SECTION – MEDICAL/NURSING SERVICES
ADMINISTRATIVE DIRECTIVE NO. 594
(Replaces A.D. No. 594 dated 4/24/06)

Effective Date: March 8, 2007

SUBJECT: TRANSFER CRITERIA TO THE ACUTE MEDICAL/PSYCHIATRIC UNIT

I. PURPOSE

To provide guidelines for transferring Individuals at Coalinga State Hospital (CSH) to the Acute Medical/Psychiatric unit.

II. AUTHORITY

California Welfare and Institutions Code Section 6606.

III. POLICY

It is the policy of CSH that Individuals needing specialized medical or psychiatric care, or increased monitoring for that care, will be housed in a unit with the unique equipment, staffing level and training to render them the best treatment possible.

IV. METHOD

A. Purpose of the Acute Care Unit (Medical):

1. To care for Individuals with long term medical conditions or medically fragile Individuals whose health is at increased risk due to increased age or associated chronic medical conditions.

2. To care for Individuals who need evaluation and/or treatment of short term, acute or emergent medical problems.

3. To care for Individuals who need specialized medical resources (equipment and staff) which are not generally available on other units (e.g. Urgent Care room, isolation, IV therapy, nebulizer administration of medications, oxygen, tub bathing etc.).

B. Examples of conditions which might require treatment on Acute Care Unit (Medical):

1. Moderate, acute or chronic orthopedic problems such as sprains, fractures, and or conditions requiring physical therapy.

2. Local or systemic infections that may require frequent dressing changes, wound care and or IV antibiotics.

3. Seizure disorders requiring observation and regulation of medications.

4. Chronic conditions (e.g. post CVA, or dementia) requiring rehabilitation, physical therapy and/or assistance with ADL.

5. Diabetes requiring frequent monitoring of diet, activities and/or medications.

6. Communicable diseases requiring isolation.

7. ASHD or COPD requiring frequent monitoring and/or regulation of their medications or special treatments.

8. Returns from community hospitals after evaluation/treatment that needs further stabilization.

9. Requirement for IV therapy.

10. Requirement for bed rest.

11. Requirement for special lab studies which are difficult to coordinate on other units.

12. Requirement for medical observation for emergence of potentially severe side effects when starting medication.

13. Recent dental/oral surgical treatment requiring special assistance, observation or treatment post-procedure.

14. Potential benefit of a short stay on MA2, even when usually cared for on home unit.

15. Nutritional deficits requiring special feeding methods (e.g. NG tube, or PEG tube).

16. Individuals identified by Program personnel as high risk due to medical conditions.

C. Decision to transfer to Acute Care (Medical):

1. A recommendation to transfer to Acute Care (Medical) can come from program, nursing, medical or administrative staff. The decision to affect the transfer is made, during business hours, by the Medical On-Call (MOC), the family practitioner seeing the patient in the clinic, or the Medical Director. The sending physician should notify the Medical Director if the decision was not made by her/him.

2. In the same way, the recommendation and decision to transfer an Individual back to an Intermediate Care Facility (ICF) or Residential Recovery Unit (RRU) unit will be made by the Psychiatric Medical On-Call (PMOC) or the Medical Director. The Program Director will be notified and the transfer will occur when an appropriate bed is available.

D. Purpose of the Acute Care Unit (Psychiatric):

1. The purpose of the psychiatric acute care unit is to stabilize Individuals who may psychiatrically decompensate when living on an ICF or RRU unit; that is, they need closer monitoring than is possible on those units. Individuals may be judged to be a suicidal risk, or to be agitated, destructive of property, or verbally threatening harm to property, staff or other Individuals.

2. It is expected that most patients will be stabilized on the acute unit and be able to return to the ICF or RRU after a brief stay (e.g. several days to several weeks).

E. Examples of conditions/situations that require the Acute Care Unit (Psychiatric) Note: these lists are not exhaustive.

1. Suicidal ideation where the clinical staff feels then is a suicide risk:

   a. Past history of suicide attempts;

   b. Serious depression;

   c. Command hallucinations to kill oneself;

   d. Presence of psychosis;

   e. Recent loss or anniversary of loss;

   f. Aggression or threats of aggression;

   g. Within 24 hours of admission.

2. Agitation, destruction, and aggression secondary to psychosis. For example: bipolar disorder, paranoid schizophrenia, substance intoxication, or cognitive deficits.

3. Need for seclusion, restraint or involuntary medication.

4. Bizarre behavior secondary to psychosis or substance abuse such as smearing feces.

F. Decision to transfer to Acute Care Unit (Psychiatric):

1. A recommendation to transfer to MA2 (medical) can come from program, nursing, medical or administrative staff. The decision to affect the transfer is made, during business hours, by the PMOC, the psychiatrist assigned to the Individual, the psychiatrist seeing the Individual in the clinic, or the Medical Director. The sending physician should notify the Medical Director if the decision was not made by her/him.

2. In the same way, the recommendation and decision to transfer an Individual back to an ICF or RHU unit will be made by the PMOC or the Medical Director. The Program Director will be notified and the transfer will occur when an appropriate bed is available.

V. SCOPE OF SERVICE

The Acute Medical/Psychiatric Care Unit is responsible for specialized medical and psychiatric services.

W. T. Voss
Executive Director