

**SECTION – MEDICAL/NURSING SERVICES
ADMINISTRATIVE DIRECTIVE NO. 596
(Replaces AD 596 dated 10/26/2006)**

Effective Date: November 9, 2006

SUBJECT: TRANSFER CRITERIA: ICF UNITS TO RRUs

I. PURPOSE

To assure that the Individuals transferring to a lower level of care have met the criteria for transfer and that supporting documentation is available in their chart.

II. AUTHORITY

California Code of Regulations, Title 22 Section 71517 and by the Order of the Hospital Executive Director of Coalinga State Hospital (CSH).

III. POLICY

It is the policy of CSH to establish and apply specific criteria for transferring to a lower level of care.

IV. METHOD

All Individuals being considered for transfer from an Intermediate Care Facility (ICF) to a Residential Recovery Unit (RRU) will be assessed for appropriateness of transfer to a less restrictive level of care, by their Wellness and Recovery Team. Decisions will be documented on the Readiness for Transfer Form and maintained in the ICF chart at the time of transfer.

A. Readiness for transfer is to be addressed in each Wellness & Recovery Treatment Plan.

1. A one line statement saying he is or is not being considered for transfer at this time.

B. When the Individual is being considered for transfer, the Readiness for Transfer Form is completed. This documentation directs and supports the team's decision regarding appropriateness.

Minimum Criteria for transfer to RRU.

1. No Axis I Active Major Psychosis or Serious Depression.

2. 90 days-No physical assault.

3. PAS level of 3.
 4. Limited use of PRN/control drugs.
 5. No chronic illness or use of devices that require nursing assistance.
- C. Readiness for Transfer Form addresses the following areas:
1. Specified criteria.
 2. Open physical conditions.
 3. Utilization and intensity of staff services and support.
 4. Individual's desire for transfer.
 5. Recommendation.
- D. The entire team must sign the Readiness for Transfer Form. If the Individual is on psychotropic medication, and the psychiatrist was not an active participant of the Wellness and Recovery Team, the psychiatrist will review the team conference and the Readiness for Transfer Form, give his impression and sign the form.
- E. In those cases where the team's recommendation and the psychiatrist recommendations differ, the team and the psychiatrist will reconvene to come to a mutually agreeable decision.
- F. In those rare cases where there is disagreement within the Team or when the Program feels a specific Individual should be moved, a program representative will meet with the team to give input into the decision process.
- G. When consensus is not forthcoming from the Team and Program, see the A.D. 524, Intra-Hospital Transfer of Individuals, for final decisions authority.
- H. Once the decision for transfer has been made, notify Health Information Management Department (HIMD) of the anticipated date of transfer.
- I. Unit Nursing Staff will complete pre-formatted "Transfer Note IDN" prior to transferring the Individual to RRU. The original will accompany RRU chart and carbon will stay in ICF chart.
- J. An employee from HIMD will come out and copy the following material from the ICF chart to set up the new RRU chart:
1. Immunization page.
 2. Most current wellness and recovery plan, including assessments.

3. Pending consults.
4. Most current state evaluation.
5. Readiness for Transfer Form CSH 096.
6. Transfer Note IDN CSH 097.
7. Physician Transfer Note (PPN).



W. T. VOSS
Executive Director

Attachments: Readiness for Transfer
Transfer Note IDN

CURRENT STATUS:

Frequency of PRN use: Multiple times per day Daily Weekly Monthly

Medication Issues: _____

Frequency of Services requiring staff intervention: 0-3 X/day 4-7 X/day 8-12 X/day 13+

Reason: _____

OPEN PHYSICAL ISSUES:

ALERTS:

Positive Behavior Support Plan in place? YES NO

INDIVIDUAL'S DESIRE FOR TRANSFER:

Seeking Transfer Neutral To Transfer Resistive To Transfer

CRITERIA

MET	NOT MET	
<input type="checkbox"/>	<input type="checkbox"/>	1. No Axis I Active Major Psychosis or Serious Depression
<input type="checkbox"/>	<input type="checkbox"/>	2. 90 days no physical assault. Give date of last incident _____
<input type="checkbox"/>	<input type="checkbox"/>	3. PAS level of 3
<input type="checkbox"/>	<input type="checkbox"/>	4. Limited use of PRN/control drugs
<input type="checkbox"/>	<input type="checkbox"/>	5. No chronic illness or use of devices requiring nursing assistance

COMMENTS: _____

TEAM RECOMMENDATION: Able to be placed on RRU Needs ICF level of care

W & R Team Comments: _____

ALL ATTENDEES OF TEAM MUST SIGN:

_____ Name	_____ Team Member	_____ Title	_____ Date
_____ Name	_____ Team Member	_____ Title	_____ Date
_____ Name	_____ Team Member	_____ Title	_____ Date
_____ Name	_____ Team Member	_____ Title	_____ Date
_____ Name	_____ Team Member	_____ Title	_____ Date

PSYCHIATRIST: (Signature Required if on Psychotropic Medication)

Attended Team or Reviewed Notes
 Move Recommended Move **Not** Recommended

Name Psychiatrist Title Date

READINESS FOR TRANSFER TO RRU

ADDRESSOGRAPH

Confidential Patient Information
See W&I Code 5328
FILE WITH WELLNESS & RECOVERY PLAN

DATE	TIME	PROB. #	ALL ENTRIES SHALL BE SIGNED WITH FIRST INITIAL AND LAST NAME AND TITLE
		0	TRANSFER NOTE:
			TRANSFER FROM UNIT _____ TO UNIT _____
			<input type="checkbox"/> ADMINISTRATIVELY <input type="checkbox"/> AS RECOMMENDED BY THE TEAM
			ALL PROPERTY TAKEN? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, give location of property:
			PROPERTY INVENTORY COMPLETED AND FILED? <input type="checkbox"/> YES <input type="checkbox"/> NO
			LANGUAGE SPOKEN: _____ LANGUAGE UNDERSTOOD: _____
			CURRENT DIET: _____
			PRECAUTIONS/ALERT (INDICATE DATE OF LAST INCIDENCE)
			<input type="checkbox"/> TARASOFF <input type="checkbox"/> PROBATE CONSERVATORSHIP <input type="checkbox"/> ADVANCE DIRECTIVES
			ALLERGIES:
			LIST PENDING CLINIC APPOINTMENTS:
			PENDING LAB TEST:
			LAB TRACKING FOLLOW-UP NEEDED:
			PPD GIVEN: DATE: _____ READING DUE: _____ FOLLOW UP NEEDED <input type="checkbox"/> YES <input type="checkbox"/> NO
			PAS LEVEL:
			INDIVIDUAL'S RESPONSE TO TRANSFER:

ADDRESSOGRAPH

**TRANSFER NOTE
IDN**

Confidential Client Information
See W & I Code Section 5328

File with IDN

CSH-

DATE TIME PROB. # ALL ENTRIES SHALL BE SIGNED WITH FIRST INITIAL AND LAST NAME AND TITLE

0 TRANSFER NOTE CONTINUED:

BEHAVIORAL CONCERNS RISKS	ACTIVE	OCCASS.	HISTORY OF (GIVE DATE)	EXPLANATIONS
Hallucinatory				
Assaultive				
Medical Compliance Issues				
Danger to self				
Sexually inappropriate				
Intrusive or Attention Seeking				
Agitates others				
Illicit drug use (Pruno)				
Weapons manufacturing				
Other Concerns				

Restraints and/or Seclusion [REDACTED] Date of last occurrence: Type:

Security Risk Assessment : LOW MEDIUM HIGH

CHECK ALL THAT APPLY

Cognitive Impairment	Hearing Aids	Glasses
Dentures	Motivated to Care for Self	Braces
Prosthesis (Self Applied))	Sleep Disturbance	Medication Compliance
Cane / Crutches	Wheel chair / Walker	Other (Specify below)

ADDRESSOGRAPH

**TRANSFER NOTE
IDN**

Confidential Client Information
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File with IDN

CSH-