	DIVISION OF CHILD AND FAMILY SERVICES Children's Mental Health
SUBJECT	SECLUSION AND/OR RESTRAINT OF CHILDREN AND YOUTH
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REFERENCES	**Federal Statutes and Regulations** Title VI and VII Civil Rights Act of 1964, as amended Section 504 Rehabilitation Act of 1973 American with Disabilities Act (ADA) of 1990 42 CFR (Code of Federal Regulations) Medicare and Medicaid Programs; Hospitals Conditions of Participation: Patients' Rights published in the Federal Register on December 8, 2006 (Volume 71, Number 236; pages 71378-71428) **Nevada Revised Statutes** NRS 432B NRS 433 and NRS 433B, inclusive NRS 449 NAC 284 **Medicaid Services Manual** MSM 100 MSM 400 MSM 2500 **Related Policy and Research** SP-3 DCFS CMH Incident Reporting Policy SP-7 DCFS CMH Intake Policy CRR-2 DCFS CMH Client's Rights and Responsibilities Policy CRR-5 Limited English Proficiency [LEP] Policy IMRT-1 Medical Records Policy 2.30 DCFS CMH Abuse and Neglect of Clients Policy 10.40 DCFS CMH Child and Family Teams Policy A-6 DCFS CMH Quality Assurance and Program Improvement Policy Child Welfare League of America: National Standards & Definitions for Restraint & Seclusion Children's Voice Is There a Therapeutic Value to Physical Restraint? by Dave Zeigler, Ph.D.

	CWLA State Regulations for Behavior Support and Interventions, "Promising Models for State Regulations," Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool by Kevin Ann Huckshorn and the National Association of State Mental Health Directors, Draft **Accreditation Standards** The Joint Commission Standards Council on Accreditation (COA) 7th edition Standards and Self-Study Manual Commission on Accreditation of Rehabilitation Facilities (CARF) HCQC Psychiatric Residential Treatment Facilities (PRTF)
ATTACHMENTS	**Reporting Forms:** DCFS Incident Reporting Form (Formerly Incident/Accident Report) DCFS Pain Assessment Form DCFS Report of Denial of Rights for Children and Youth with Mental Illness DCFS Seclusion and/or Restraint Debriefing and Positive Behavior Intervention Plan - PRTF DCFS Seclusion and/or Restraint Debriefing and Positive Behavior Intervention Plan - DWTC DHHS Directors Office Critical Incident Report CIR Commission on Behavioral Health Seclusion and/or Restraint Emergency Procedures for Children and Youth Denial of Rights **Supplemental Information:** DCFS CMH Glossary of Terms DCFS Philosophy of Care Prevent and Reduce Use of Seclusion and/or Restraint Statement and Acknowledgement: DCFS Seclusion and/or Restraint Trainer Agreement **Worksheets:** DCFS Individual Safety Risk Reduction Worksheet DCFS Positive Behavioral Intervention Plan DCFS Safety Assessment and Crisis Plan DCFS Self-Control Strategy DCFS SODAS and POPS DCFS Solution Sheet DCFS Wheel of Self-Control

I. POLICY

It is the policy of the Division of Child and Family Services (DCFS) Children's Mental Health (CMH) that the practices of seclusion and/or restraint (S/R) are considered as interventions of last resort.

S/R methods shall only be used as a last resort, and only in those circumstances in which less restrictive efforts have failed to de-escalate the child's or youth's behavior that created the threat of harm, including physical injury to self or others, or severe property damage, pursuant to **NRS 433**

II. PURPOSE

The purpose of this policy is to provide governance to DCFS staff regarding the use of S/R for children and youth served by DCFS Residential Program Services and DCFS Early Childhood Day Treatment Services.

III. PRACTICE GUIDELINES AND PROCEDURES

A. Introduction

With this policy statement, DCFS recognizes that the use of S/R creates significant risks for children and youth, especially those who have been determined to be Severely Emotionally Disturbed (SED) and/or who need the mental health services DCFS provides. These risks include serious injury or death, retraumatization of children and youth, loss of dignity, and other psychological harm. DCFS also recognizes the potential risk to staff who may experience secondary or vicarious trauma when they use or are exposed to S/R in their working environment.

In light of these risks and the potential for serious consequences, S/R methods shall only be used when there exists an imminent risk of danger to the youth, others, or harming others through property destruction, and when there is no other safe and effective intervention possible. DCFS staff is strictly prohibited from using S/R as a means of punishment or retaliation against a child or youth. S/R shall never be used for the purposes of discipline, coercion, staff convenience, or as a replacement for adequate levels of staff or active treatment (National Association of State Mental Health Program Directors). The *DCFS Philosophy of Care Prevent and Reduce Use of S/R Statement and Acknowledgement* may be included in Admission Packets. Program Managers may require staff to sign the Acknowledgment during new hire orientation to ensure consistency throughout the agency.

Pursuant to **NRS 433.5493**, DCFS recognizes S/R as a denial of client rights. Each incident of S/R is reported as a denial of client rights on the *Commission on Behavioral Health Seclusion and/or Restraint Emergency Procedures for Children and Youth Denial of Rights* to the State of Nevada Commission on Behavioral Health.

B. DCFS Philosophy of Treatment and the Use of S/R

The Division recognizes that the safety of children and youth is paramount at all times, and if medical attention is needed, obtaining medical attention for them shall supersede all behavioral priorities. The *DCFS Philosophy of Care Prevent and Reduce Use of S/R Statement and Acknowledgement* dictates that the use of S/R methods shall be used only in an emergency when a child or youth is at imminent risk of harming self or others, and only in those situations in which non-physical de-escalation interventions have failed or are not viable, or when safety issues require an immediate physical response by appropriately trained DCFS staff.

When necessary to resort to S/R practices, DCFS staff shall implement restraint in the least restrictive manner possible and shall employ safe techniques at all times. DCFS staff members who have not been trained in S/R are strictly prohibited from implementing any type of S/R, including manual guidance.

Staff shall continually monitor and assess children and youth placed in S/R, and all incidents of S/R shall terminate immediately when the emergency or crisis has abated.

The use of chemical restraints is prohibited throughout DCFS except for Desert Willow Treatment Center when a medical/psychiatric emergency has been declared, and relevant procedures are followed pursuant to **433.5503.**

C. Admission: Informed Consent

At the time of admission to DCFS, CMH DCFS staff is to advise the child or youth and the legally responsible individual (LRI/Parents) for the psychiatric care of the child regarding the following:

1. The Division's Philosophy of Treatment;

2. The Division's commitment to preventing and reducing the need for the use of S/R;

3. The role the child or youth may have in calming him or herself when they begin to become agitated;

4. The Division's policies related to the use of S/R including responsibilities of and the notice provided to the LRI/Parents for the psychiatric care of the child; and

5. The roles of all those involved (i.e., the child/youth, family, LRI/Parents, DCFS staff) in the child's or youth's treatment plan and their involvement in the S/R incidents.

D. Personal Safety Assessment and Psychiatric Advance Directive for Residential Programs:
   a. PRTF Document is entitled *DCFS Safety Assessment and Crisis Plan*
   b. DWTC Documentation Packet is outlined in the DWTC Policy and Procedure

The personal safety assessment and psychiatric advance directive is required for every residential youth. Prior to or at the time of admission, DCFS staff is to assess relevant risk factors, trauma history, and history of S/R to inform the provision of treatment services. If it is not possible to complete this by admission, it must be completed within 72 hours of admission. DCFS staff is to include the child or youth in this assessment.

If the child or youth is not able to participate in the development of the Personal Safety Assessment and Psychiatric Advance Directive by admission or within 72 hours of admission, DCFS staff shall document attempts and rationale for exceptions into the medical record. DCFS staff will continue to provide the child or youth, along with the Child and Family Team (CFT) members, additional opportunities to participate in the development of the Personal Safety Assessment and Psychiatric Advance Directive. Each DCFS Residential Services Program will develop a Standard Operating Procedure (SOP) for conducting the Personal Safety Assessment and Psychiatric Advance Directive to identify triggers and specific interventions for children and youth who may need emergency interventions to ensure safety.

The Personal Safety Assessment and Psychiatric Advance Directive shall include:

1. The child's or youth's strengths and needs, history of trauma, age, gender identity and expression, and cultural considerations; and,

2. Collaboratively developed intervention alternatives to use in times of conflict and behavioral escalation.

Staff shall refer to and implement interventions described in the Personal Safety Assessment and Psychiatric Advance Directive as needed to de-escalate situations and prevent and/or minimize S/R.

E. Seclusion and/or Restraint Procedures

In the event that the use of S/R becomes necessary, DCFS staff shall comply with the following standards for each S/R incident:

1. S/R methods will be initiated only in those situations in which a child or youth is in danger of physical injury to self or others, or severe property damage, pursuant to **NRS 433**,(NRS 433.5493, NRS 433.5496, 433.5499, and NRS 433.5503) and only when no less restrictive measure has been or is likely to be effective to avert imminent danger.

   Only the least restrictive S/R methods that are safe and effective will be administered. There are no exceptions to this requirement.

2. All DCFS staff who provide direct service to children and youth, as well as those who supervise and manage these programs, shall be trained in the use of de-escalation interventions and, as applicable to their program, in the proper use of S/R. These individuals must clearly demonstrate

competency in the prevention and reduction of the use of S/R, as well as in effective de-escalation methods for child and youth safety, and the proper and safe use of S/R, when needed.

a. Special populations might include persons who have medically complex needs, older adolescents transitioning to adulthood, LGBTQ+ youth, foster children and youth, or programs that specialize in working with persons who have autism, sexual offenders, or victims of trafficking or domestic abuse.

b. Risk assessment is conducted by qualified QMHP and/or medical staff, and shall include but not be limited to:
   i. Medical history;
   ii. Trauma history;
   iii. History of unsafe behaviors resulting in S/R;
   iv. . Identification of interventions that have been successful in interrupting unsafe behaviors, when applicable;

   That result(s) in identification of risks associated with the potential use of S/R.

Additionally, in administering S/R and towards the goal of minimizing/preventing/ eliminating S/R use, DCFS staff shall demonstrate a thorough understanding of the child's/youth's Personal Safety Assessment and Psychiatric Advance Directive and must follow the child's/youth's individualized treatment plan at all times.

3. Only appropriately trained, competent DCFS staff who have received agency-identified and -approved S/R training are allowed to implement S/R methods. DCFS staff who have not received such training are strictly prohibited from implementing any type of S/R.

   Training must include but is not limited to:
   a. Physical and behavioral health conditions;
   b. Prevention of unsafe behaviors;
   c. Prevention and de-escalation of a crisis;
   d. Crisis intervention;
   e. Active listening;
   f. Documentation;
   g. First aid;
   h. CPR; and,
   i. Signs of physical distress.

   Newly-hired DCFS staff must receive a minimum of eight (8) hours of seclusion, restraint, and de-escalation training pursuant to the approved DCFS model of S/R within the first thirty (30) days of hire, and a minimum of four (4) hours annually, which may be broken into two (2) hours of training semiannually pursuant to the DCFS-approved model.

4. DCFS staff is required to protect the dignity, privacy, and safety of children and youth who are in S/R to the greatest extent possible at all times.

5. Only the DCFS Medical Director or their designee, or the attending physician who has training and competence in the prevention and management of unsafe behaviors can order the use of S/R (**NRS 433. 5503.** All physician orders related to S/R are to be documented in the child's or youth's medical record.

   Physical restraint may be used on a child or youth in order to conduct medically necessary examinations or treatments. In such cases, a *Commission on Behavioral Health Seclusion and/or Restraint Emergency Procedures for Children and Youth Denial of Rights* will be initiated

addressing the denial of rights for written consent to medical treatment. All orders are entered into the S/R recipient's medical record as soon as possible per facility timeline policy

6. Notification to the Legally Responsible Individual (LRI/Parents)
   The LRI/Parents shall be notified of each incident of S/R as soon as practical following the incident, but not to exceed 24 hours after the incident, using language the LRI/Parents understands. The Division will provide interpreters or translators as needed as described in **DCFS CMH Policy CRR-5**, Limited English Proficiency (LEP).

   DCFS staff shall document both in the medical record and on the *Commission on Behavioral Health Seclusion and/or Restraint Emergency Procedures for Children and Youth Denial of Rights* that the required notification to the LRI/Parents was provided. Documentation on both must include the date and time of notification, and the name and credentials of the DCFS and collateral staff who provided the notification. Documentation in the medical record should also include the name and relationship of the LRI/Parents who was notified. If the S/R resulted in an injury to any person, DCFS staff must also complete *DCFS Incident Reporting Form (Formerly Incident/Accident Report)* and attach it to the *Commission on Behavioral Health Seclusion and/or Restraint Emergency Procedures for Children and Youth Denial of Rights (within 30 days).*

7. Documentation
   Each DCFS Program must document all S/R incidents on the *Commission on Behavioral Health Seclusion and/or Restraint Emergency Procedures for Children and Youth Denial of Rights.*

   Documentation shall include:

   a. A behavioral description of the S/R incident including antecedents, child/youth behaviors, and de-escalation techniques used by DCFS staff prior to the S/R implementation;

   b. The date, and the beginning and ending times of the incident;

   c. Precipitating events;

   d. The age, height, weight, gender, race, and ethnicity of the child or youth;

   e. The exact methods of the de-escalation, manual guidance and/or restraint used, the reasons for their use, and the duration of the incident;

   f. Names, credentials, and titles of all involved people in the incident, and their professional relationships to the child or youth;

   g. Names of witnesses to the precipitating incident and subsequent S/R

   h. The name, credentials, and title of the person making the report;

   i. A detailed description of any injury to the child or youth and/or others involved in the incident;

   j. Actions taken by staff as a result of any injuries;

   k. Preventive actions to be taken in the future;

   l. The follow up required;

m. The following staff are responsible for the documentation of supervisory, managerial, and administrative reviews with which to assure the S/R was justified, the DCFS staff involved were trained and competent in the use of S/R, the procedure was an approved method, and the documentation is a clear and objective description of the incident. If any of these staff determines the S/R was unjustified or otherwise inappropriate, they are to return the documentation to relevant DCFS staff for further clarification and/or justification.
   i. The Clinical Program Manager I (CPM I).
   ii. Clinical Supervisor if applicable, Designated Quality Assurance Specialist, or Delegate; and,
   iii. Director of Nursing (DON)/Nurse Supervisor, or Psychologist (or delegate as applicable to each program).

n. The debriefing is to be described on the *DCFS Seclusion/Restraint Debriefing and Positive Behavior Intervention Plan-PRTF* or *DCFS Seclusion/Restraint Debriefing and Positive Behavior Intervention Plan-DWTC* and attached to the *Commission on Behavioral Health Seclusion and/or Restraint Emergency Procedures for Children and Youth Denial of Rights*. The **DCFS CMH Policy SP-3** entitled Incident Reporting and Management Policy may be referred to for proper documentation procedures for S/R incidents.

Following each Restraint incident, DCFS residential staff must complete a *DCFS Pain Assessment Form* with the child or youth. If an S/R incident leads to an injury to the child or staff, DCFS staff must also complete a *DCFS Incident Reporting Form (Formerly Incident/Accident Report).*

DCFS staff must provide verbal notification regarding all S/R incidents to the assigned CPM II and the supervisor, or their designee, by the end of the shift in which the incident occurred. All documentation required and described in **Section III.D.6-7.** of this policy must be forwarded to the appropriate supervisor or manager no later than three (3) working days following the S/R incident and stored per facility Policy and Procedure.

F. Safety Procedures for Initiating and/or Providing Care for Children and Youth in S/R

1. Monitoring and Assessment
Trained DCFS staff shall continuously (without interruption or gaps) monitor all uses of physical S/R and assess the child or youth recipient to ensure safety.

   a. Trained DCFS staff is assigned and required to constantly monitor the S/R situation.

   b. Trained DCFS staff is required to perform regular and periodic assessment to identify medical concerns, indications of injury, and appropriate time for release.

   c. DCFS staff who perform S/R monitoring and assessment must be trained in the use of emergency safety interventions, cardiopulmonary resuscitation (CPR), and first aid.

   d. The DCFS staff shall conduct a *DCFS Pain Assessment Form* with the child or youth immediately following the conclusion of the S/R incident. Every assessment shall include, but is not limited to:
      i. Signs of physical injury; e.g., bleeding, swelling, physical distress, difficulty breathing, visual acuity, etc.

ii. The child's or youth's behavior and emotional condition.
iii. The appropriateness of the procedure.
iv. Any resulting complications or unintended consequences, including visual acuity.
v. Continuing need for the emergency procedures, including S/R.

e. Each DCFS residential services program shall maintain and implement standards to ensure the individual comfort of the child or youth, e.g., bathroom breaks, covering areas of the body exposed during a restraint, etc.

2. During all incidents of S/R, DCFS staff will immediately address medical, psychological, or emotional problems and needs of the child or youth and will document findings and interventions into the child's or youth's medical record.

3. DCFS staff will remove all potentially dangerous items from the child or youth and from the room/environment prior to placement in seclusion.

4. DCFS staff will ensure there are adequate personnel present to ensure the seclusion procedure is conducted safely.

5. DCFS staff must evaluate children or youth who are sleeping while in seclusion and remove them from seclusion if behavioral release criteria are met and as defined in the child's or youth's individualized treatment plan. Staff will continue to monitor the child or youth for safety. If an emergency arises that requires evacuation (including drills), the staff member will remove the child or youth from S/R and remain one-on-one with them.

6. Staff may not restrain children or youth in a prone (on the stomach) position while lying on furniture such as a couch or a mattress and must also ensure the location of the restraint surface is safe and appropriate.

7. Incident Reporting
If a staff or youth injury results from an S/R method, regardless of how minor, it must be reported on a *DCFS Incident Reporting Form (Formerly Incident/Accident Report)* pursuant to **DCFS CMH Incident Reporting and Management SP-3 Policy**. The *DCFS Incident Reporting Form (Formerly Incident/Accident Report)* must be attached to the *Commission on Behavioral Health Seclusion and/or Restraint Emergency Procedures for Children and Youth Denial of Rights* whenever an injury occurs as a result of S/R.

8. Prohibited Practices
The following practices regarding S/R are prohibited. DCFS staff must also adhere to their respective licensure, certification or accreditation standards, as applicable.

a. Peer restraint;

b. Use of seclusion areas that do not meet DCFS, licensing, or accreditation standards;

c. Use of restraint when the child or youth could be medically compromised;

d. Pressure or weight on the chest, lungs, sternum, neck, diaphragm, back or abdomen causing chest compression;

e. Straddling or sitting on any part of the body, or any maneuver that places pressure, weight, or leverage on the neck or throat, on any artery, or on the back of the child's

or youth's head or neck, or that otherwise obstructs or restricts the circulation of blood or obstructs an airway;

f. Any type of choking, hand chokes, and any type of neck or head hold;

g. Any technique that involves pushing on or into the child's or youth's mouth, nose, eyes, or any part of the face, or covering the face or body with anything, including soft objects such as pillows or washcloths; and,

h. Any maneuver that involves punching, hitting, poking, pinching, or shoving and use of aversive interventions as defined in **NRS 433.5453** means any of the following actions:
   i. The use of noxious odors and tastes;
   ii. The use of water and other mists or sprays;
   iii. The use of blasts of air;
   iv. The use of corporal punishment;
   v. The use of verbal and mental abuse;
   vi. The use of electric shock;
   vii. Requiring a child or youth to perform exercise under forced conditions,
   viii. Any intervention, technique or procedure that deprives a child or youth of the use of one or more of his or her senses, regardless of the length of the deprivation, including, without limitation, the use of sensory screens; and
   ix. The deprivation of necessities needed to sustain the health of a child or youth, regardless of the length of the deprivation, including, without limitation, the denial or unreasonable delay in the provision of medication and/or food or liquid at a time when it is customarily served.

9. Procedure to Address Prohibited Practice Occurrence
Should any prohibited practice be discovered by any DCFS employee, or during any Administrative Review, or by the Commission on Behavioral Health, the following actions shall be implemented immediately:

a. The identified DCFS staff member(s), under the supervision of the CPM II, shall initiate and complete a *DCFS Report of Denial of Rights for Children and Youth with Mental Illness/SED* to be forwarded to the DCFS Administrator, the DCFS Deputy Administrator, and the Commission on Behavioral Health.

b. The identified DCFS staff member(s) will immediately complete and forward a *DCFS Incident Reporting Form (Formerly Incident/Accident Report)* to the DCFS Administrator and the DCFS Deputy Administrator in a manner consistent with the **DCFS CMH Incident Reporting and Management SP-3 Policy**.

c. The CPM II or designee will make a report to Child Protective Services (CPS), the appropriate public child welfare agency pursuant to **DCFS CMH Abuse and Neglect of Clients 2. 30 Policy.**

d. The DCFS Administrator and/or the DCFS Deputy Administrator may require the identified DCFS staff member(s) to institute a corrective action plan (CAP) as a consequence of the prohibited practice within 30 days.

   i. The DCFS Administrator and/or the DCFS Deputy Administrator or their designee will review, make recommendations to, and approve the CAP.

ii. The Planning and Evaluation Unit (PEU) will monitor the staff's CAP and actions, and evaluate the outcomes to ensure implementation, effectiveness and improvement in practices and processes.

iii. The PEU will provide a written report of the review and monitoring process at least monthly and will forward this report to the DCFS Administrator and Deputy Administrator until it is determined that the CAP has been completed and improvements have been successfully implemented to ensure the prohibited practice does not recur.

iv. The PEU shall collaborate with assigned Program Officers or Program Quality Liaisons to ensure the CAP process meets Joint Commission, CARF, and other relevant oversight requirements.

10. Penalty for Prohibited Practices

Any DCFS staff involved in any prohibited practice shall be disciplined up to and including termination, based on the DCFS Personnel Policies and applicable State of Nevada administrative code regulations and legislative statutes.

G. Child/Youth and Staff Debriefing

1. An initial DCFS staff debriefing shall occur immediately after each S/R incident and prior to any shift change. The purpose of the initial debriefing is to ensure everyone involved has their immediate concerns addressed regarding injuries, follow-up, need for support, stabilization adequacy, ability to perform job duties, and so forth. If the child or youth is unwilling or unable to participate in this initial debriefing, the DCFS staff will document this in the medical record. DCFS staff shall continue to encourage the child or youth, as appropriate, to participate in debriefing when they feel prepared and able to do so and document these efforts.

   A formal debriefing is to occur not later than 24 hours following the incident, whenever possible. Staff will complete either the *DCFS Seclusion and/or Restraint Debriefing and Positive Behavior Intervention Plan-PRTF* or *DCFS Seclusion and/or Restraint Debriefing and Positive Behavior Intervention Plan-DWTC* and submit it to (a) their CPM I in the PRTFs; or (b) their DON or designee in DWTC. The formal debriefing includes all DCFS staff involved in the incident, the child or youth, and other individuals including witnesses (when appropriate) and other children or youth (when appropriate), medical staff, designated administrative staff, LRI/Parents, and other CFT members if possible and appropriate.

   The purpose of the formal debriefing is to answer the following questions:
   a. Who was involved?
   b. What happened?
   c. Where did it happen?
   d. Why did it happen?
   e. What did we learn?

   The most important purpose of the debriefing process is to learn from and honor the individuals who went through the process and involve them in the solutions.

2. Debriefing Goals
   a. To reverse or minimize the adverse effects of the implementation of S/R by evaluating the physical and emotional impact on all involved in the incident; and by identifying the need for and providing therapeutic support and services for the individuals involved to address any consequential trauma;

b. To prevent the future use of S/R by helping all involved parties identify what led to the incident; and what could have been done differently; and by determining if all intervention alternatives were considered;

c. To identify, address, and make changes to relevant organizational barriers so that S/R practices can be further eliminated. To make recommendations regarding the organization's philosophy, policies and procedures, environments of care, treatment approaches, and education and training;

d. DCFS staff may choose from several DCFS-approved debriefing worksheets based on which form is most suited for child's or youth's engagement in the debriefing process. Required debriefing elements include staff and youth discussion; an evaluation of the situation including precipitating events, primary interventions, the S/R process, and the effect on staff and youth; and recommendations for improvement

The findings of the debriefing shall be documented on the chosen debriefing form and the *Commission on Behavioral Health Seclusion and/or Restraint Emergency Procedures for Children and Youth Denial of Rights* and forwarded to the DCFS CPM I and CPM II, and the Deputy Administrator for Residential Services for review and follow up, including corrective action.

DCFS staff shall document the debriefing process in the progress notes in the medical record. The information garnered through the debriefing process is to be used to update the child's personal safety assessment and psychiatric advance directive and treatment plan, as needed, as a method to minimize the risk of future incidents of seclusion and restraint.

3. All S/R incident documentation will be reviewed by the CPM I or CPM II or the QAS III, as applicable. They are responsible for ensuring documentation completeness, evaluating whether the incident warranted a seclusion or restraint response, and if so, evaluating whether the S/R was performed in accordance with current practice standards and DCFS policy. They are responsible for securing all other necessary signatures from the Medical Director or designee who signs the *Commission on Behavioral Health Seclusion and/or Restraint Emergency Procedures for Children and Youth Denial of Rights* confirming they gave the restraint order, and the restraint was necessary; and also responsible for securing signatures from the nursing staff if warranted, and lastly the CPM II.

   Upon obtaining all the requisite signatures, they are responsible for submitting the form to the Deputy Administrator for review and signature within 30 days.

4. Once this review is completed, they are to submit a copy of all documentation to the PEU for data collection, analysis and program improvement feedback.

   PEU will prepare the documentation to present to the DCFS Administrator or the Administrator's designee. The DCFS Administrator or the Administrator's designee reviews and signs the *Commission on Behavioral Health Seclusion and/or Restraint Emergency Procedures for Children and Youth Denial of Rights* and submits it to the Attorney General's designee for review and signature, who then returns it to the PEU. The PEU will prepare the documentation to present to the Commission on Behavioral Health for review and feedback.

H. Chemical Restraints

1. The use of chemical restraints is prohibited in all DCFS CMH programs when used to control behavior or to restrict a child's or youth's freedom of movement and when not a standard treatment for the child's or youth's medical or psychiatric condition.

2. Medications are only to be used to treat the symptoms of the child's or youth's psychiatric and medical condition.

3. When a child or youth is given medication for which the LRI/Parents has not previously signed written consent, staff will initiate a *DCFS Report of Denial of Rights for Children and Youth with Mental Illness*. (The only exception to this is when a medical/psychiatric emergency has been declared at DWTC as defined in the *DCFS CMH Glossary of Terms*).

4. The use of chemical restraints is strictly prohibited in all DCFS Psychiatric Residential Treatment Facilities, including PRTF-North (Formerly ATC-Adolescent Treatment Center), PRTF-Enterprise (Formerly FLHs-Family Learning Homes), and PRTF-Oasis (Formerly OCTH-Oasis On-Campus Treatment Homes), with the exception of PRN medications that have been medically prescribed as part of the youth's pharmacological regimen.

I. Staff Training

1. DCFS shall maintain a statewide group of approved trainers capable of training in the DCFS approved seclusion, restraint and de-escalation models at all times. To be approved as a trainer in the DCFS models, DCSF staff must:

    a. Complete 24 hours of training provided by a DCFS-approved trainer;

    b. Demonstrate mastery of the skills to an approved/certified instructor by teaching a minimum of one class under observation;

    c. Only approved/certified instructors using DCFS-approved methodologies may provide training in safe physical restraint and manual guidance techniques.

2. DCFS trainers shall be responsible for providing initial instruction to newly hired DCFS staff and for providing the required refresher training.

3. To serve as a DCFS-approved trainer, DCFS staff must meet the following criteria:

    a. Have appropriate experience and qualifications, including having at least one year of successful experience in the use of the DCFS-approved model;

    b. Have successfully completed training in the DCFS-approved model of restraint and de-escalation;

    c. Have successfully demonstrated a sound understanding of the philosophy of the face-to-face DCFS-approved model of restraint and de-escalation;

    d. Have received a positive recommendation from their direct supervisor and manager to be a trainer;

    e. Have a minimum of a "Standard" rating on their annual State of Nevada job performance evaluation;

    f. Be current in all required DCFS trainings as directed by the supervisor and manager;

g. Be able to commit and sign a *DCFS Seclusion and/or Restraint Trainer Agreement* stating they will commit to a minimum of 18 months as a trainer.

4. The DCFS-approved training shall focus on appropriate seclusion and restraint models as well as in prevention, Trauma-Informed Care, and the uses of restraint. Specifically, DCFS staff training will cover the following components at a minimum:

    a. The use of emergency safety procedures;

    b. Verbal de-escalation;

    c. Prevention strategies;

    d. Types of emergency safety procedures;

    e. The differences between physical restraint, pain compliance techniques, and permissible physical restraints;

    f. Monitoring procedures;

    g. Recording and reporting procedures;

    h. Maintenance of personal safety for the child or youth and DCFS staff;

    i. Medical and physical restrictions to be considered;

    j. Self-protection, including escape and evasion;

    k. Physical risks of S/R;

    l. Psychological risks of S/R;

    m. How to continually assess for the earliest release of S/R;

    n. The continuum of least to most restrictive interventions;

    o. Approved techniques;

    p. Prohibited techniques;

    q. Debriefing and post-restraint activities;

    r. Safe escort, manual guidance, and transport;

    s. Stages of crisis;

    t. Verbal limit setting;

    u. Understanding personal space, body language, and non-verbal communication; and,

    v. Consideration of child and adolescent development and cultural issues.

All DCFS staff, including supervisors and managers, who may have occasion to use S/R shall participate in refresher training as required to ensure continued competency in the uses of S/R.

DCFS supervisors and clinical program managers are responsible for ensuring all relevant staff

a. Receive training in the proper use of S/R, preventing and reducing the use of S/R, and effective de-escalation methods for child safety.

b. Receive refresher training as required

J. Planning and Evaluation Unit (PEU)

1. The PEU shall develop methods and tools for collecting relevant data on the use of S/R in DCFS programs. They will analyze the data in a timely manner to help DCFS staff minimize/eliminate S/R practices, help develop program improvement, and make best practice recommendations.

2. CPM Is, CPM IIs, and Program Officers in collaboration with the PEU will maintain a performance improvement program designed to continuously review, monitor and analyze S/R and denial of rights data with the goal of decreasing and ultimately eliminating these practices in DCFS programs. This task force shall meet at least once per quarter and maintain the ongoing Plan for Elimination of Seclusion and/or Restraint, as presented to the Commission on Behavioral Health. They will:

    a. Ensure ongoing documentation, monitoring and evaluation of data regarding children and youth placed in S/R is maintained;

    b. Review the necessity for the use or continuation of these procedures based upon documentation of rationale and justification; and unsuccessful, less restrictive alternatives, attempts at child and youth education of stress reduction behaviors and trigger identification;

    c. Review debriefing episodes; review clinical response to seclusion, treatment plan, and personal safety plan; review revisions and incidents of failure to meet timelines as outlined in this policy;

    d. Include and collaborate with relevant staff in this Continuous Quality Improvement process, including MHC IIIs, CSW IIIs, and psychologists;

        i. Staff identified for this purpose will work in partnership with the task force to monitor staff performance and individual and critical programmatic incidents.

        ii. The Deputy Administrator shall ensure the completeness and accuracy of, and subsequentially provide the *Commission on Behavioral Health Seclusion and/or Restraint Emergency Procedures for Children and Youth Denial of Rights* (or *DCFS Report of Denial of Rights for Children and Youth with Mental Illness*) and all other related documentation to the PEU within 30 days of each S/R incident. This documentation should contain at a minimum, the following information prior to submitting it to the PEU:
            1. Child/youth medical record number;
            2. Child/Youth age, gender, and ethnicity;
            3. Location and shift;
            4. Children identified in Specialized Foster Care

5. Date, day of the week, time, and length of time of incident;
6. Incident antecedents;
7. Type of S/R;
8. DCFS staff involved;
9. Follow-up plan and
10. All required signatures

3. PEU Logistical Support to the Commission on Behavioral Health
   The PEU provides logistical support to the Commission on Behavioral Health.

4. If the Commission makes such a request, the PEU will forward the *Commission on Behavioral Health Seclusion and/or Restraint Emergency Procedures for Children and Youth Denial of Rights* (or *DCFS Report of Denial of Rights for Children and Youth with Mental Illness*) for Desert Willow Treatment Center to the Nevada Division of Public and Behavioral Health (DPBH) (**NRS 449.786**), the licensing entity for that DCFS facility, within one working week of review at a Commission meeting and communicate the Commission's concerns to the appropriate person at the DPBH or licensing entity as requested.