SECTION - MEDICAL/NURSING SERVICES
ADMINISTRATIVE DIRECTIVE NO. 524
(Replaces A.D. No. 524 dated 9/1/06)

Effective Date: June 14, 2007

SUBJECT: INTRA-HOSPITAL TRANSFER OF INDIVIDUALS

I. PURPOSE

To provide guidelines for the transferring of Individuals within Coalinga State Hospital.

II. AUTHORITY

Welfare and Institution Code (WIC) 6606; Penal Code (PC) 2684; Title 15; and Title 22, Sections 71517, 73303 (a), 73305, 73517, and 73519.

III. POLICY

It is the policy of this hospital that each Individual is provided care on a unit that is most appropriate to meet his medical and psychological needs. Each Individual is assigned to the care of a multidisciplinary, Wellness and Recovery Team (WRT) and a treating physician. It is the responsibility of the treating physician to admit the Individual and to provide necessary medical treatment until the Individual is transferred to another physician or is discharged from the hospital. No Individual may be transferred for clinical reasons from one level of medical care to another without a physician's order, except when required for administrative reasons. Individuals may be transferred administratively on the authority of the Executive Director. The processes outlined in this policy are intended to provide guidelines to assist staff in identifying the most appropriate placement of Individuals. In all cases the final placement must consider the Individual's unique wellness and recovery needs within the context of current and anticipated bed availability and availability of necessary resources to meet the Individual's clinical and security needs. Other operational considerations that would reasonably be expected to affect the appropriateness or effectiveness of a specific placement should also be considered.

IV METHOD

A. Definitions:

1. Acute Units: These units are licensed by the Department of Health Services (DHS) as Acute Psychiatric and are governed by specific Title 22 regulations. Units are staffed to meet the medical needs of the Individuals served. Minimum staff-to-Individual ratios are 1:6, 1:6, and 1:12 for nursing staff on the a.m., p.m., and NOC shifts, with patient-acuity ratings requiring additional staff as needed, above the minimums. Acute units are considered as the highest level of medical care.

2. Intermediate Care Facility (ICF) Units: These units are licensed by DHS as units consistent with an ICF. Such units are governed by licensing regulations specified in Title 22 and require a minimum staffing ratios of 1:8, 1:8, and 1:16 for nursing staff on the a.m., p.m., and NOC shifts. When California Department of Corrections and Rehabilitation (CDCR) prisoners are placed on an ICF unit, select elements of Title 15 also apply to that unit (e.g., restrictions on pornography and personal computers).

3. Residential Recovery Units (RRU): These RRUs are available for Individuals committed pursuant to the Sexually Violent Predator (SVP) law, defined in the WIC 6600 et seq. and specifically authorized by Section 6605 (d) RRUs are not licensed by the DHS and are not regulated by Title 22. Standards are set by the Department of Mental Health (DMH) Special Orders, DMH regulations, and Hospital policies. RRUs are considered as the lowest level of medical care.

B. Transfers from a Higher Level of Medical Care to a Lower Level:

1. Acute to ICF Units: When the placement on the Acute unit was for physical-medical reasons, the treating physician determines when the Individual no longer requires the acute level of medical care and writes an order for transfer to an appropriate, lower level of medical care. The Program Director over the Acute Unit coordinates the actual transfer date and unit assignment with the Program Director of the receiving program/unit. In most cases, the Individual will be returned to the unit where he resided prior to the Acute-unit placement. When the placement on the Acute unit was for psychiatric reasons, the WRT including the Acute and home-unit psychiatrists and determines readiness for return to a lower level of medical care and the appropriate placement. The Positive Behavior Support (PBS) team or the Senior Psychologist and the Program Director need to be consulted in this determination. In those situations where there is no consensus, program management is responsible for facilitating an agreement. When consensus is not forthcoming, the Clinical Administrator and Medical Director are consulted, and the Medical Director is the final authority on transfer and placement.

2. ICF Units to RRUs: The WRT determines the Individuals appropriateness for placement on an RRU. When the Individual is receiving prescribed treatment by a psychiatrist, the psychiatrist participates in the Wellness and Recovery Planning (WRP) conference in which the Individual's appropriateness for such transfer is considered. In all cases, the psychiatrist must provide a recommendation on an Individual's readiness for RRU placement (see Readiness for Transfer to RRU form). When there is disagreement, the Program management(s) needs to be involved. The specific criteria for transfer and the required documentation are specified in AD 596. When consensus is not forthcoming, the Clinical Administrator and Medical Director are consulted, and the Medical Director is the final authority on transfer and placement.

C. Transfers from a Lower Level of Medical Care to a Higher Level:

1. ICF to Acute Units: For physical care needs, the treating physical-care physician determines when the Individual requires an Acute level of medical care and writes an order for transfer (see AD 594 for specific admission criteria). The Individual is transferred as soon as a bed is available. For psychiatric needs, the assigned psychiatrist in collaboration with the Medical Director determines the appropriate placement of an Individual on an Acute unit. The WRT and Program Management are to be consulted in arriving at the decision for transfer. Such transfers may be temporary and limited according to specific objectives.

2. RRU to Acute Units: For physical care needs, the treating physical-care physician determines when the Individual requires an Acute level of medical care and writes an order for transfer (see AD 594 for specific admission criteria). The Individual is transferred as soon as a bed is available. For psychiatric needs, the assigned psychiatrist in collaboration with the Medical Director determines the appropriateness of an Individual's placement on an Acute unit. The WRT and Program Management are to be consulted in arriving at the decision for transfer. Such transfers may be temporary and limited according to specific objectives.

3. RRUs to ICF Units: For physical care needs, the treating physical-care physician determines when the Individual requires an ICF level of medical care and writes an order for transfer. For psychiatric needs, the WRT in collaboration with the Senior Psychologist and Program Director determines the Individual's appropriateness for placement on an ICF unit. Behavioral interventions and alternative RRU placements should be considered and implemented prior to a decision for transfer. Before any decision for transfer, the treating physician or Medical Director must approve the move and a physician order must be written. The Program Director of the transferring unit coordinates the move with the Program Director over the ICF unit for date and unit placement. Such a transfer may be temporary and limited according to specific objectives.

D. Transfers within the Same Level of Medical Care:

1. Acute Units: The physician(s) in collaboration with the WRT and Program Director(s) determines the Individual's need for placement on another Acute unit. A physician order is required for transfer. Where there is disagreement, the Medical Director is the arbiter and final authority. The Program Director(s) coordinates the date and placement dependent on bed availability.

2. ICF Units: The WRT in collaboration with the Senior Psychologist(s) and Program Director(s) determines the Individual's need for placement on another ICF unit. A physician order is required for the transfer and the physician or Medical Director must concur with the transfer decision. Where there is disagreement, the Medical Director is the arbiter and final authority. The Program Director(s) coordinates the date and placement dependent on bed availability.

3. RRUs: The WRT in collaboration with the involved Senior Psychologist(s) and Program Director(s) determines the Individual's appropriateness for placement on another RRU. Where there is disagreement, the Clinical Administrator is the arbiter and final authority. No physician order is required. The Program Director(s) coordinates the date and placement dependent on bed availability.

E. Transfers Based on Administrative Decisions:

1. Administrative transfers of Individuals may be authorized by the Executive Director to accommodate anticipated admissions, relieve overcrowding, reduce staffing demands, address security or safety concerns, or if hospital management determines that reorganizing or reassigning the treatment-mission of a program or unit is necessary to fulfill the current needs and objectives of the hospital.

2. When such administrative transfers are required, either within a program or involving more than one program, the affected Program Director(s) will take the lead in planning and implementing the changes.

3. Whenever such an administrative transfer is being considered, it shall not occur until agreement is reached among the involved program management(s).

4. If agreement on an administrative transfer cannot be reached between the involved Programs, the transfer decision shall be immediately referred to the Clinical Administrator. The Clinical Administrator in consultation with the Medical Director will make the final decision/resolution.

5. Prior to the physical transfer(s) of the affected Individual(s), arrangements should include discussion between members of the involved WRTs and their respective Program management(s).

F. Transfer Procedures

1. Scheduled Transfers:

a. Transfers between units/programs are to occur so that Individuals' orders for treatment, WRPs, and other relevant material can be reviewed in order to ensure continuity of care.

b. The unit receiving an Individual by transfer from another unit shall notify the Department of Police Services (DPS) Communication Center by telephone.

c. Except for emergencies, transfers will be accomplished on Monday through Friday during the following hours:

i. In the morning between 8:30 a.m. and 11:00 a.m.

ii. In the afternoon between 1:00 p.m. and 2:30 p.m.

2. Placement of Commitment Populations:

a. Individuals committed under PC 2684 will be placed on designated ICF units which are staffed specifically for the Mentally Ill Prisoners.

b. Individuals committed under WIC 6600 et seq. will be placed on SVP designated ICF units and RRUs/BRUs (Behavioral Recovery Units).

3. Court Returns:

Individuals who have returned to the hospital from court leave shall be returned to their previous unit and program if possible. If, due to time constraints or bed space considerations, the Individual must be placed in an alternate program, when possible an eventual return of that Individual to his home program may be arranged.

G. Procedures for Individual Refusal of Movement from one Unit to Another:

1. Staff may request the assistance of the DPS when an Individual refuses a request to move to another unit. DPS will ask the Individual to comply with the request and if necessary issue a lawful order. If he continues to refuse, he will be placed in custody and transported to the next unit. DPS officers will apply metal restraints if necessary. If metal restraints are applied, a physician's order is not necessary. Use of handcuffs will constitute need for a Special Incident Report (SIR) being completed and incident being documented in the Individual's chart.

2. DPS will transport the Individual to the next unit, accompanied by clinical staff, at which point the metal restraints will be removed. Clinical staff will evaluate the Individual in terms of the danger he poses to himself or others and decide whether the need exists for the application of restraint and/or seclusion.

H. Observation/Seclusion Rooms:

Each ICF and Acute unit shall maintain specific rooms for the purpose of restraint and seclusion. When the need for seclusion rooms exceeds the capacity of a unit, it is permitted to transfer the Individual to a vacant seclusion room or to an Acute Unit. The clinical accountability for the care of the Individual remains with the transferring team. In the unlikely case that a room is not available, clinical determination will be made to move an Individual out of a single room who will experience the least amount of disruption to his WRP. In all cases, terminal cleaning must take place prior to occupying of the seclusion rooms.

V. PHYSICIANS' RESPONSIBILITIES

A. When a Physician's Order is required, the transferring Physician shall:

1. Write a "transfer order" on a physician's order sheet.

2. When there is a transfer of responsibility to another physician, the transferring physician/psychiatrist should communicate orally with the receiving physician/psychiatrist.

3. Write a "transfer summary" on the physician's progress notes. This summary shall include reasons for transfer with supporting clinical findings.

B. All Unit Transfers Require that the Receiving Physician Shall:

Review the Pharmacy reprinted orders, revise as necessary, and sign prior to the end of that attending physician's shift.

C. All transfers to an ICF or an Acute Unit require the Receiving Physician to:

1. Document on the physician's progress notes pertinent physical and mental findings.

2. If the Transfer is to the Acute Unit for Physical-Care Needs:

   a. Document pertinent physical and mental findings, as well as diagnostic impressions.

   b. Within 24 hours, complete an admission physical examination, including review of systems.

3. If the transfer is to the Acute Unit for psychiatric needs:

   a. Document pertinent mental findings, as well as diagnostic impressions.

   b. Within 24 hours complete a psychiatric examination, including mental status examination.

VI. NURSING STAFF RESPONSIBILITIES

A. Transferring Nursing Personnel:

1. Prior to transfer of any Individual, the alert section of the record will be reviewed for security alerts. In the event an Individual is noted as a potential assailant or security alert, the Unit Supervisor will notify the DPS Watch Commander and discuss the proposed transfer. Any concerns or issues raised by DPS will be forwarded to Program Management for review and resolution.

2. Record time, how and where transferred.

3. Record in Interdisciplinary Notes (IDN) the Individual's current behavior and physical complaints, response to medications, WRP services, and individual teachings. For transfers to RRU, see AD 596 for documentation requirements.

4. Include description of reason for which Individual is being transferred, including medical or psychiatric condition when indicated.

5. Medication labeled specifically for the Individual should be transferred with the Individual. (No control drugs may be transferred.)

6. The Unit Supervisor/designee will assure the record is complete and current through review of the record and completion of the Intra-hospital Transfer Checklist form.

7. If the Individual has an order for a modified diet or nourishment, notify Nutrition Services of the transfer before the next meal service.

B. Receiving Nursing Personnel:

1. Record on IDNs the date and time the Individual is received, and notify the Communication Center of the transfer.

2. Record description of Individual's physical condition, behavior, and reaction to current placement.

3. Perform physical inspection for signs of illness or injury.

4. Obtain and record blood pressure, temperature, pulse, respiration, height, weight, and physical description.

5. Within 24 hours update nursing assessment.

6. If medication labeled for the Individual was transferred with the Individual, make entry in log.

7. The Unit Supervisor or designee will assure the record is complete and current through review of the record and completion of the Intra-hospital Transfer Check List form.

8. If the Individual has an order for a modified diet or nourishment, notify Nutrition Services as soon as possible before the next meal service. Complete a Diet or Nourishment Order Form and forward to Nutrition Services within 24 hours.

9. Nursing staff shall orient the Individual to the new unit and document this in the IDNs.

VII. WELLNESS AND RECOVERY RESPONSIBILITIES

A. When there is a transfer to a new WRT, it is the responsibility of each member of the transferring WRT to ensure that the Individual's medical record is up-to-date with respect to that Team member's services and observations.

B. The new, receiving WRT shall modify as necessary the Individual's WRP to ensure continuity of care and continuation of his plan to the extent that his medical condition permits, when he is undergoing medical/surgical treatment.

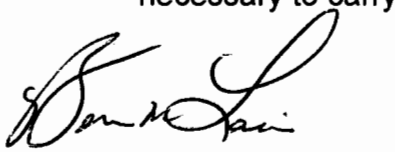
C. The receiving psychologist, social worker, and rehabilitation therapist shall update assessments before the Admission/Transfer (14-day) Team Conference.

D. It is the responsibility of the WRT to clarify any questions that the Individual has about the reason for his transfer. Documentation of relevant issues and the discussion shall be noted in the IDNs.

VIII. TRAINING

A. The Program Director, Senior Psychologist-Supervisor, and Coordinator of Nursing Service shall ensure that unit staff and covering nurses are trained in procedures necessary to carry out this directive.

B. The Medical Director shall ensure that physicians are trained in procedures necessary to carry out this directive.



BEN MCLAIN
Executive Director (Acting)

Cross Reference(s):
A.D. No. 594 Transfer Criteria to the Acute Medical/Psychiatric Unit
A.D. No. 596 Transfers from ICF to RRU