Policv CRR-1.14
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____ D.R.C.
____ Rural
____ S.R.C
____ Other (specify)
_____

Restraint and Denial Form (RAD):

*Commission MHDS Developmental Services Restraint Report Form and Denial of Rights for Restraint Form per NRS 433*Case #_____ Age____ Sex___(Identifying information on side 2 only.)

_____/_____/_____ _____/_____ _____

Date of Restraint Time Start Time End (AM/PM) Total Time

1. **Type(s) of Restraint (Check all that apply.)**

____**Physical Restraint** ". . .the use of physical contact to limit a person's movement or hold a person immobile."

____**Mechanical** Is this a one time report for a continuing restraint w/Physician's orders? ___Yes ___No

____**Chemical Restraint**

(the administration of drugs for the **specific** and **exclusive** purpose of controlling an acute or episodic aggressive behavior . . .)

2**. Reason(s) for use of restraint (Check all that apply.)**

____Aggression toward others ____Harmful to self ____Property destruction ***(Emergency use of restraint)***

Briefly describe incident: _____

_____

_____

3. **Details of restraint**:

a. Is this part of approved treatment plan? ___Yes ___No

b. Number of staff assisting in restraint_____ (Staff names on reverse)

c. Physical Restraint

What type ___Prone ___Basket-hold ___Carry ___Physical Escort (resistive)

___Other (specify_____

d. **Mechanical restraint**:

What type: ____Reciprocal Wrist ____Waist/wrist _____Chair posey ____Bed Posey ____Mitts

____Other (specify)_____

4. **Methods used to avoid restraint (Check all that apply.)**

____Redirection/Counseling ____One-to-one supervision ____Physical Escort (minimal resistance)

____Other (please specify)_____

Briefly describe actions

_____

_____

5. Are **there any team directed limits or modifications to the use of restraint**? ___Yes ___No **If Yes** describe the limits or modifications: _____

6. **Were there any injuries to the client as a result of the restraint?** ___Yes ___No **If Yes**, briefly describe the injury:

_____

7. **Was a nurse or physician contacted during or following the use of restraint?** ___Yes ___No

a. Was there any medical treatment? ___Yes ___No **If yes**, describe _____

_____

_____ _____ _____

Signature/title of staff completing form Date Signature of witness Date

____*Denial of Rights for Restraint form (Administrative use only.) If checked, forward to the Commission on MH/MR*

Reviewed by: (Note: All signatures may not be required by individual agency policies.)

_____ _____ _____ _____

PC/Case Mgr. Res./Comm. Dir. Q.A. Other

Administrative comment and suggested action, if any.

_____

_____

_____/_____/_____ Date received QA or designee | _____ Initials | _____ Agency Administrator Date | _____ Administrator MHDS Date

(Must be on canary yellow paper Side 1 of 2)

CONSUMER NUMBER _____

____LCC ____NNAMHS ____SNAMHS ____ DWTC

PRIVATE_____
(SPECIFY HOSPITAL)

Rationale for seclusion and/or restraint:
☐ harmful to self ☐ harmful to others

Methods used to avoid restraint and seclusion:
☐ ventilation of feelings ☐ verbal reassurance/redirection ☐ 1 - 1 interaction with staff ☐ reduction in stimuli
☐ environmental change ☐ limit setting ☐ time out
☐ medication(s) name/dosage:_____ ☐ P.O. ☐ I.M.

RN narrative: _____

_____

_____

Is the patient medically compromised? ☐ **Yes** ☐ **No** **If yes, check all that apply:**
☐ morbid obesity ☐ spinal injury ☐ known history of cardiac or respiratory disease
☐ recent vomiting ☐ pregnancy ☐ on seizure precautions ☐ other: _____

Physician's clinical assessment justifying use of seclusion or restraint: _____

_____

Behavioral criteria necessary for release:
Patient to be:
Adults:
☐ secluded and restrained for up to 4 hours ☐ secluded for up to 4 hours ☐restrained for up to 4 hours
Children and Adolescents ages 9 – 17:
☐ secluded and restrained for up to 2 hours ☐ secluded for up to 2 hours ☐restrained for up to 2 hours
Children under 9:
☐ secluded and restrained for up to 1 hours ☐ secluded for up to 1 hours ☐ restrained for up to 1 hours
☐ **RN may extend order once, up to the maximum allowable hours.** ☐ **Yes** ☐ **No**
Place patient in:
☐ seclusion ☐ locked seclusion ☐ cuff/belt ☐ legs ☐ wrists ☐ 4-point ☐ 5-point ☐ mitts ☐ geri chair
☐ Physical intervention required

Placed in seclusion/restraint **Date:** _____**Time:** _____
Released from seclusion/restraint **Date:** _____**Time:** _____

CONTINUATION OF ORDER

The RN evaluation and documentation for continuation of orders must include a face-to-face reassessment of the patient's current behavior that warrants the extension of the restraint/seclusion.

_____
_____
_____
_____
_____

Discussed with physician: _____ _____/_____
R.N. Signature Date/Time

Verbal/phone order by Dr._____ Date: _____ Time: _____
R.N. signature: _____ Date: _____ Time: _____
Physician signature: _____ Date: _____ Time: _____

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Order noted by: _____ Date: _____ Time: _____

COMMISSION ON MHDS REPORT FORM

Revised 7/07

INSTRUCTIONS

List client number only. Consumer's name, initials, date of birth, social security number, etc. should not appear anywhere on this front page.

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SECLUSION/RESTRAINT REVIEW

MEDICAL RECORD NO. _____

DON REVIEW:

_____

_____

_____

_____

_____
Signature Date

MEDICAL DIRECTOR REVIEW:

_____

_____

_____

_____

_____
Signature Date

AGENCY DIRECTOR REVIEW:

_____

_____

_____

_____

_____
Signature Date

DIVISION MHDS REVIEW:

_____

_____

_____

_____

_____
Signature Date

(Side 1 of 2)

REPORT OF DENIAL OF RIGHTS FOR PERSONS WITH MENTAL ILLNESS

Case#_____
Assigned by Division staff only

To: **MHDS Division Administrator** (Division agencies only) _____

Agency Director (signature indicates review only)_____

Agency:_____ **Date:** _____ **Time:**_____

Person's age: _____ **Current Admit Date:**_____

Reporting Staff (Print full name and title):_____

Reporting staff signature: _____

CIRCUMSTANCES

Per NRS 433.454 a person's rights must not be denied unless that person has a mental illness AND is a danger to the health and safety of themselves or others.

This person has a mental illness and is a danger to the health and safety of: ☐ **Self** ☐ **Others**

Right has been denied/restricted ☐ **Intent to deny/restrict right** ☐

We have denied or intend to deny/restrict this person's right to:

☐ Refuse medication (person refuses/unable to provide consent for medications)

☐ Refuse Tx other than medication (person refuses/unable to provide consent for treatment, sign plan)

☐ Have information remain confidential (specify) _____

☐ Have visitors each day (specify)_____

☐ Make/receive confidential phone calls (specify) _____

☐ Keep personal possessions/wear own clothing (specify) _____

☐ Other (please describe using MHDS Policy #2.001) _____

_____

Please describe the specific behavior of the person receiving services that is leading to this denial:

_____

_____

Please indicate what interventions staff used to prevent the need for this denial: (Check all that apply)

☐ 1/1 counseling ☐ PRN medication ☐ Time out ☐ Reduction in stimuli ☐ Ventilings

☐ Other (Describe) _____

Witness to denial incident (full name and title): _____

MEDICATIONS If this denial involved the administration of medication, complete the following:

Ongoing Meds: _____, _____, _____, _____, _____

Med administered for this episode:

Med _____ **Dosage** _____ **Route** _____ **Time administered** _____

Name of MD called: _____ **Time MD called:** _____

Report of MD ordering denial (Please include justification for and consequences of denial action. Use additional page if necessary.)

_____

_____

_____

Inpatient only MD signature:_____ **Date:** _____

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REPORT OF DENIAL OF RIGHTS FOR PERSONS WITH MENTAL ILLNESS

Person receiving services (Name):_____

Agency Case Number:_____

NOTE: Person's name and case number are NOT to appear in the body of the report

DO NOT WRITE BELOW THIS LINE – COMMISSION USE

(Side 1 of 2)

REPORT OF DENIAL OF RIGHTS FOR PERSONS WITH DEVELOPMENTAL DISABILITY

NOTE: Reporting Staff fill out the *UNSHADED* portions of both sides)

Case#_____
Assigned by Division staff only

To: **MHDS Division Administrator** (Division agencies only) _____

Agency Administrator (signature indicates review only) _____

Agency Quality Assurance (signature indicates review only) _____

Agency: _____ **Date:** _____ **Time:** _____

Person's age: _____ **Exact Location:** _____

Reporting Staff (print full name and title): _____

Reporting Staff Signature: _____

CIRCUMSTANCES

In accordance with NRS 435.350 a person's rights can be denied only for cause.

Right has been denied/restricted ☐ **Intent to deny/restrict right** ☐

We have denied or intend to deny/restrict this persons right to:

☐ Refuse medication (person refuses/unable to provide consent for medications)

Current Medications _____

Planned Medications _____

☐ Refuse Tx other than medication (person refuses/unable to provide consent for treatment, sign plan)

☐ Have visitors each day (specify) _____

☐ Make/receive confidential phone calls (specify) _____

☐ Keep personal possessions/wear own clothing (specify) _____

☐ Other (please describe using MHDS Policy #2.001) _____

_____

Please describe the specific behavior of the person receiving services that is leading to this denial:

_____

_____

_____

Please indicates what interventions staff used to prevent need for this denial: (Check all that apply)

☐ 1/1 counseling ☐ PRN medication ☐ Time out ☐ Reduction in stimuli ☐ Vent feelings

☐ Other (Describe) _____

Contacted/Notified: _____

Witness to denial (full name and title): _____

Agency investigation and action:

REPORT OF DENIAL OF RIGHTS FOR PERSONS WITH DEVELOPMENTAL DISABILITY

Person receiving services (Name):_____

Agency Case Number:_____

NOTE: Person's name and case number are NOT to appear in the body of the report

DO NOT WRITE BELOW THIS LINE – COMMISSION USE ONLY

Commission's Statement of Denial Rights Review

(Commission Staff Use Only)

Denial, as set forth, was reviewed and:

_____No action requested ____Further information requested (See below) ___Other action or comments (See below)

Date of Commission Meeting: _____

Signature _____

Commission Mental Health and Developmental Services

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