMHS, (2) Northern Nevada Adult Mental Health Services-NNAMHS, (3) Rural Community Health Services-RCHS, (4) Lakes Crossing Center-LCC.

4.0 DEFINITIONS

Agency – A local entity within the DPBH Clinical Services Branch providing services to a defined geographic area or a defined population. Examples would include SNAMHS, NNAMHS, RCHS, and LCC.

Clinical Services – A Branch within the DPBH with the primary purpose of providing statewide inpatient, outpatient and community-based public and behavioral health services to Nevadans.

CMS – The Centers for Medicare & Medicaid Services. CMS is part of the Federal Department of Health and Human Services (HHS) and administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.

DPBH – The Nevada Division of Public and Behavioral Health, part of the Nevada Department of Health and Human Services, protects, promotes and improves the physical and behavioral health of the people in Nevada.

HCQC – The Bureau of Health Care Quality and Compliance (HCQC) licenses medical and other health facilities, laboratories, dieticians, and music therapists in Nevada.

LCC – Lake's Crossing Center (LCC) is Nevada's first forensic psychiatric facility. The program provides inpatient and outpatient services statewide to individuals involved with the criminal justice system who have concurrent mental health issues.

NNAMHS – Northern Nevada Adult Mental Health Services. The Agency within the Clinical Services Branch of DPBH providing inpatient and outpatient services to individuals and families in northern Nevada.

PI – Performance Improvement. The part of QAPI that focuses on continuously analyzing performance and developing systematic efforts to improve it.

PIP – Performance Improvement Plan. A concentrated effort on a particular problem in one area of a facility/agency or facility/agency wide.

Program – A service delivery entity within a local agency focused on a specific population or specific outcomes.

QA – Quality Assurance. The process of meeting quality standards and assuring that care reaches an acceptable level.

QAPI – Quality Assurance Performance Improvement. A comprehensive approach to ensuring high quality care and services. Also, the name for the Department within the Clinical Services Branch responsible for oversight of QAPI initiatives.

RCHS – Rural Community Health Services. The Agency within the Clinical services Branch offering outpatient behavioral health services to both children and adults in 13 clinics and one integrated care center in the northern rural areas of the state.

SNAMHS – Southern Nevada Adult Mental Health Services. The Agency within the Clinical Services Branch of DPBH providing inpatient and outpatient services for adults living in Clark County and adults, children and adolescents in four southern rural communities – Pahrump, Mesquite, Caliente and Laughlin.

TJC – The Joint Commission. An independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

5.0 PROCEDURES:

5.1. QAPI team members will provide technical assistance, support and training to leadership and staff regarding QAPI processes, including the standards used by HCQC, TJC and CMS for site reviews, which may include, but is not limited to: (a) consumer surveys; (b) staff surveys; (c) administrative/fiscal review; (d) environment of care review; (e) contract service provider review; (f) clinical record review; (g) individual centered evaluation; (h) cultural competency.

5.2. QAPI activities are the responsibility of all staff at all levels of the Division. Coordination of these activities is the responsibility of the DPBH Clinical Services QAPI Department. Coordination and implementation of the QAPI process at the Agency level (including contract providers) is the responsibility of the Agency Director. QAPI team member(s) located at the agencies shall assist and provide technical support to Agency Directors in order to implement and coordinate the QAPI process. It is the responsibility of QAPI personnel to resist the tendency to assume full responsibility for QAPI activities at the Agency and/or Program level and instead provide guidance, technical assistance, consultation and oversight.

5.3. Division Administration and Agency Directors will participate in the analysis of QAPI reports and approval of remediation plans. QAPI

Activity Reports and Program Evaluation Data Reports shall be considered QAPI reports.

5.4. The Division shall have a defined process for reviewing, analyzing and noting actions required of QAPI reports. This process shall include Division staff, the Agency Director, other management staff and QAPI personnel. Each Agency shall have a defined process for reviewing, analyzing and noting actions required of QAPI reports. This process shall include the Agency Director, other management staff and QAPI personnel.

5.5. All QAPI activities will be aligned with accreditation, certification and licensing requirements to the extent possible.

5.6. Each Agency shall develop and maintain a comprehensive and integrated QAPI process throughout all programs (clinical and administrative) at the Agency (including the role of contract providers). Each Department and/or Program within each Agency will submit a Performance Improvement Plan (PIP) on an annual basis. Each PIP should be: (a) multi-tiered, (b) involve staff at all levels, (d) approved by the Agency QAPI Coordinator and the Agency Director.

5.7. QAPI will collaborate with staff training coordinators at the Division and Agency levels to enhance competencies related to performance improvement activities.

5.8. QAPI may be involved with, but is not limited to, the following initiatives at the Division and Agency levels: (a) licensure, certification and accreditation of DPBH hospitals; (b) developing and implementing the DPBH Annual Medicaid State Plan; (c) DPBH Strategic Planning; (d) Reviewing Serious Incident Reports; (e) Administering the Statewide PASRR Program in collaboration with the Division of Health Care Financing and Policy; (f) Patient Safety; (g) Patient Satisfaction; (h) Patient Advocacy, Compliments, Complaints and Grievances; (i) Policy and Procedure Development and Management; (j) Disaster Management

and Emergency Preparedness; (k) Corrective Action Plans and Measures of Success; (l) Root Cause Analyses; (m) Staff Development and Training.

6.0 ATTACHMENTS: N/A

7.0 Implementation of Policy:

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

Control #	Rev.	Title	Effective Date: 03/2017
A6.2	03/2019	Clinical Services Disaster Plan Requirement	Next Review Date: 03/2021

1.0 POLICY:

The Division of Public and Behavioral Health is responsible for mitigation against, preparation for, response to, and recovery from emergencies and disasters in order to provide assistance that saves lives and protects health, safety and property.

1.1 Public Health Preparedness and Behavioral Health (ESF 8-1) are part of the Statewide Comprehensive Emergency Management Plan which describes the methods by which the State of Nevada will mobilize resources and conduct disaster response and recovery activities.

1.2 The Division of Public and Behavioral Health is also part of the overall Continuity of Operations Plan for state agencies.

1.3 Each facility and agency under the Clinical Services Branch of DPBH is required to have an All Hazards Emergency Operations Plan that is reviewed and updated annually.

2.0 PURPOSE:

This policy serves to ensure that the DPBH, Clinical Services Branch, is prepared in the event of a natural or manmade disaster or state or federally - declared emergency, in collaboration with other disaster response efforts at state and local levels within the National Incident Management System and NRS 414 Emergency Management.

3.0 SCOPE:

Division of Public and Behavioral Health, Clinical Services Branch

4.0 DEFINITIONS:

4.1 The Joint Commission (TJC): a United States-based nonprofit tax-exempt 501 (c) organization that accredits health care organizations and programs.

4.2 Centers for Medicaid and Medicare Services (CMS): Part of the U.S. Department of Health and Human Services which oversees many federal healthcare programs.

4.3 Disaster: Per NRS 414.0335 "Disaster" means an occurrence or threatened occurrence for which, in the determination of the Governor, the assistance of the Federal Government is needed to supplement the efforts and capabilities of state

agencies to save lives, protect property and protect the health and safety opersons in this state, or to avert the threat of damage to property or injury to or the death of persons in this state.

4.4 Emergency: Per NRS 414.0345 "Emergency" means an occurrence or threatened occurrence for which, in the determination of the Governor, the assistance of state agencies is needed to supplement the efforts and capabilities of political subdivisions to save lives, protect property and protect the health and safety of persons in this state, or to avert the threat of damage to property or injury to or the death of persons in this state.

4.5 Emergency Management: Per NRS 414.035 "Emergency management" means the preparation for and the carrying out of all emergency functions, other than functions for which military forces are primarily responsible, to minimize injury and repair damage resulting from emergencies or disasters caused by enemy attack, sabotage or other hostile action, by fire, flood, earthquake, storm or other natural causes, or by technological or man-made catastrophes, including, without limitation, a crisis involving violence on school property, at a school activity or on a school bus. These functions include, without limitation:

4.5.1 The provision of support for search and rescue operations for persons and property in distress.

4.5.2 Organized analysis, planning and coordination of available resources for the mitigation of, preparation for, response to or recovery from emergencies or disasters.

4.5.3 Essential Service Function 8-1 (ESF 8-1) facilitates behavioral health support to assist victims, victim's families, emergency responders, and community members during the immediate, intermediate and long term.

4.6 National Incident Management System (NIMS) is a comprehensive, national approach to incident management that is applicable at all jurisdictional levels and across functional disciplines. It is intended to be applicable across a full spectrum of potential incidents, hazards, and impacts, regardless of size, location or complexity.

4.7 Hazard Vulnerability Assessment (HVA): a systematic approach to recognizing hazard that may affect demand for agency services or its ability to provide those

services. The risks associated with each hazard are analyzed to prioritize planning, mitigation, response and recovery activities. The HVA serves as a needs assessment for the Emergency Management Operations Plan.

5.0 REFERENCES:

4.1 NRS 414.0335
4.2 NRS 414.0345
4.3 NRS 414.035
4.4 Nevada Behavioral Health Emergency Operations Plan
4.5 Emergency Preparedness: Preparing Hospitals for Disasters, California Hospital Association; http://www.calhospitalprepare.org/hazard-vulnerability-analysis

6.0 PROCEDURE:

6.1. Each facility, to include but not limited to Dini-Townsend Psychiatric Hospital of Northern Nevada Adult Mental Health Services (NNAMHS), Rawson-Neal Psychiatric Hospital and Stein Forensic Facility of Southern Nevada Adult Mental Health Services (SNAMHS), Lakes Crossing Center, and Rural Counseling and Supportive Services, under the DPBH Clinical Services Branch shall maintain an All Hazards Emergency Operation Plan that is consistent with NIMS and based on annual HVA.

6.2 Each facility shall identify essential staff including a designated Emergency Management Coordinator and provide those staff with information regarding their responsibilities in preparation for possible disasters and in the event of a disaster.

6.3 Each facility will maintain and Emergency Operations Plan and Emergency Management Protocols that are reviewed and updated annually.

6.4 The Emergency Opeations Plan shall include requirements for appropriate training activities to ensure that staff are prepared to implement the plan in the event of a disaster.

6.5 The Joint Commission and CMS require psychiatric hospitals such as Dini-Townsend Psychiatric Hospital and Rawson-Neal Psychiatric Hospital to have All Hazards Emergency Operations Plans, as well as multi-year emergency preparedness training plan for all staff.

6.6 Agencies are encouraged to partner with other entities within their community and the State, as necessary to implement the plan.

6.7 Emergency Operations Plans at each facility or agency level under the Clinical Services Branch, shall be based on a Hazard Vulnerability Assessment (HVA).

6.8 Each agency or facility under the Clinical Services Branch will develop specific written procedures to implement this policy.

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY:

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

EFFECTIVE DATE: 03/2017
DATE APPROVED BY DPBH ADMINISTRATOR: 03/2017, 05/2019
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 03/2017, 05/2019

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°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°C and that this temperature does not fall below 50°C at any point within the circulation pipework.

c) Ensure that all pipework carrying blended water at temperatures of between 25°C and 43°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°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

Control #	Rev.	Title	Effective Date: 10/16
GOV 1.1	09/18	**CLINICAL SERVICES HOSPITAL GOVERNING BODY POLICY**	**Next Review Date 09/20**

1.0 POLICY:

The Division of Public and Behavioral Health (DBPH) in accordance with Nevada Revised Statutes NRS 449.0302 and NAC 449.286 has an established Governing Body that is legally responsible for the conduct of DBPH Inpatient Facilities. One Governing Body may be responsible for all DBPH inpatient facilities regardless of differing CMS Certification Numbers

2.0 PURPOSE:

To define procedures that guide the process of DBPH inpatient facility governance and to define the shared and unique responsibilities of Hospital Administration, Medical Staff Leadership and the Governing Body.

3.0 SCOPE:

Division wide, including all DBPH run inpatient facilities**.**

4.0 DEFINITIONS:

4.1 Governing Body (NRS 440.0302 and NAC 449.286) - the person or group of persons, including a board of trustees, board of directors or other body, in whom the final authority and responsibility is vested for conduct of a hospital.

5.0 REFERENCES:

5.1 NRS 440.0302
5.2 NAC 449.286
5.3 TJC LD.02.02.01 EP1

6.0 PROCEDURE:

6.1 The Governing Body will:

6.1.1 Include a member or members of the hospital's medical staff
6.1.2 Identify those responsible for the provision of care.
6.1.3 Hold meetings at least quarterly and more frequently when needed.

6.1.4 Adopt a workable set of bylaws which must be in writing and available to all members.

6.1.5 Establish and follow processes for formal approval of policies, bylaws, rules and regulations of the medical staff and its departments in the hospital.

6.1.6 Participate in the appointment of a qualified Chief Executive Officer (hospital administrator) using as its criteria the actual experience, nature and duration, or similar field, of the appointee.

6.1.7 A member of the Governing Body may participate in the hiring panel for the Chief Executive Officer (Hospital Administrator).

6.1.8 Determine, in accordance with state law, which categories of practitioners are eligible for appointment to the medical staff.

6.1.9 Approve appointment of members of the medical staff after considering the recommendations of the existing medical staff.

6.1.10 Review written and verbal reports from the medical staff highlighting the quality of care which the medical staff provide to patients.

6.1.11 Ensure the criteria for selection of medical staff includes individual competence, training, experience and judgment.

6.1.12 In conjunction with senior managers and leaders of the organized Medical Staff work together to define in writing conflicts of interest involving leaders that could affect safety and quality of care, treatment and services.

6.1.13 The Governing Body will assure that every patient is under the care of:

6.1.13.1 A Doctor of Medicine or osteopathy

6.1.13.2 A Physician Assistant. Advanced Practice Registered Nurse (APRN)

6.1.14 Patients are admitted to the hospital only by the order of a licensed practitioner, permitted by the state to admit patients to a hospital.

6.1.14.1 A Doctor of Medicine or osteopathy is on duty or on call at all times.

6.1.15 A Doctor of Medicine or osteopathy is responsible for the care of each patient with respect to the medical or psychiatric problem that a present on admission or develops during the hospitalization

6.1.16 A PA or an APRN is responsible for the care of each patient with respect to the medical or psychiatric problem that a present on admission or develops during the hospitalization as qualified and approved for practice by their respective State Board.

6.1.17 Meetings of the Governing Body shall be to:

6.1.17.1 Evaluate the conduct of the hospital, including the care and treatment of patients.

6.1.17.2 The Governing Body shall take necessary actions sufficient to correct noted problems.

6.1.17.3 A record of all governing body proceedings which reflects all business conducted, including findings, conclusions and recommendations, shall be maintained for review and analysis.

6.1.17.4 Take all appropriate and necessary action to monitor and restore compliance when deficiencies in the hospital's compliance with statutory and/or regulatory requirements are identified, including but not limited to monitoring the hospital administrator's submission and implementation of all plans of correction.

6.1.17.5 Shall be responsible for the quality of patient care services, for the conduct of the agencies and for ensuring compliance with all Federal, State, and Local law.

6.2 Medical Staff will:

6.2.1 Ensure that the medical staff is accountable to the Governing Body for the quality of care provided to the patients.

6.2.2 Ensure that under no circumstances is the accordance of medical staff membership or professional privileges dependent solely upon certification, fellowship or membership in a specialty body or society.

6.2.3 Ensure that when telemedicine services are furnished to patients through an agreement with a facility. The agreement is written and that it specifies that it is the responsibility of the Governing Body of the receiving facility to meet the requirements in sections (A)(1) through (A)(8) of this section with regard to the originating facility's physicians and practitioners that are authorized to provide telemedicine services.

6.2.3.1 The Governing Body of the facility whose patients are receiving telemedicine services may in accordance with CFR 482.33(A)(3) grant privileges based on its medical staff recommendations that rely on information provided by the originating site facility.

6.2.4 Ensure that when telemedicine services are provided to patients through an agreement with an originating-site telemedicine entity, the written agreement specifies that the originating -site telemedicine entity is a contractor of services.

6.2.4.1 The contractor furnishes the contracted services in a manner that permits the hospital to comply with all applicable conditions of participation for the contracted services, including but not limited to the paragraphs of this section with regard to the distance-site's medical staff.

6.2.4.2 The originating site's medical staff providing telemedicine services may be granted privileges based on the facility's medical staff recommendations;

6.2.4.3 Staff recommendations may rely on information provided by the distance-site telemedicine entity.

6.3 The Chief Executive Officer is/will:

6.3.1 Assume responsibility for management of the hospital and for providing liaisons among the governing body, medical staff, nursing staff and other departments, units or services of the hospital.

6.3.2 Keep the governing body fully informed of the conduct of the hospital through regular written reports.

6.3.3 Ensure that the hospital has an overall institutional plan which includes an annual operating budget that is prepared in accordance with generally accepted accounting principles (GAAP)

6.3.3.1 The annual budget must include anticipated income and expenses.

6.3.3.2 The hospital is not required to identify item-by-item components of each anticipated income or expense.

6.4 Contracted Services – The Governing Body is responsible for services whether they are provided by contractors. The Governing Body ensures that contractor services comply with all applicable conditions of participation and standards.

6.4.1 The Governing Body must ensure that the Organized Medical Staff oversee services performed under a contract.

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: 10/2016
REVIEW DATE: 10/16, 09/18
APPROVED BY THE COMMISSION ON BEHAVIORAL HEALTH: 9/18

Control #	Rev.	Title	Effective Date: 03/16/2018
HR 2.0	New	Employee use of Personal Adaptive Equipment in Client Care Areas	Next Review Date: 03/01/2020

1.0 POLICY:

DPBH Clinical Services Branch is committed to providing an accessible work environment for employees while maintaining safety for both employees and clients.

2.0 PURPOSE:

To provide guidance regarding employee use of Personal Assistive Devices (PAD) in Clinical Services Branch Facilities.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 Essential job functions are the fundamental duties of a position: the things a person holding the job absolutely must be able to do. Essential job functions are used to determine the rights of an employee with a disability under the Americans with Disabilities Act (ADA).

4.2 Mobility Impairment: refers to the inability of a person to use one or more of his/her extremities, or a lack of strength to walk, grasp, or lift objects also defined as the state in which an individual has a limitation in independent, purposeful physical movement of the body or of one or more extremities.

4.3 Personal Assistive Devices: are products used either temporarily or permanently to assist persons with disabilities. PADs include a wide range of products such as wheelchairs, walkers, scooters (manual or electric), white canes, oxygen tanks, orthopedic assistive devices such as; boots, slings, braces, casts, boots or other products not listed here.

4.4 Return to work light-duty programs include temporary light-duty, limited-duty or modified-duty assignments.

4.5 Light duty: typically involves excusing an employee from performing certain tasks that he or she would normally perform.

4.6 Limited duty reduces the number of hours an employee normally works in a day.

4.7 Modified duty eliminate some tasks and replace them with others more suitable for the employee's physical limitations in the employee's normal position.

4.8 Release to Work can be a written or typed note signed by the employee's healthcare provider on the provider's letterhead, outlining when the employee can return to work and with what restrictions, if any. his or her job duties or what limitations pose a threat to the safety of the employee or others.

4.9 Family and Medical Leave Act (FMLA) generally requires an employee to be restored to his or her former position upon return, restoration is not necessarily required under the FMLA if the employee is physically unable to perform the essential functions of his or her position.

4.9.1 Under FMLA, an employer also is not required to create a new position simply to accommodate the employee's need for light duty. As FMLA regulation 825.215, paragraph (c) states: If the employee is unable to perform an essential function of the position because of a physical or mental condition, including the continuation of a serious health condition or an injury or illness also covered by workers' compensation, the employee has no right to restoration to another position under the FMLA.

4.9.2 The employer's obligations may, however, be governed by the Americans with Disabilities Act (ADA), as amended.

4.9.3 Light duty should not be confused with a reduced or intermittent leave schedule.

5.0 REFERENCES:

5.1. Society for Human Resource Management (2015 May) How to Create a Return to Work Light Duty Program. Retrieved from www.shrm.org

5.2 State of Nevada: Employee Handbook; Department of Administration, Division of Human Resource Management.

5.3 NAC 284.6014-284.6019

6.0 PROCEDURE:

6.1 Early Return to Work Program

6.1.1 The supervisor evaluates the information on the Physical Assessment form and determines if a light duty assignment is necessary.

6.1.2 If the employee will not be performing their regular job duties, the supervisor shall contact the agency HR office to coordinate an early return to work program.

6.1.3 Supervisors will follow procedures identified in the State of Nevada Early Return to Work program guidelines prepared by the Risk Management Division. Guidelines for supervisors are available in the agency personnel office.

6.1.4 Supervisors will continue to code timesheets using appropriate codes.

6.1.5 If an employee has been taken off work and/or if a modified duty assignment is not available, HR and the supervisor shall continue to communicate with the employee on a regular basis and initiate return to work efforts in collaboration with the agency HR office.

6.2 Modified Duty

6.2.1 When a supervisor is notified of the need for modified duty, the supervisor must notify HR

6.2.1.1 The supervisor is responsible for providing all worker's comp paperwork to HR.

6.2.1.2 The employee must provide copies of all doctor visits to HR as soon as possible.

6.2.2 HR will send a confirmation email to all parties (dept. heads, supervisors, staffing, temp supervisor and the employee), outlining the assignment and any restrictions and modified light duty requirements.

6.3 Responsibilities

6.3.1 Employees

6.3.1.1 Ensure client and staff safety and promote a safe working environment.

6.3.1.2 Follow established safety rules and policies for job/work location.

6.3.1.3 Report all work-incurred injuries, accidents or illness whether directly involved or witnessed, to their supervisor immediately.

6.3.1.4 Employees must accurately report and correctly code any work-related absences in their NEATS timesheet.

6.3.1.5 Cooperate with the intent and requirements of the Early Return to Work Program.

6.3.1.6 Follow up with the healthcare provider as needed and forward paperwork to the supervisor and or the HR Worker's Comp. Liaison.

6.3.2 Supervisors

6.3.2.1 Ensure client and staff safety and maintain a safe work environment.

6.3.2.2 Follow established safety rules and policies for job/work location.

6.3.2.3 Provide information and guidance to employees regarding safety rules and injury reporting procedures,

6.3.2.4 Report all work-incurred injuries, accidents or illness whether directly involved or witnessed, to their supervisor immediately.

6.3.3. Release to return to work

6.3.3.1 When an employee is released to work with restriction that will not allow them to perform the essential functions of their position, HR will determine whether reasonable accommodation can be made.

6.3.3.2 If reasonable accommodation cannot be made, every effort will be made to place the employee in a vacant position for which they are qualified, and which accommodates the stated work conditions.

6.3.3.3 Employees may be reemployed into a position that they qualify for and their restrictions DO NOT preclude them from performing the essential functions of the job.

6.3.3.4 Employees may be reemployed at or below their pre-injury position grade level. (NAC 284.6014-284.6019)

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

Control #	Rev.	Title	Effective Date: 03/16/2018
HR 2.0	New	Employee use of Personal Adaptive Equipment in Client Care Areas	**Next Review Date:** 03/01/2020

Control #	Rev.	Title:	Effective Date: 9/17
SP 7.1	New	Seasonal Influenza Vaccine Program	Next Review: 9/19

1.0 POLICY:

It is the policy of the Department of Public and Behavioral Health (DPBH) Clinical Services Branch to have an annual influenza vaccination program for the prevention and control of seasonal influenza.

2.0 PURPOSE:

To maintain a safe and healthy environment for employees, patients, visitors, and the general public by using vaccination as a potential means to minimize the spread of influenza.

3.0 SCOPE: DPBH Clinical Service Branch

4.0 DEFINITIONS:

4.1 Influenza: ("flu") is a mild to severe contagious disease caused by a virus that causes an average of 36,000 deaths each year in the U.S., mostly among the elderly. Influenza spreads from an infected person to the nose and throat of others and can cause fever, sore throat, cough, chills, headache and muscle aches. Influenza can lead to pneumonia and can be dangerous for people with heart or breathing conditions.

4.2 Influenza Season: The time period (generally between October and March) when influenza is most prevalent in the United States.

4.3 Influenza Vaccine: A preparation of Influenza viruses (live or inactivated virus), which stimulate the production of specific antibodies when introduced into the body.

4.4 Personnel: All DPBH Clinical Services Branch employees and contracted staff, students, residents, trainees, and volunteers.

4.5 Personnel with Client Contact: All personnel who routinely (Medical Staff, Nurses, CNs, MHTs) perform work tasks or intermittently (Maintenance, Food Service Staff, AT staff) within six (6) feet of patients or who have contact with their environment in the performance of their duties.

Control #	Rev.	Title:	Effective Date: 9/17
SP 7.1	New	Seasonal Influenza Vaccine Program	Next Review: 9/19

5.0 PROCEDURE:

5.1 The State Health Officer prescribes a standing order and protocol for the administration of an annual influenza vaccination for DPBH clinical Service Branch staff.

5.1.1 Vaccine will be offered free of charge at various times and locations, as soon as the vaccine becomes available. Vaccines will be offered throughout the flu season or our allotment of vaccines has been depleted (whichever occurs first).

5.2 All individuals covered by this protocol must be immunized within six (6) weeks after the vaccine becomes available to employees.

5.2.1 If individuals covered by this protocol are immunized through services other than Employee Health Services (i.e. private physician office, public clinics, or other employers) they must provide proof of immunization to Employee Health Services.

5.2.2 Proof of immunization must be provided within six (6) weeks after the vaccine becomes available to employees.

5.2.3 Proof of immunization must include:

1) Name of the individual immunized
2) Date of the immunization
3) Immunization type

5.3 Every year, a log will be maintained documenting how many people (staff, volunteers, and independent licensed contractors) receive the vaccine, as well as the numbers who refused and the reason for declination. These data will be shared with the infection prevention committee and the executive committee during monthly meetings.

5.4 All staff shall be provided with information explaining the influenza vaccine, its risks, and the risks versus benefits of vaccination.

5.4.1 Documentation must show that specific education was provided, that the staff either received influenza vaccine or did not receive the vaccine, and whether a refusal was due to medical contraindications.

5.4.2 The Infection Control Practitioner or designated Registered Nurses employed by DPBH Clinical Services Branch are authorized to administer influenza vaccine and anaphylaxis treatment agents, including epinephrine

for the emergency of treatment of anaphylaxis as set forth below to all agency employees.

5.4.3 DPBH nurses are authorized to administer the influenza and anaphylaxis treatment agents only in the course of their employment.

5.4.4 Any Personnel who decline (regardless of reason) to be vaccinated must complete a declination form.

5.4.5 Personnel who decline or are unable to have the flu immunization and who have patient contact are required to wear a surgical mask when within six (6) feet of a client or when they enter a client area such as a unit, waiting room, exam room, treatment area, reception area or an outpatient clinic area.

5.4.5.1 The surgical mask must be changed every four (4) hours with a fresh new surgical mask.

5.5 The exact dates for the requirement to wear respiratory protection will be determined annually when influenza is identified in the community.

5.5 These dates will be communicated DPBH staff via email and/or other rapid means of communications.

5.6 If a non-immunized DPBH employees, contracted staff, students, residents, trainees, and volunteers who have submitted a declination fails to comply with the requirement to wear a mask, they will be subject to progressive corrective action, up to and including termination.

5.7 Criteria for Influenza Vaccine for DPBH Clinical Services Branch Employees:

5.7.1 All healthcare workers who qualify for vaccination based on CDC recommendations.

5.7.2 All persons will be screened for contraindications to influenza vaccine which can include:

5.7.2.1 Serious allergic reaction to chicken, feathers, eggs or egg products;

5.7.2.2 Allergies to dry rubber, rubber products or latex;

5.7.2.3 Allergies to thimerosal (a preservative) or gelatin;

5.7.2.4 History of anaphylactic reactions to the influenza vaccination or any vaccination;

5.7.2.5 History of Guillian-Barre Syndrome within six (6) weeks of any influenza vaccination

5.7.2.6 Illness at the time of inoculation, including acute respiratory

infection, other active infection, or serious febrile illness;
5.7.2.7 Acute evolving neurological disorder;
5.7.2.8 Bleeding disorders such as hemophilia or thrombocytopenia;
5.7.2.9 Anticoagulant therapy (e.g. Warfarin); and
5.7.2.10 Use of Theophylline, and Phenytoin

5.8 The Infection Preventionist and/or designated Registered Medical Nurse Shall:
5.8.1 Ensure that all recipients of the vaccine is provided with the current seasons Vaccine Information Sheet (VIS) from the CDC.
5.8.2 Ensure that the potential recipient is assessed for contraindications to immunization.
5.8.3 Confirm each recipient of the vaccination has received a copy of the appropriate Vaccine Information Statement and has been informed of the potential side effects and adverse reactions, orally and in writing, before administering the immunization.
5.8.4 Confirm that each recipient as completed the Influenza Consent/Declination form prior to the administration of the vaccine.
5.8.5 The Infection Preventionist will be responsible for the record of all persons immunized including the recipient's name, date, address of immunization, administering nurse, immunization agent, manufacturer, lot number, expiration date, recommendations for future immunization and standing order and protocol is maintained and reviewed/revised annually.
5.8.5.1 These records will be kept for up to 30 years as part of the employees health records.
5.8.6 The Infection Preventionist will be responsible to maintain a record of all personnel declining the influenza vaccination. These records will be kept for 2 years.

5.9 Any designated RNs involved in the administration of immunizing agents in accordance with standing order and protocol must be currently certified in CPR by the American Red Cross, American Heart Association or an equivalent organization.

6.0 Administration of Influenza Vaccine (Multidose Vial):
6.1 A separate sterile syringe and needle will be used for each injection to prevent

possible transmission of infectious agents from one person to another.

6.1.1 The expiration date of the vaccine will be noted on the vial using an auxiliary label. The expiration date will be 28 days from the date the vial was first opened and used. Any expired vaccine will *not* be used.

6.1.2 Shake the container vigorously each time before withdrawing vaccine.

6.1.3 Never remove the stopper from the container. Moisten the stopper with a sterile alcohol wipe, allowing the antiseptic to act for a few moments.

6.1.4 Draw into the syringe 0.5 ml of air.

6.1.5 Shake the vaccine container vigorously then pierce the center of the stopper with the sterile needle attached to the syringe. Turn the vial upside down and inject the air from the syringe. Keeping the point of the needle immersed in the vaccine, withdraw immediately into the syringe 0.5 ml vaccine.

6.1.6 Primarily: Disinfect the skin at the site of injection (deltoid muscle) with a suitable antiseptic wipe. Inject 0.5 ml of vaccine intramuscular (never IV), aspirating to ensure that the needle has not entered a blood vessel before injection.

6.1.7 Secondary: Disinfect the skin at the site of the injection (deltoid muscle) with a suitable antiseptic wipe. Remove bandage from package and apply safe barrier bandage to skin. Make injection through center of bandage and remove. Inject 0.5 ml of vaccine intramuscular (never IV), aspirating to ensure that the needle has not entered a blood vessel before injection. Suggest that this should read aspirating BEFORE injecting.

6.1.8 Dispose of safety syringe in appropriate sharps container.

6.1.9 All vaccinated persons should be observed for about fifteen (15) minutes after vaccinations.

6.2 Alternate Administration Prefilled Syringe:

1. Use of prefilled syringes to deliver a single dose.
2. Each prefilled syringe will be used once, and then discarded into a puncture resistant container.

6.3 Anaphylaxis Reactions

6.3.1 All addresses, clinic areas and units where immunizations are administered will be supplied with anaphylaxis treatment agents and will be equipped with appropriate syringes, needles and supplies for treatment administration.

6.3.2 In the event that a person who received an influenza vaccine develops signs and symptoms consistent with anaphylaxis, (e.g. but not limited to; difficulty in breathing, hives, swelling of face, throat or airway and loss of consciousness), the nurse is to administer one (1) adult dose of EPI-PEN IM or epinephrine 0.3 mg [USP 1:1000, 0.3 ML] subcutaneous and **CALL 911 IMMEDIATELY.**

6.3.3 The RN shall ensure that a record of all persons to whom they administered an anaphylaxis treatment agent, including the recipient's name, date, address of administration, administering nurse, anaphylaxis treatment agent, manufacturer, and lot number is kept in the medical record in the person's medical file.

6.3.4 The RN shall report to the local emergency medical system or other provider equivalent follow-up care information regarding the administration of the anaphylaxis treatment agent, including when it was administered, the dosage, strength, and route of administration.

6.3.5 The nurse shall also report information to the person's primary care provider if one exists, unless the patient is unable to communicate the identity of his or her primary care provider.

6.3.6 The Infection Preventionist is responsible to report adverse reactions of immunizations to Vaccine Adverse Event Reporting System, (VARES).

7.0 Data and Tracking:

7.1 The Infection Preventionist/Employee Health program will be responsible for tracking seasonal influenza rates.

7.2 Rates will be calculated as a percentage (%).

7.2.1 Numerator will be all staff receiving vaccinations.

7.2.2 Denominator will be all staff within the agency between the start of the flu season and the end of the flu season.

7.2.3 Declinations will recorded for all staff declining the vaccine/all staff within the agency between the start of the flu season and the end of the flu season.

7.2.3.1 Declinations will be further calculated based on reason for declination.

7.2.4 Data will be presented to the Agency Infection Control Committee and Executive Leadership Committee annually at the end of each flu season.

7.2.4 The Agency Infection Preventionist/Employee Health coordinator will be responsible for entering the vaccine information into the State of Nevada's vaccination tracking system, WebIZ.

8 REFERENCES:

8.2 Centers for Disease Control "Immunization Recommendations for Health Care Workers"

8.3 New York State Department of Education: NYC Department of Health and Mental Health

8.4 CDC, FDA Fact Sheet for Vaccine Information Statements, current year

8.5 Link http://injectsafebandages.com/ Quick reference

9 ATTACHMENTS:

10 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: 9/01/2017
DATE APPROVED BY DPBH ADMINISTRATOR: 9/01/2017
DATE APPROVED BY THE COMMISION ON BEHAVIORAL HEALTH: 9/2017