

CHAPTER 36

PATIENT SUPERVISION AT STATE PSYCHIATRIC HOSPITALS

Authority

N.J.S.A. 30:1-12 and 30:4-27.21a.

Source and Effective Date

R.1998 d.62, effective December 22, 1997.
See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 36, Patient Supervision at State Psychiatric Hospitals, expires on June 20, 2003. See: 34 N.J.R. 4290(a).

Chapter Historical Note

The provisions of Chapter 36, Patient Supervision at State Psychiatric Hospitals, became effective August 18, 1986, by R.1986 d.331. See: 17 N.J.R. 2593(a), 18 N.J.R. 1704(a). Subchapter 3, Transfers of Involuntarily Committed Patients Between State Psychiatric Facilities, became effective September 4, 1990, by R.1990 d.430. See: 21 N.J.R. 2751(a), 22 N.J.R. 2710(b).

Pursuant to Executive Order No. 66(1978), Chapter 36 was readopted by R.1991 d.453. See: 23 N.J.R. 1652(a), 23 N.J.R. 2637(a). By Division decision, an expiration date of June 30, 1992, was assigned to the chapter.

Pursuant to Executive Order No. 66(1978), Chapter 36 was readopted by R.1992 d.302, effective June 29, 1992. See: R.1992 d.302, effective June 29, 1992. See: 24 N.J.R. 1728(a), 24 N.J.R. 2730(b). By Division decision, an expiration date of December 31, 1992, was assigned to the chapter.

Pursuant to Executive Order No. 66(1978), Chapter 36 was readopted by R.1992 d.58, effective December 29, 1992. See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).

Pursuant to Executive Order No. 66(1978), Chapter 36 was readopted by R.1998 d.62, effective December 22, 1997. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. LEVEL OF SUPERVISION SYSTEM

10:36-1.1 Introduction and purpose

(a) The Levels System is designed to provide a uniform process which affords each patient the structure and intensity of supervision appropriate to his or her condition during the course of hospitalization. Level determination is based primarily upon the clinical condition of the patient and related behaviors. The Levels System is not a treatment modality. It is a mechanism to be utilized in determining the degree of structure and supervision necessary for each patient to successfully participate in treatment and rehabilitation programs while maintaining a safe and secure therapeutic milieu for patients and staff alike through clinical determination of the degree of structure and supervision necessary for each patient. Appropriate structure and supervision will also facilitate each patient's successful participation in treatment and rehabilitation programs which are designed to improve functioning and promote positive social adjustment while hospitalized and after discharge in the community.

(b) The Levels System will be interpreted and implemented in a manner that facilitates the effective treatment of each patient while maintaining the least restrictive setting necessary to accomplish individual goals identified in the treatment plan. Under no circumstances will this policy be interpreted and implemented in any manner that abridges liberties specified in the "Patients Bill of Rights" (N.J.S.A. 30:4-24.1 et seq.).

(c) The Interdisciplinary Treatment Team will determine the appropriate level for each patient upon admission with periodic review of the assigned level during the course of hospitalization. Level determinations will be made in accordance with guidelines set forth herein. Treatment teams should utilize these guidelines to promote increased responsibility, accountability and independence on the part of the patient while decreasing structure and intensity of supervision provided by the staff. Incremental steps taken towards this goal should be viewed as part of a continuum that progresses through each level of the system.

(d) The purpose of the system is:

1. To establish clear guidelines which define parameters of structure and supervision necessary to maintain a safe and secure environment during patient movement to and from programming and related patient treatment services.

2. To ensure that all patients receive such considerations in an equitable, consistent and justifiable fashion based on individual clinical considerations.

3. To establish a system which maximizes continuity of care for patients whenever transfer from ward to ward, or hospital section to hospital section becomes appropriate and necessary.

4. To facilitate patient groupings which are optimal for positive social interaction and support progress towards discharge.

Amended by R.1993 d.58, effective February 1, 1993.
See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).

At (c): changed 'assign' to 'determine' regarding Interdisciplinary Treatment Team and appropriate level of patient.

10:36-1.2 General provisions

(a) A copy of the Levels System will be posted on all wards and will be communicated to patients.

(b) All "Not Guilty by Reason of Insanity and Incompetent to Stand Trial" status patients and others identified as appropriate for special treatment review procedures must have court approval prior to implementation of an increase in level recommended by the treatment team. Each hospital may determine whether the Interdisciplinary Treatment Teams need administrative approval in addition to court approval for their Level of Supervision determinations for these patients and, if so, in what manner the administrative approval shall be obtained.

(c) A patient may be discharged from any level, when documented as clinically appropriate.

(d) A patient does not have to go through each level in sequence. The treatment team may increase or decrease the assigned level as warranted in consideration of a significant change in the patient's clinical condition.

(e) A current list of all patients and their individual privilege level must be posted on each ward.

(f) Patients who disagree with the treatment team regarding their assigned level of supervision may appeal through hospital patient grievance procedures or to the Division of Mental Health Services Representative assigned to each institution. The Client Service Representative will involve hospital administration and/or clinical staff as indicated in the resolution of the disagreement.

(g) The Levels System applies to the four adult regional State Psychiatric Hospitals (Trenton, Ancora, Marlboro, Greystone Park).

(h) The Levels System will be monitored by the Quality Assurance Department at each hospital to insure that any staffing, programmatic, clinical or other problems are identified and addressed.

Amended by R.1993 d.58, effective February 1, 1993.
See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).

In (b): added text to clarify administrative approval needed for special status patients.

Amended by R.1998 d.62, effective January 20, 1998.
See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).

In (f), substituted references to the Division of Mental Health Services Representative for references to the Department of Human Services Client Advocate.

10:36-1.3 Procedures

(a) Upon admission patients will be placed on Level I of the Levels System until evaluation by the treatment team (within 72 hours) who will assign the level that is most appropriate to the clinical condition and treatment needs of the patient.

(b) Guidelines that reflect the nature of the individual hospital program and specific environment are to be used for determining a patient's level. Examples of criteria in concert with the definitions are defined in this policy. Additional guidelines may be considered by treatment teams in determining the clinically appropriate level.

(c) Each patient's level will be evaluated minimally in accordance with the treatment plan review schedule or sooner if clinically indicated or requested by the patient. The treatment plan review schedule shall minimally comply with the standards set by the applicable accrediting body for the hospital.

(d) Minimum time spent at each privilege level will be determined by the treatment team based upon the individual patient's clinical needs and treatment goals.

(e) In crisis or emergency situations constituting a significant change in the patient's behavior or clinical condition, temporary limitations on activities may be authorized by clinical staff in charge to maintain a safe and secure environment. The rationale for temporary limitations must be documented in the patient's clinical record and the treatment team must review the rationale by the next working day and document their findings in the clinical record.

(f) All patients ordered "Conditional Extension Pending Placement" by the court will be considered to be on LEVEL IV unless there is documentation in the clinical record to show that the responsible treatment team has identified clinical considerations which require and justify that the patient be placed at a level which provides the necessary structure and supervision. In such instances, a treatment team note shall be entered into the clinical record which documents the clinical considerations which justify the level determined necessary by the treatment team.

Amended by R.1993 d.58, effective February 1, 1993.

See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).

In (c): revised treatment plan review schedule.

In (f): revised text to read "Conditional Extension Pending Placement."

10:36-1.4 Level I definition, criteria and program structure

(a) All programming is provided on-ward except for those essential services which cannot be provided on the ward. Determination of what off-ward services are essential is the responsibility of the treatment team and will be documented in the patient's clinical record. These services include, but are not limited to, access to the outdoors along with special medical and clinical services. All attendance at off-ward services must be staff escorted. Brief home visits are not permitted at level I.

(b) Mental condition criteria include, but are not limited to:

1. Suicidal/homicidal ideation or behavior (High Suicide Risk);
2. Severe impulse control problems;
3. Imminent arson risk;
4. So severely confused or disoriented as to be unable to adjust to unfamiliar surroundings;
5. So grossly psychotic or mood disordered that an imminent risk of harm to self or others is present; and
6. High elopement/walkaway risk as indicated by verbal intent and/or recent history.

(c) Risk factors related to homicidal/suicidal behavior include:

1. Past history of violent or homicidal behavior; and
2. Past suicide attempts and their lethality.

(d) Physical condition criteria may include:

1. Bed rest due to physical deterioration; or
2. The presence of acute medical problems.

(e) Programming for patients on Level I will require highly supportive and structured activities to facilitate the beginning of successful participation by the client in the treatment regimen. Provision of an environment which is highly organized and supervised maximizes the opportunity for successful experiences in treatment for individuals who exhibit Level I criteria. In general, on-ward individual or small group sessions provide excellent opportunities to introduce and reinforce processes that elicit information about the patient's needs, problems, and priorities of treatment as well as introduction of expectations regarding the patient's responsibility and ability to influence the course of treatment while hospitalized.

Amended by R.1993 d.58, effective February 1, 1993.

See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).

In (b): added "but are not limited to" to clarify listing of medical condition criteria.

Amended by R.1998 d.62, effective January 20, 1998.

See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).

Inserted new (c); and in (d), inserted "may" following "criteria".

10:36-1.5 Level II definition, criteria and program structure

(a) Programming is provided both on-ward and off-ward. Attendance and appropriate participation in on-ward activities becomes the responsibility of the patient (i.e. There is less need for staff support and direct supervision). Staff escort is required for all off-ward activities. Brief home visits are permitted at this level if clinically indicated and the family is capable and willing to provide direct supervision for the duration of the visit.

(b) Mental condition criteria include, but are not limited to:

1. No longer high suicide, elopement/walkaway, medical or assault risk;
2. Follows general directions and generally attends onward therapies and programs on a regular basis;
3. Psychotic symptoms or mood disturbances may be present but does not act in response to them in such a way as to create an imminent risk of harm;
4. Mildly confused and disoriented but able to adapt to unfamiliar surroundings; and
5. Able to control impulses except when severely stressed.

(c) In addition to the risk factors associated with Level I, risk factors for Level II related to elopement and/or clinical behavior include:

1. Past history of attempts to elope or walk away from the hospital;
2. Past history of criminal behavior; and
3. Past history of violent behavior directed towards others.

(d) Physical condition criteria include:

1. Non or partially ambulatory patients at risk of accidental self-harm (e.g. by falling).
2. Patients with medical problems requiring constant evaluation.

(e) The patient's demonstrated ability to participate in treatment activities on the ward by virtue of a greater degree of self-initiated responsible participation should result in involvement and assignment to more off-ward activities and programs. To maximize the probability of success in the change in the treatment regimen these off-ward activities need to be structured and supportive with staff

escort at all times. On-ward therapies and activities, however, should utilize the patient's developing sense of responsibility and initiative by providing less direct supervision and structure while continuing to evaluate progress frequently.

Amended by R.1993 d.58, effective February 1, 1993.

See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).

In (b): added "but are not limited to" to clarify listing of medical condition criteria.

Amended by R.1998 d.62, effective January 20, 1998.

See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).

Inserted new (c), and recodified existing (c) and (d) as (d) and (e).

10:36-1.6 Level III definition, criteria and program structure

(a) Programming is provided both on-ward and off-ward with an increasing emphasis upon off-ward programming. The frequency, duration and types of unescorted off-ward activities is determined by the treatment team. The resident's participation in each scheduled off-ward program will be defined by time accountability and the clinical relevance of the program. Participation in unescorted off-ward activities can and should be implemented incrementally. Brief home visits are permitted at this level if the family is capable and willing to provide the level of supervision considered necessary by the treatment team in consideration of the clinical needs of the patient.

(b) Mental condition criteria include, but are not limited to:

1. Absence of psychotic or mood disordered symptoms, or if chronic residual symptoms are still present, does not act in response to them;
2. Oriented and aware of surroundings;
3. Cooperative with established plan and schedule of activities;
4. Appropriate on and off ward behavior resulting in no precautions for a certain number of day/weeks (to be set by treatment team);
5. Minimal elopement/walkaway risk;
6. Able to control impulses except when severely stressed; and
7. If recent behavior indicates substance abuse risk, is willing to agree to search upon return if team determines necessary and documents in master treatment plan.

(c) In addition to risk factors associated with Levels I and II, additional risk factors for Level III related to potential harm to other patients from unsupervised contact on the grounds of the hospital include:

1. Past history of anti-social behavior; and
2. Past history of sexual impulse disorders.

(d) Physical condition criteria include:

1. Ambulatory patients and non-ambulatory patients who have demonstrated an ability to utilize their adaptive equipment safely.

2. Medical problems requiring only intermittent evaluation by ward staff.

(e) The patient's responsible and cooperative participation in both on-ward and escorted off-ward activities should result in the team encouraging more independent activity by gradually increasing the number of unescorted off-ward programs. These programs and activities generally include centralized (off-ward) social and rehabilitative programs and activities. Level III patients will generally require periodic observation by staff to ensure program participation.

Amended by R.1993 d.58, effective February 1, 1993.

See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).

In (b): added "but are not limited to" to clarify listing of medical condition criteria.

Amended by R.1998 d.62, effective January 20, 1998.

See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).

Inserted new (c), and recodified existing (c) and (d) to (d) and (e).

10:36-1.7 Level IV definition, criteria and program structure

(a) Attendance and appropriate participation at any approved activity on-ward, off-ward, or off-grounds is expected through the self-initiated behavior of the patient, and is without staff escort. Determination of recommended programs and activities is the responsibility of the treatment team.

(b) Mental condition criteria include, but are not limited to:

1. No recent instances of substance abuse;
2. Oriented to and capable of utilizing community or transportation services;
3. Resident exhibits sound judgement under reasonable conditions; and
4. Resident exhibits accountability and responsibility through adherence to treatment plan program schedule.

(c) In addition to the risk factors associated with Levels I, II and III, additional risk factors for Level IV related to potential harm to the patient, to other patients and/or to the local community should he or she elope include:

1. Past history of alcohol and substance abuse or of treatment non-compliance; and
2. Past history of violence, threats towards identifiable third parties.

(d) Physical condition criteria include:

1. No physical/medical contraindications.

(e) Programming and activities at this level would be the least structured. While staff will evaluate the patient's behavior for compliance with the schedule, direct supervision will be decreased. Most often, community-based programs and activities (transitional programs, community day programs, community trips), as well as larger group activities, will be part of the individual's overall program at Level IV.

Amended by R.1993 d.58, effective February 1, 1993.
See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).

In (b): added "but are not limited to" to clarify listing of medical condition criteria.

Amended by R.1998 d.62, effective January 20, 1998.
See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).

Inserted new (c), and recodified existing (c) and (d) to (d) and (e).

ation of the clinical review process because they possess the potential for serious violent behavior.

4. If a patient's criminal charges have been dismissed or NGRI or IST status removed, their special status designation shall be removed unless they meet the standard in (c)3 above.

Amended by R.1993 d.58, effective February 1, 1993.

See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).

In (b): added text to clarify responsibility of hospital staff.

Amended by R.1998 d.62, effective January 20, 1998.

See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).

In (b), added "and to insure that hospital staff conduct an appropriate risk/benefit assessment balancing the patient's need for effective treatment and the safety needs of all parties when special status patients are given privileges" at the end of the first sentence, and added a reference to the Patient Bill of Rights at the end of the second sentence.

SUBCHAPTER 2. CLINICAL REVIEW PROCEDURES FOR SPECIAL STATUS PATIENTS

10:36-2.1 Statement, purpose and scope

(a) The Division of Mental Health Services of the Department of Human Services recognizes that the management of some patients within our hospital system requires a more comprehensive and complete evaluation of the clinical, judicial and administrative factors relevant to treatment plan development and implementation.

(b) The purpose of this procedure is to establish a mechanism which provides a comprehensive review of the clinical treatment and management of special status patients through insuring appropriate treatment interventions, levels of supervision and planning at the time of movement to less restrictive settings, decrease of structures and security, or discharge, and to insure that hospital staff conduct an appropriate risk/benefit assessment balancing the patient's need for effective treatment and the safety needs of all parties when special status patients are given privileges. However, nothing in these procedures is intended to alter the responsibility of hospital staff to comply with the provisions of valid court orders regarding specific patients and with the Patient Bill of Rights at N.J.S.A. 30:4-24.2.

(c) Special status patients are those who:

1. Have been charged with or are convicted of one of the following offenses: murder, manslaughter, sexual assault, criminal sexual contact, first degree robbery, aggravated assault, aggravated arson, weapons offense or kidnapping.
2. Have been adjudicated "Not Guilty By Reason of Insanity" or "Incompetent to Stand Trial" for one of the above enumerated crimes.
3. Have been determined by their treatment team to be clinically and behaviorally appropriate for consider-

10:36-2.2 Committee composition

(a) The Clinical Director/Medical Director will appoint the committee members and will designate a Committee Chairperson. The committee shall, at a minimum, include a psychiatrist.

(b) The composition of the Special Status Patient Clinical Review Committee (also known as Clinical Review Committee) should include, but need not be limited to: the Medical Director or Chief of Psychiatry, the Director of Psychology, the Director of Nursing Services, the Director of Rehabilitation Services, and the Director of Social Services. These individuals may appoint designees to the committee who are of sufficient experience to appropriately review these matters. Such designees shall not endorse recommendations they may have already made as a treatment team member.

Amended by R.1993 d.58, effective February 1, 1993.

See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).

Revised to add flexibility to the composition of the Clinical Review Committee.

Amended by R.1998 d.62, effective January 20, 1998.

See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).

In (a), substituted a reference to the Clinical Director/Medical Director for a reference to the Clinical Director; and in (b), inserted a reference to the Clinical Review Committee, added "who are of sufficient experience to appropriately review these matters" at the end of the second sentence, and added a third sentence.

10:36-2.3 Procedures

(a) Special status patients will be invited, and even expected, to attend their own treatment team meetings and thus involved in the privileging recommendation process from the start.

(b) The treatment team will prepare and forward the information concerning the patient whose status requires clinical review to the Committee Chairperson/designee. Whenever a privileging recommendation is being forwarded to the committee and the special status patient has an opinion that differs from his or her treatment team, either a statement by the patient or a summary of the patient's

opinion must be included in the information forwarded to the committee.

(c) The Committee Chairperson may designate a committee member to interview the patient prior to the committee review whenever, in his or her judgement, the situation warrants. One of the special status patient's treatment team members familiar with the current privilege recommendation must meet with the committee during their review process.

(d) The committee will meet and review the team proposals within three working days of receipt of the information.

(e) The Committee Chairperson or designee will forward the committee's recommendations in response to the team proposals to the Clinical Director within two working days.

(f) The Clinical Director/Medical Director will review the committee recommendations regarding endorsement of the team proposals and respond to the Chairperson within two working days. The Clinical Director/Medical Director may either endorse the committee recommendation, withhold endorsement or require additional information prior to making an endorsement decision. One of the above responses must be made to the Committee Chairperson within two working days. All recommendations must be endorsed by the Clinical Director/Medical Director prior to implementation.

(g) The Clinical Director/Medical Director will periodically attend Clinical Review Committee meetings in his or her institution in order to monitor the thoroughness and quality of clinical recommendations and compliance with this policy and procedure. Additionally, the Quality Assurance Department within each hospital shall also monitor the hospital's compliance with the rules within this subchapter.

(h) Whenever a hospital treatment team and the hospital's Clinical Review Committee recommend the granting of a privilege increase to Level III or Level IV or the discharging of any patient subject to the hospital's Clinical Review Committee's review procedures, the Endorsement Review Forms regarding those privilege and discharge reviews shall be forwarded to the Division Medical Director and his or her designee by the Clinical Review Committee Coordinator to ensure that an appropriate risk/benefit assessment balancing the patient's need for effective treatment and the safety needs of all parties has been performed. Final Division Medical Director action shall be communicated to hospital staff no more than five working days after receipt of the hospital Clinical/Medical Director approval.

(i) Whenever N.J.S.A. 30:4-27.17b requires written notice to a county prosecutor or deputy attorney general who participated in a patient's commitment, a designated hospital staff member shall notify the appropriate individual in accordance with that statutory provision.

Amended by R.1993 d.58, effective February 1, 1993.
See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).

Added new subsection (g).

Amended by R.1998 d.62, effective January 20, 1998.
See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).

In (f) and (g), substituted references to the Clinical Director/Medical Director for references to the Clinical Director; and added (h) and (i).

10:36-2.4 Clinical Review Committee Coordinator

(a) Each hospital will designate a staff person to be responsible for coordination of all activities relative to the functioning of the Clinical Review Committee. The responsibilities of the coordinator will include:

1. Consultation with treatment teams regarding preparation of information to be submitted to the Clinical Review Committee.
2. Maintaining files on all cases presented to the Clinical Review Committee.
3. Functioning as executive secretary to the Clinical Review Committee (i.e. recording, distributing and filing of minutes).
4. Responsible for the coordination of information flow among treatment teams, Clinical Review Committees, hospital administration and Central Office regarding special or extenuating circumstances, current or pending legislation, etc., relative to cases under consideration of the Clinical Review Committee.

10:36-2.5 (Reserved)

Repealed by R.1993 d.58, effective February 1, 1993.
See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).

Section was "Quality assurance activities."

SUBCHAPTER 3. TRANSFERS OF INVOLUNTARILY COMMITTED PATIENTS BETWEEN STATE PSYCHIATRIC FACILITIES

10:36-3.1 Purpose

The purpose of this subchapter is to define the factors to be used by State psychiatric facility staff in evaluating the need for inter-hospital transfers among the facilities cited in N.J.A.C. 10:36-3.2. The subchapter also delineates the procedures related to such transfers.

10:36-3.2 Scope

(a) The rules of this subchapter apply in all instances to involuntarily committed patients who are residing at and being considered for transfer to any of the following facilities specified in N.J.S.A. 30:4-160:

1. Greystone Park Psychiatric Hospital;
2. Trenton Psychiatric Hospital;

3. Marlboro Psychiatric Hospital;
4. Ancora Psychiatric Hospital;
5. The Forensic Psychiatric Hospital; and
6. The Senator Garrett W. Hagedorn Gero-Psychiatric Hospital.

(b) Prior to a patient's initial commitment hearing, only emergency transfers may be made. Postponement of such hearings beyond 20 days after admission may not be requested by hospital staff due to the emergency transfer of a patient.

Amended by R.1991 d.453, effective September 3, 1991.

See: 23 N.J.R. 1652(a), 23 N.J.R. 2637(a).

Added new subsection (b).

Amended by R.1998 d.62, effective January 20, 1998.

See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).

In (a)6, substituted "Gero-Psychiatric Hospital" for "Center for Geriatrics".

10:36-3.3 Factors

(a) Any of the factors described below may serve as a basis for the transfer of a patient from and to any facility cited in N.J.A.C. 10:36-3.2:

1. To place him or her in closer proximity to family members;
 - i. If a patient and his or her family members disagree on a transfer request based on proximity to family members, a clinical determination shall be made by the hospital staff based solely on the clinical best interest of the patient;
2. To place the patient in the appropriate hospital according to the patient's residence (catchment area);
3. To provide a new clinical and personal relationship in exceptional circumstances when a treatment impasse has developed over a sustained period of time;
4. To provide greater or lesser clinical structure or security;
5. To participate in a specialized psychiatric service that is offered at another hospital or in the community that is more accessible from the receiving hospital;
6. As a result of a change in legal status;
7. To spare patients the consequences of overcrowding at a specific mental health facility;
8. In response to natural catastrophes, fires, or other life-safety concerns which necessitate transfer; and
9. As a consequence of inter-regional consolidation of services.

(b) A patient's stated preference for treatment at a particular State psychiatric facility shall always be a relevant consideration in transfer decisions. Transfers over the objection of a patient are permitted, however, when a clinical

determination has concluded that the transfer is in the transferee's clinical best interest or necessary for the safety of other patients or administratively necessary due to a factor listed in (a) above. A transfer is permitted only when, in the judgment of the treatment team, the transfer's permissible purpose outweighs any potential harm to the patient from the transfer.

1. When a transferring facility is capable of meeting the clinical or administrative purpose for a proposed transfer as contained in the factors at (a) above, an objecting patient shall not be transferred.

2. Transfers shall be the least restrictive available treatment alternative necessary to achieve the purposes of the transfer request as contained in the factors at (a) above.

Amended by R.1991 d.453, effective September 3, 1991.

See: 23 N.J.R. 1652(a), 23 N.J.R. 2637(a).

Added new (a)1i and subsection (b).

10:36-3.4 General procedures

(a) A written request for transfer, supported by a statement of the factors justifying the request, shall be forwarded from the chief executive officer (CEO) or designee of the sending institution to the chief executive officer or designee of the receiving institution. Transfers shall be subject to clinical review. A copy of that request is to be sent to the Assistant Director, Office of Quality Assurance.

(b) Transfers occurring as a result of overcrowding, life-safety concerns, natural catastrophes, treatment impasse or consolidation of services shall require the approval of the Director, Division of Mental Health Services.

(c) The following procedures shall be followed in cases of non-emergent transfers:

1. The designee of the sending institution must consult with the designee of the receiving institution. If they agree to the transfer, they will arrange for a specific date and time for the transfer to occur.

2. Institutional staff should actively promote resident input into non-emergency transfer decisions.

3. Both the residents scheduled to be transferred to a different facility and their family should be notified by institutional staff in advance of the transfer plans and the reason for the transfer plan.

4. It is the responsibility of the institution initiating the transaction to make arrangements for transfers, including arrangements for transporting the patient from one facility to the other.

5. If the designees do not agree on the transfer, the matter shall be referred to the CEO's of the respective institution for resolution.

6. If the chief executive officers do not agree, the case is to be referred for resolution to the appropriate regional

Assistant Directors, Division of Mental Health Services, who may, in making their decision, request clinical and technical input from central office staff. Resolution, in instances of continuing disagreement, rests with the Division Director or the Director's designee.

7. All transfer requests are to be handled in a timely manner.

(d) The following procedures shall be followed in cases of emergency transfers:

1. Emergency shall be defined, for the purposes of this subchapter, as imminent danger of serious bodily harm to self or others which less restrictive available treatment alternatives other than transfer cannot adequately address. Only these factors in N.J.A.C. 10:36-3.3(a)4 or 8 may serve as the basis for an emergency transfer.

2. The family and attorney of residents being transferred shall be notified by institutional staff of the transfer and the reason for the transfer as soon as possible after the transfer decision has been made.

3. The designee or, when unavailable, the administratively responsible person of the sending institution must contact directly his or her counterpart at the receiving institution and transmit verbally the factors supporting the transfer, as well as the reasons for the emergent nature of the transfer. This information must be submitted, in writing, to the receiving institution by close of the first regular business day after the transfer.

4. If, after transfer, the CEO of the receiving institution objects to an emergency transfer, he or she may review the case with the CEO of the sending institution. If agreement cannot be reached, it is referred to the Assistant Director of the receiving region.

5. That Assistant Director shall consult with his or her counterpart from the sending region to resolve the issue.

6. If agreement cannot be reached by the Assistant Directors, the issue shall be referred for resolution to the Director or the Director's designee.

Amended by R.1991 d.453, effective September 3, 1991.

See: 23 N.J.R. 1652(a), 23 N.J.R. 2637(a).

In (b): added "treatment impasse" to list of situations.

Revised subsection (d)1.

Deleted subsection (d)4 on "clinical urgency," recodifying existing 5.-7. as 4.-6. with no change in text.

Amended by R.1998 d.62, effective January 20, 1998.

See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).

In (b), deleted "and Hospitals" and added "Services"; and in (c)6, deleted "and Hospitals" and added "Services".

10:36-3.5 Procedures when patients object to transfer

(a) Regarding non-emergency transfers, the following apply:

1. At least seven days prior to the transfer date, patients and their attorneys shall receive notice of proposed non-emergency transfers and their procedural rights in this chapter.

2. If a patient objects to such a transfer, he or she shall be provided an opportunity to state the basis for his or her objection, and present any relevant facts including statements by other individuals, with or through a representative if so desired, before an individual who is not a member of the treatment team seeking transfer. The hospital's Clinical Director/Medical Director shall designate this individual, who may be a member of the office of the hospital's clinical director or other hospital staff member capable of providing an independent review of the need for the proposed transfer.

3. The individual who reviews the proposed transfer shall have the authority to approve or disapprove the proposed transfer.

(b) Regarding emergency transfers, the following apply:

1. In an emergency as defined at N.J.A.C. 10:36-3.4(a)1, a patient may be transferred in accordance with procedures outlined at N.J.A.C. 10:36-3.4.

2. If a patient or a representative of the patient objects to such a transfer, a designee of the Division Director shall review the basis for the transfer, including providing the patient or his or her representative with an opportunity to state the basis for their objection and present any relevant facts or statements. The designee shall not be a member of the patient's treatment team at either the sending or receiving hospital and shall provide an independent review of the need for the proposed transfer.

3. The individual who reviews the proposed transfer shall have the authority to approve or disapprove the proposed transfer.

New Rule, R.1991 d.453, effective September 3, 1991.

See: 23 N.J.R. 1652(a), 23 N.J.R. 2637(a).

Amended by R.1998 d.62, effective January 20, 1998.

See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).

In (a)2, substituted a reference to the Clinical Director/Medical Director for a reference to the Clinical Director.