Government of **Western Australia**
Department of **Health**

Admission Policy Reference Manual 2020-21

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Contents

1. Introduction

The Admission Policy Reference Manual has been developed to assist the Western Australian (WA) health system to count and classify admitted care activity correctly. This ensures standardisation of inpatient data across the health sector. This Manual is a related document under the MP 0058/17 *Admission Policy.*

This manual is revised annually, with reference to national policy and legislation, other jurisdictions, and stakeholder consultation to make improvements and ensure relevance and currency.

This manual should be read in conjunction with the MP 0058/17 *Admission Policy* and other related documents and supporting information, for which links are provided in Appendix 1.

How to use this Reference Manual

This Reference Manual must be read in its entirety to understand the rules governing the relevant admitted activity reporting requirements. The manual is set out in sections:

- Section 2, Admitted and non-admitted care definitions
- Section 3 Admitted care requirements
- Section 4 - 9, Admission Criteria and reporting
- Section 10, Definitions
- Section 11, Appendices.

Where reference to another information source is made, a hyperlink is provided in Appendix 1: Reference manuals and supporting information.

Submit a query

For all queries regarding this manual please email: RoyalSt.PSPInfoManagement@health.wa.gov.au

2. Admitted vs non-admitted care

All activity must be recorded by Health Service Providers (HSPs) regardless of whether it is to be reported for Activity Based Funding (ABF) purposes or not. To ensure data integrity for a wide range of uses, only inpatient activity that meets the requirements outlined in this manual must be recorded as admitted care.

2.1. Admitted care

Admitted care is care which qualifies for admission as set out in Section 3.1 and meets admission criteria specific to same day or overnight admission and the applicable care type. The patient must undergo the hospital's documented admission process Section 3.3 to receive inpatient treatment and/or care for a period of time.

Admitted care may also be referred to as inpatient care and is provided in a hospital inpatient ward or unit, or in the patient's place of residence under specific admission criteria within hospital in the home programs.

While a patient may meet the criteria to be eligible for admission, this does not mean that this activity is to be automatically recorded as admitted care. It may be recorded as non-admitted care.

An episode of care must not be recorded as admitted if the care is provided entirely in a non-admitted setting such as an outpatient clinic, Emergency Department (ED) or other non-admitted service.

Admission to a virtual or administrative ward, with very few exceptions, is not valid admitted care.

Stillborn babies and patients who are dead on arrival to the hospital with no active resuscitation cannot be recorded as admitted care.

2.2. Non-admitted care

Non-admitted care is defined as care provided to patients who do not meet the above requirements of admitted care. For example, care provided in the following locations:

- Emergency Departments
- Outpatient clinics
- Community based clinics
- Patient's home
- Service areas other than an inpatient ward or unit.

It may be more convenient, less intrusive to the patient, and a better use of resources to provide treatment in a non-admitted setting. Non-admitted care includes:

- patients attending for a procedure on the non-admitted Type C procedures list, without justification for admission documented by the treating medical practitioner in the medical record. See Section 4.1.2
- patients who receive their care within an Emergency Department
- care provided by hospital staff outside of the hospital, for example community or outreach services
- care provided in the patient's home (except hospital in the home - see Section 6.1)
- patients who receive their care during an outpatient or other non-admitted service event

An outpatient attendance during admission (at the same hospital) is to be recorded but will not be reported for ABF purposes. Except for an ED attendance, an episode of care cannot be double counted and reported as both an admission and a non-admitted service event for a single attendance at the same hospital.

3. Requirements for admitted care

3.1. Qualification for admission

Each of the following must be met to qualify for admission:

i. The decision to admit follows a clinical assessment that a patient requires same day/short stay or overnight inpatient (admitted) care, which:

- Meets the definition of admitted care in section 2.1 (2.1 Admitted care)
- Is documented in the patient's medical record as per Section 3.3
- Is authorised by a medical, dental, nurse or midwife practitioner, credentialled to admit the patient under their care and management.

ii. The patient must meet at least one of the following qualifications:

- The patient requires expert clinical management and facilities that are only available in an inpatient ward or unit (see Appendix 2 for information relating to intensity of service and severity of illness that may warrant inpatient admission).
- The patient requires at least daily assessment of their medication needs.
- The patient is aged nine days or less.
- There is a legal requirement or social circumstances necessitating admission, see Section 3.2.
- The patient requires management of labour and/or delivery.
- The patient has died after admission to an inpatient ward or unit.

iii. The care meets the criteria for same day or overnight care (see Section 4).

iv. The care provided must also meet the admission criteria for the applicable care type (see Section 5).

Due to national reporting standards, a patient must not have more than one planned formal or statistical admitted episode of care reported on the same day at the same hospital. Only one patient day may occur per 24-hour period from 00:00 - 23:59.

All elective procedures performed in the WA health system must meet an identified clinical need to improve the health of the patient. A list of excluded procedures is provided in the Elective Surgery Access and Waiting List Management Policy.

3.2. Other Circumstances necessitating admission

There may be exceptional circumstances under which a decision to admit is made to ensure a person's welfare or there may be legal or social factors such as:

- child at risk (for example, a child under state protection, suspected child abuse)
- adult at risk (for example, domestic abuse or inadequate level of social support to safely leave the hospital)
- short-term unavailability of the patient's usual carer (care type: maintenance-respite)

Exceptional cases which do not meet admission criteria, but which the treating medical practitioner determines require admission, must have the reason or circumstances requiring admission documented in the patient's medical record and the care must be provided in an inpatient ward or unit.

3.3. Documentation

All admissions must be supported by documentation and a record of treatment and/or care that includes:

- Administrative documentation (e.g. registration on the Patient Administration System and financial election forms).
- Documentation in the medical record by a Medical Practitioner or authorised clinician to evidence the provision of admitted care compliant with the requirements outlined in Section 2.1 admitted care:
    - decision to admit and time, and
    - the reason for admission, and
    - the intended clinical treatment plan for admitted care, and
    - factors/ exceptional patient circumstances contributing to the admission, and
    - conditions treated, and care provided, and
    - the time of discharge from hospital
- Specific documentation requirements of the admission category and care type.

3.4. Financial election

Patients must not be discharged and readmitted for the purposes of changing their financial election.

Refer to Section G24g of the National Health Reform Agreement and the WA Health Fees and Charges Manual.

4. Admission Categories

4.1. Same day admissions

Same day admissions occur when a patient is admitted and discharged on the same day. Short stay admissions which span midnight, but otherwise meet the medical criteria below, are included as 'same day' for the purposes of determining applicable admission criteria.

A same day admission must meet the definition of admitted care in Section 2.1 and qualify for admission as set out in Section 3.1.

Same day admissions are split into the following subcategories:

4.1.1. Same day admitted procedures

Admissions for a same day admitted procedure must meet both of the following criteria:

- The patient is admitted for the purpose of receiving at least one procedure listed on the WA health system Type B admitted procedure list.
    - This includes any procedure where general anaesthetic or intravenous/inhalation sedation is required, and all types of sedation by any route for patients <= 16 years of age.
- The patient must receive treatment on the same day.

Patients who have had a procedure completed during non-admitted care are not automatically eligible for admission.

A procedure provided in a non-admitted setting, is to be counted and classified within the relevant non-admitted classification group for that service.

Intravenous therapy is included as a same day admitted procedure, for the administration by intravenous infusion of a pharmacological agent as therapy for an established diagnosis, excluding the following:

- ancillary, preparatory and line maintenance procedures
- placement of an IV cannula or drug loading device only
- IV injections
- IV therapy as part of, or given at any time during, a same day non-admitted procedure (for example, IV contrast in radiological procedures or IV normal saline in diagnostic tests)
- administration of a pharmacological agent by other than infusion technique (e.g., subcutaneous, intramuscular, intradermal).

4.1.2. Same day non-admitted procedure exceptions

Procedures on the WA health system Type C same day non-admitted procedure list do not normally require admitted care and are provided as non-admitted care.

An admission for the purposes of providing a same day non-admitted procedure may only occur if:

- there are exceptional medical or patient circumstances that require an altered treatment protocol for the procedure, resulting in an increased level of care and clinical management only available as an inpatient admission.
- the exceptional circumstances will be supported and confirmed by the documented evidence of care provided in the medical record.
- the treating medical practitioner documents suitable evidence to justify the admission in the medical record and/or completes a Type C certification form for admission for a non-admitted procedure. The documentation must:
    - describe the exceptional medical or patient circumstances that require admitted care.
    - describe how the circumstances would compromise accepted medical practice if not provided as admitted care
    - be completed and signed by a medical practitioner.

Certification must be specific to the individual patient and document a condition or circumstance that is present at the time of the decision to admit. Provision of a diagnosis and proposed treatment alone, or the use of generic, non-patient-specific certification is not acceptable.

Please refer to the *Private Health Insurance (Benefit Requirements) Rules 2011* for certification requirements for private patients.

The fact that a procedure on the non-admitted procedure list is undertaken in an operating room, inpatient ward or same day care unit does not automatically make the activity eligible to be counted as admitted care.

Audits may be conducted for the purpose of ensuring that documentation is provided that justifies the treatment of such patients, and is specific to the individual patient, provided in an admitted patient setting.

4.1.3. Procedure code lists

Australian Classification of Health Interventions (ACHI) codes have been allocated to one of the procedure lists. The lists do not cover all ACHI codes or all Medicare Benefits Schedule (MBS) codes. The lists also indicate inclusions and exclusions applicable to specific procedures and/or circumstances.

The admitted Type B procedures list contains a list of ACHI codes relating to a range of procedural and surgical interventions that would qualify for admitted care. This list does not apply to patients intended to be treated on an overnight/multi-day basis.

The non-admitted Type C procedure list contains a list of ACHI codes relating to a range of minor procedures. Patients who receive a procedure on this list will be either; treated on a non-admitted basis or meet the same day non-admitted procedure exceptions.

Health Service Providers and Contracted Health Entities seeking reclassification of a specific non-admitted procedure may apply by email to: RoyalSt.PSPInfoManagement@health.wa.gov.au.

4.1.4. Same day medical treatment

The same day medical category excludes booked procedures. Admissions for same day medical treatment must meet at least one of the following three criteria with documented evidence in the patient's medical record of this care having been provided to the patient:

1. A minimum of four hours of continuous active management is provided to the patient, in the form of one or more of the following:
    - Regular observations or monitoring of vital or neurological signs undertaken on a repeated and periodic basis such as continuous monitoring via electrocardiogram (ECG) or similar technologies. Routine continuous blood pressure or pulse monitoring is an insufficient level of care for this purpose.
    - Continuous active treatment by clinical staff as prescribed by a medical practitioner.
    - The patient requires an essential period of mental health observation, assessment and management.
2. There is a legal requirement or social circumstances placing the patient at risk necessitating admission. See Section 3.2 for other circumstances necessitating admission.
3. The patient requires life sustaining intensive care only available in an inpatient ward or unit.

For emergency department admissions see also Section 4.1.5 same day medical admissions.

4.1.5. Emergency Department Short Stay Admissions

Patients admitted from the Emergency Department (ED) to a short stay unit (SSU) with the intention of being discharged on that same day are categorised as same day admissions. This includes patients whose admitted episode spans midnight, but who otherwise would have been regarded as an intended short stay admission, for example: admission at 20:00 hours with discharge at 01:00 hours.

ED short stay unit

The purpose of an ED short stay unit is to:

- provide evidence-based, high-quality, intensive short-term observation and treatment for selected ED patients
- reduce inappropriate admissions to inpatient beds and associated healthcare costs
- improve patient flow by providing timely assessments and treatment, thereby allowing patient discharge in the shortest, clinically appropriate time.

The Commonwealth and states and territories have agreed to implement the following definition of an ED short stay unit, or equivalent, with the following characteristics[1]:

- are designated and designed for the short-term treatment, observation, assessment and reassessment of patients initially triaged and assessed in the ED
- have specific admission and discharge criteria and procedures
- are designed for short term stays no longer than 24 hours
- are physically separate from the ED acute assessment area
- have a static number of available treatment spaces with oxygen, suction and patient ablution facilities; and
- are not a temporary ED overflow area, nor used to keep patients solely awaiting an inpatient bed, nor awaiting treatment in the ED.

For use of virtual wards in ED, please refer to Section 6.3.

ED short stay admission criteria

The following requirements apply to patients attending the ED that are admitted to the ED short stay unit or equivalent, including transit/discharge wards.

Admissions from the ED to a short stay unit must meet:

- definition of admitted care in Section 2.1, and
- qualification for admission as set out in Section 3.1, and
- the criteria for one of the same day admission categories Sections 5.1-5.3

For patients with social or legal circumstances necessitating admission see Section 3.2 Other circumstances necessitating admission.

Refer to Appendix 3 quick reference chart to assist in determining the applicable same day admission criteria.

Same day procedures

In addition to the same day admission criteria Section 4.4.1, a patient may be admitted where a same day admitted procedure commenced in ED and continues in the SSU, for example:

- an IV infusion that commenced in ED and is continuing in a SSU
- recovery from anaesthetic or sedation provided with a procedure in ED.

Same day medical admissions

In addition to the same day admission criteria Section 4.1.4, it is recommended that health services develop local processes for determining that a patient has met these criteria for admission to the short stay unit. For example, guidelines for admission of common emergency department presentations and how this care constitutes continuous active management. These guidelines should be consistent with established clinical pathways, protocols or accepted clinical practice.

[1] As per clause C48 of the National Health Reform Agreement

To allow for delays in availability of a short stay unit bed, where the patient is ready for admission, the calculation of four hours continuous active management may include the time continuous active management commenced in ED, with the following qualifications:

- calculation of four hours may only commence after the time of the decision to admit as documented in the medical record and the ED information system.
- the calculation of four hours duration can include continuous active management provided within the ED after the time of the decision to admit.
- admitted care must be provided to the patient in the SSU (not only in ED), with continuous active management continuing after the patient is admitted. Admitted care provided entirely in the ED must be recorded as non-admitted care only.
- the patient must arrive in the SSU with a documented admitted care management plan.
- the admission time is recorded as the time the patient physically leaves the clinical area of the ED
- the recorded admitted care episode commences once the patient has left the ED[2] not the time of the decision to admit.
- not applicable to patients who are awaiting transfer to another health service for their ongoing care or admission.

Exclusions:

An admission must not be recorded for the following reasons:

- where the entirety of care occurs within the ED (these are non-admitted patients)
- for no other reason but the patient remaining in the ED for longer than four hours
- to avoid breaching a measured performance threshold target
- where the patient has been provided with clinical intervention/s for their condition and requires time to rest prior to discharge home
- where the patient has a length of stay of more than four hours, primarily consisting of waiting for:
    - allocation of an inpatient bed
    - review by a specialist medical practitioner
    - diagnostic tests e.g. medical imaging or results of diagnostic tests
    - equipment or medications
    - transport home or transfer to another health care facility:
        - patients awaiting transfer to another hospital should only be admitted if their condition requires care that meets the same day admission criteria.

[2] Treatment provided entirely in ED is not reported in the clinical coding for the inpatient admission.

4.1.6. Maternal Fetal Assessment Unit short stay admissions

A Maternal Fetal Assessment Unit (MFAU) is an Immediate Care Clinic - Non-admitted service, similar to an Emergency Department attendance for the following purpose:

- To allow a pregnancy to be monitored outside normal clinic appointments.
- To detect any abnormalities that may arise between antenatal clinic appointments.
- To identify complications of pregnancy and initiate a change in management.

An attendance at the MFAU may be planned or unplanned and usually consists of an initial “triage” midwife assessment and prioritisation of care.

In addition to the provision of non-admitted assessment and treatment (clinic), the MFAU may also have a co-located short stay inpatient ward. If there is a need for more intensive care and/or a high risk necessitating inpatient care the patient may be admitted to the MFAU short stay unit (SSU) directly or after assessment in the clinic.

Health services are to:

- Develop protocols to inform ‘triage’ of patients presenting to the MFAU in determining their non-admitted or admitted care pathway.
- Record non-admitted care provided in the MFAU as Tier 2 outpatient activity.
- Only admit patients to MFAU short stay unit who meet the admission criteria for same day inpatient care.

Admission Criteria

Admissions to the MFAU short stay unit must:

- Meet the definition of admitted care in Section 2.1, and
- Qualify for admission as set out in Section 3.1, and
- Meet the admission criteria for one of the same day admission categories Sections 5.1-5.3 , and
- In addition to the documentation requirements in Section 3.3, ensure there is documentation to evidence:
  - the provision of admitted care that meets admission criteria, and
  - the decision to admit time, and
  - authorisation by a medical practitioner.

In addition to the same day medical admission criteria Section 4.1.4, it is recommended that health services develop local processes for determining that a patient has met the same day criteria for admission to the short stay unit. For example, guidelines for admission of common obstetric presentations and how this care constitutes continuous active management. These guidelines should be consistent with established clinical pathways, protocols or accepted clinical practice.

Patient's with social or legal circumstances necessitating admission, e.g. domestic violence risk, qualify for admitted care. See Section 3.2 Other Circumstances necessitating admission.

Planned Readmissions

Where a patient is discharged from the MFAU SSU with the intention that they will return for admission within 7 days, for continuation of the current care (e.g. once labour has progressed for induction of labour or for elective caesarean section) they must not be discharged but placed on leave and returned from leave as per Section 9.2 Planned leave. This admitted care episode becomes and overnight admission.

4.2. Overnight admissions

An overnight admission occurs when it is intended that a patient will be admitted for a minimum of one night. This includes patients who are initially admitted as an unplanned (not planned) same day admission and sent home on leave to return for surgery. See Section 9.2 planned leave.

An overnight admission must meet:

- the definition of admitted care in Section 2.1
- the requirements for admitted care as set out in Section 3.
- the admission criteria for the applicable care type in Section 5

Exclusions:

- patients' whose treatment is expected to be concluded on the same day
- not applicable to planned (elective) same day admissions. For example, a patient cannot be admitted (administratively) and sent on leave for a planned same day procedure/treatment scheduled for following day.
- ED short stay admissions whose admitted episode spans midnight, but who otherwise would have been regarded as an intended same day admission (for example, admission at 21:00 hours with anticipation of discharge at 02:00 hours)

5. Care types

An episode of care refers to a phase of treatment and is designed to reflect the overall nature of a clinical service, the changing diagnosis and/or primary clinical intent and purpose of care. The care type of an episode of care is determined and authorised by the medical practitioner who will be responsible for the management of the patient's care.

Correct assignment of care type for admitted patient episodes will ensure that each episode is classified appropriately for Activity Based Funding (ABF). This is vital as the classification used will also determine how the episode is reported, weighted, costed and funded.

An overnight patient may receive more than one type of care during a period of hospitalisation. In this case the period of hospitalisation is broken into episodes of care, one for each type of care.

The medical practitioner responsible for the management of care may not necessarily be located in the same facility as the patient. In these circumstances, a medical practitioner at the patient's location may also have a role in the care of the patient. The expertise of this medical practitioner does not affect the assignment of care type.

Currently, there are ten care types in use:

- acute
- newborn
- mental health
- rehabilitation
- geriatric evaluation and management (GEM)
- psychogeriatric
- palliative
- maintenance
- organ procurement
- hospital boarder.

Residential aged care or flexible care may be recorded for Health Service Provider's purposes but not reported as inpatient care to the Hospital Morbidity Data Collection (HMDC). If the aged care or flexible care resident requires hospitalisation for admitted care, within the same hospital, it must be treated as a formal acute care type admission using home as the transferring medical facility.

Although there are ten different care types, not all hospitals are equipped or approved to deliver the program of care indicated by the care type.

Care type classification

All admitted episodes of care are clinically coded using the following classifications:

- The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)
- The Australian Classification of Health Interventions (ACHI).

Admitted episodes of care are grouped to the following casemix classification systems:

- Acute and newborn care: Australian Refined Diagnosis Related Groups (AR-DRGs) derived from ICD-10-AM and ACHI codes and other data items.
- Subacute and maintenance care: Australian National Subacute and Non-Acute Patient (AN-SNAP) classification, which requires the use of specialised clinical assessment tools to report phase of care, assessment of functional impairments, age, and other measures.
- Mental health care: Australian Mental Health Care Classification (AMHCC), which requires the phase of care and relevant clinical measures from the National Outcome Casemix Collection (NOCC) to be reported.

5.1. Care type changes

A patient's care type is changed when the focus of clinical care provided meets the admission criteria for a different type of care. The care type of the new episode of care is determined and authorised by the medical practitioner, who will be responsible for, or informing, the management of the new type of care for the patient.

To change a patient's care type, a new episode of care is recorded by creating a statistical discharge and admission. For example, the patient is discharged and then readmitted to the same health service with a different care type. This may only occur once per day, excluding the posthumous organ procurement care type. See also Section 8.2 statistical discharge.

If a patient's condition deteriorates on the day their care type was changed and requires a change back to acute care type, the new episode must be cancelled, and the previous acute care episode reinstated.

A patient's care type cannot be changed on the day of formal admission or discharge as only one admitted care episode per day can be reported. If it is determined that the focus of clinical care requires a change of care type on the day of admission, the new care type must be applied to a single admission for the day. See also Section 3 requirements for admitted care.

A reduction in the intensity of acute care does not trigger a change to a sub-acute care type if the patient is not receiving care that meets the admission criteria for sub-acute care. It is therefore essential that any care type change reflects a clear change in the primary clinical purpose or treatment goal of care provided.

The care type allocated should not reflect the care that is intended for the patient to receive at some time in the future when, for example, another service takes over care

of the patient or when the patient is moved to a different ward or health service.

Change of care type[3] by statistical discharge must not occur:

- on the day of formal admission or discharge
- for a change in location without a change in the primary clinical purpose of care
- when the intensity of treatment or resource utilisation changes but the primary clinical purpose or treatment goal does not change. For example, a temporary/short interruption to the current treatment plan due to a change in patient condition that:
  - is inherent to the current diagnosis/condition being treated, and/or
  - does not require management by a different specialist care type medical practitioner.
- for a same day procedure/ treatment with planned return
- for a non-admitted care attendance for example, emergency department or outpatient
- for the recovery (mobilisation) period of an acute episode prior to discharge
- for any waiting period before the intended new type of care commences, as this is not in itself a new or separate episode of care
- pending transfer to another hospital for a change in type of care
- for a patient seen by the psychiatric consultation liaison or psychiatric specialist medical practitioner, when there is no change in the primary clinical purpose of admitted care
- who community mental health care plan for follow-up care on the day of discharge for a specialist medical practitioner consultation only
- to correct the incorrect assignment of a care type
- based on documentation in the medical record that does not meet the requirements below
- for transfers to HITH where there is no change in the primary clinical purpose of care
- from newborn to acute care type.

Documentation

The care type to which the episode is allocated must be evidenced by documentation in the patient medical record, i.e. if an episode is changed to the rehabilitation care type, there must be evidence in the medical record that rehabilitation care, meeting the admission criteria is provided.

[3] If the patient required ICU overnight care, it would be appropriate to change the care type.

To initiate a care type change, the following documentation must be completed in the medical record:

- actual time the care type change is effective
- name of the specialist medical practitioner authorising the change of care type
- authorisation by the medical practitioner who will be providing or informing the new type of care.
    - Initiation of the change may be delegated to a specialist clinician, but documentation must evidence the care type change was authorised by the specialist medical practitioner.

5.2. Acute care

An episode of acute care is one in which the principal clinical intent is to do one or more of the following:

- manage labour (obstetrics)
- cure illness or provide definitive treatment of injury
- perform surgery
- relieve symptoms of illness or injury
- reduce severity of illness or injury
- protect against exacerbation or complication of an illness or injury which could threaten life or normal function
- perform diagnostic or therapeutic procedures
- provide accommodation to a patient due to social circumstances (refer to Section 3.2).

Acute care excludes care which meets the definition of mental health care, see section 5.4.

Patients who remain in a public hospital bed with an acute care type after 35 days must have their care type assessed by a medical practitioner and the need for continuing acute hospital level of care documented in the patient's medical record. If assessed as no longer receiving acute care, there must be a change to the appropriate care type. See section 5.6 Maintenance care

5.2.1. Endorsed Privately Practicing Midwives

Acute admitted care to manage labour may can be provided under the care and management of an endorsed privately practicing midwife[4]. At the time of revising this manual, changes to patient administration systems and the Hospital Morbidity Data System (HMDS) are required to correctly capture the specialist medical practitioner on admission and separation data elements. Interim arrangements will require the notification of privately practicing midwife admissions for manual processing within the HMDS.

[4] MP0093/18 Access for Endorsed Midwives into Public Maternity Units Policy

Further information will be provided to health services as processes are confirmed.

Should the patient admitted under the care of the private midwife require management by an Obstetrics specialist medical practitioner, as a public patient; the patient is not to be discharged and re-admitted. The financial election and funding source must be altered to public for the current admission.

5.3. Newborn care

Newborn care is initiated when the patient is born in hospital or is nine days old or less at the time of admission. Newborn care continues until the care type changes or the patient is separated, noting:

- the day of birth is counted as zero days of age
- patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders
- patients who turn 10 days of age and require clinical care continue in a newborn episode of care until separated
- patients aged less than 10 days and not admitted at birth (for example, transferred from another hospital) are admitted with a newborn care type
- patients aged greater than 9 days not previously admitted (for example, transferred from another hospital) are either boarders or admitted with an acute care type and status of admitted patient
- within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day
- The newborn baby's qualified days are eligible for health insurance benefits purposes and the patient day count under the Australian Health Care Agreements. In this context, newborn qualified days are equivalent to acute days and may be denoted as such.

Refer to the HMDS Reference Manual for instruction on the reporting of data elements for newborn care only, current admission criteria and requirements are contained herein.

For a quick reference guide see Appendix 4 *Classification of Newborn Admitted Care Guide.*

5.3.1. Qualified newborn

A qualified newborn is a patient who is nine days old or less at the time of admission and meets at least one of the following criteria:

- the newborn requires intensive or special care and is admitted to a Level 2 Special Care Nursery (SCN2) or Neonatal Intensive Care (NICU) facility approved for the purpose of provision of that care[5]
- the newborn is the second or subsequent live born infant of a multiple birth

[5] Obstetrics and Neonatal Service Definitions, Appendix 2, WA Health Clinical Services Framework 2014-2024.

- the newborn remains in hospital after their mother is separated. For example, the mother becomes a boarder, is discharged home or transferred to another hospital
- the newborn is admitted to hospital without its mother.

A newborn patient day is recorded as unqualified if the infant does not meet any of the above criteria.

Newborn special care is care provided to a newborn suffering from illness or disability at birth or during the birth period, that requires specialist medical and nursing care.

Approved SCN 2 and NICU facility beds (cots) are licensed through the Licensing and Accreditation Regulatory Unit (LARU) and specified in the Clinical Services Framework -Neonatology.[3]

If remaining in or admitted to hospital without the mother, the newborn may be admitted to an inpatient ward/unit.

Excludes:

- Newborns admitted to a SCN or NICU that do not require intensive or special admitted care. For example, the newborn is in the SCN for routine observations, tests or other non- clinical care/reason.
- Newborns receiving treatment whilst rooming with the Mother without admission to a SCN or NICU.

The day on which a change in qualification status occurs is counted as a day of the new qualification status.

If there is more than one qualification status in a single day, the day is counted as a day of the final qualification status for that day.

5.3.2. Unqualified newborn

An unqualified newborn is a patient that is nine days old or less at the time of admission but does not meet any of the criteria in section 5.3.1 for a qualified newborn. As care provided to an unqualified newborn is considered inherent to the care of the Mother, unqualified days are not separately [6].

A newborn single birth child rooming with the mother is an unqualified newborn and cannot be recorded as qualified newborn (admitted patient) separate to the Mother. [7]

Unqualified newborns that remain in the hospital at ten days of age must be:

- changed to boarder care type (episode of care type change), or
- if requiring ongoing acute care, subjected to a change in qualification status to qualified newborn. In this case the newborn episode continues and every day of acute care from day 10 onwards is a qualified day.

[6] METeOR Newborn qualification status https://meteor.aihw.gov.au/content/index.phtml/itemId/327254
[7] Definition of 'patient' http://www. austlii. edu. au/au/legis/cth/consol_act/hia1973164/s3. html

5.4. Mental health care

Mental health care type (MHCT) is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient's mental disorder.

Admission criteria

The following requirements must be met for the admission to be recorded as a MHCT admitted care episode. Mental health care:

- is delivered under the management of, or regularly informed by, a medical practitioner with specialised expertise in mental health:
    - is usually initiated with a referral to a mental health specialist medical practitioner which may result in a consultation only, or they may also authorise a change in care type to Mental Health. If so, they will either assume management of the patient, or the clinical governance will not change, and they will inform the management of care through providing direct care or overseeing the provision of mental health care.
- is evidenced by an individualised formal mental health assessment or the implementation of a documented mental health plan during the episode of care:
    - A mental health plan comprises a series of documented and agreed initiatives or treatments (specifying program goals, actions, and timeframes) which have been established through consultation with the specialist medical practitioners and the client and/or carer. A copy of the mental health plan must be kept in the patient's medical record as evidence to inform audit.
- requires the mental health phase of care and relevant clinical measures to be recorded.
- Clinical measures refer to the clinician-rated measure from the National Outcome Casemix Collection (NOCC).

A patient transferred to another facility for same day electroconvulsive therapy (ECT) will not require additional clinical measures and phase of care to be recorded. The transferring medical facility is responsible for completion of the clinical measures not the facility providing the ECT.

Scope

Mental health care is provided in a specialist mental health inpatient service (psychiatric hospitals or designated mental health unit) where the clinical staff are equipped to provide the specialised care necessary to deliver optimal mental health care, and complete the necessary mental health assessments, plans and data collection.

Mental health care may include admission for psychiatric assessment only. For example, those patients detained pending psychiatric assessment under the *Mental Health Act 2014*.

An acute admitted patient may have a mental health principal diagnosis without assignment of a mental health care type.

The scope of the MHCT includes admitted patients meeting the MHCT admission criteria and receiving treatment in wards other than specialised mental health services.

Patients transferred to another health care facility for same day electroconvulsive therapy (ECT) are to be admitted as MHCT.

Mental health legal status

Patients with a MHCT must have a mental health legal status recorded. Patients admitted under an involuntary treatment order under the *Mental Health Act 2014*', must have their involuntary mental health legal status recorded irrespective of care type and location of care.

Information pertaining to mental health legal status is contained in the HMDS Reference Manual and the Mental Health Act.

Detained pending assessment

At the time of detainment for psychiatric assessment the mental health legal status is voluntary until, if required, a clinical decision is made to admit the patient as an involuntary patient under the *Mental Health Act 2014.*

Mental health Hospital in the Home (HITH)

Hospital in the Home rules apply to mental health HITH. Refer to Section 6.3

5.5. Subacute care

Subacute care is specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life. A person's functioning may relate to their whole body or a body part, the whole person in a social context, and to impairment of a body function or structure, activity limitation and/or participation restriction. Paediatric patients aged >10 days may, where applicable, qualify for subacute care.

Subacute care is health care for people who are not severely ill but need:

- support to regain their ability to carry out activities of daily life after an episode of illness
- help to manage new or changing health conditions
- assistance to live as independently as possible.

Subacute care comprises of the following care types:

- palliative
- rehabilitation
- geriatric evaluation and management (GEM)
- psychogeriatric.

Subacute generic admission criteria

See Sections 5.5.1 to 5.5.4 for additional information and requirements specific to each subacute care type.

A subacute patient is required to be admitted for overnight care for at least one night. Subacute care is always delivered under the management of or informed by a medical practitioner with specialised expertise in the subacute care type.

The subacute specialist medical practitioner will either assume management of the patient or inform the care by providing or overseeing the provision of subacute care.

Where the care plan is being 'informed by' a medical practitioner with specialised expertise, the requirement for necessary documentation within the patient's medical record still exists.

The specialist medical practitioner responsible for informing the management of the subacute care may not necessarily be located in the same facility as the patient. In these circumstances, a clinician at the patient's location will continue to provide care of the patient; the expertise of this clinician does not affect the assignment of care type. Clinicians at the patient location may need to be trained to complete the clinical assessments and data collection requirements.

If a patient is authorised for a change in care type to subacute care, the care type should not be changed until the new type of care commences. However, when a patient is transferred to another hospital for planned subacute care this is the care type to be assigned on admission to that hospital.

Each subacute care type has specific data collection requirements to enable the activity to be classified using the Australian National Subacute and Non-Acute Classification (AN-SNAP) and staff require training, and in some cases accreditation, to be able to administer the associated assessment tools.

Further information on the clinical and administrative data collection and reporting requirements for all subacute care types are contained in the SANADC Reference Manual.

5.5.1. Palliative care type

Palliative care type is specialist palliative care in which the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs.

Palliative care type excludes admitted patients receiving end of life palliation that is not managed or informed by a specialist palliative care (SPC) medical practitioner.

If the hospital does not have access to a SPC medical practitioner and the primary clinical intent of patient care is or becomes palliation, the care type cannot be changed to palliative. The care is to be managed within the existing admitted care episode.

Where palliative care is a component of the admitted care without a change to specialist palliative care type this is identified through the clinical coding of this treatment.

Patients who are placed on the Care Plan for the Dying Person (CPDP) do not automatically qualify as 'specialist palliative care type'. Patients must be assessed by a specialist palliative care team and meet the following admission criteria.

Admission Criteria

In addition to the Subacute generic admission criteria, Palliative care type is always delivered under the management of or informed by a medical practitioner with specialised expertise in palliative care, and is evidenced by:

- a multidisciplinary assessment and management plan for the patient, documented in the medical record that covers the physical, psychological, emotional, social and spiritual needs of the patient and negotiated goals
- recording of Resource Utilisation Groups – Activities of Daily Living (RUG-ADL) measures and Phase of Care at the beginning of each palliative phase.

Palliative care type is usually initiated with a referral to a SPC medical practitioner which may result in a consultation only, or they may authorise a change to Palliative care type. If so, the SPC medical practitioner will either assume management of the patient, or the clinical governance will not change, and they will inform the management of care through providing direct care or overseeing the provision of specialist palliative care.

5.5.2. Geriatric evaluation and management care type

Geriatric evaluation and management (GEM) care type iscare in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with multi-dimensional needs associated with medical conditions related to ageing, such as tendency to fall, incontinence, reduced mobility and cognitive impairment. The patient may also have complex psychosocial problems.

Patients are more appropriately classified as GEM where:

- admission is for reconditioning of an older patient with significant co-morbidities
- they have geriatric syndromes which require specialist geriatric medical input such as:
    - poor cognitive status
    - falls without significant injury
    - frailty

It includes care provided:

- in a geriatric evaluation and management unit
- in a designated geriatric evaluation and management program
- under the principal clinical management of a geriatric evaluation and management physician.

GEM care type is generally applicable to older patients, however; younger adults with clinical conditions generally associated with old age can also be classified under this care type.

Admission Criteria

In addition to the Subacute generic admission criteria, Geriatric evaluation and management care type is always delivered under the management of or informed by a clinician with specialised expertise in GEM care, and evidenced by:

- an individualised multidisciplinary management plan which is documented in the patient's medical record, that covers the physical, psychological, emotional and social needs of the patient, and includes negotiated goals within indicative time frames, and a formal assessment of functional ability, and
- recording of the Functional Independence Measure (FIM), for AN-SNAP classification.

5.5.3. Rehabilitation care type

Rehabilitation care type is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating.

Rehabilitation is typically more goal oriented than GEM. Rehabilitation is provided for a patient with an impairment, disability or handicap for whom the primary treatment goal is improvement in functional status. Rehabilitation usually occurs after a readily defined event such as:

- stroke
- orthopaedic surgery
- traumatic injury
- defined disability.

Admission Criteria

In addition to the Subacute generic admission criteria, Rehabilitation care type is always delivered under the management of or informed by a clinician with specialised expertise in rehabilitation, and evidenced by:

- an individualised multidisciplinary management plan, which is documented in the patient's medical record that includes negotiated goals within specified time frames and a formal assessment of functional ability, and
- recording of the clinical and functional assessment measures for AN-SNAP classification.

5.5.4. Psychogeriatric care type

Psychogeriatric care type is care in which the primary clinical purpose or treatment goal is improvement in the functional status, behaviour and/or quality of life for an older patient with significant psychiatric or behavioural disturbance, caused by mental illness, age-related organic brain impairment or a physical condition.

Psychogeriatric care type is not applicable if the primary focus of care is acute symptom control.

Admission Criteria

Psychogeriatric care type is always delivered under the management of or informed by a clinician with specialised expertise in psychogeriatric care, and evidenced by:

- an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and a formal assessment of functional ability, and
- recording of the Health of the Nation Outcomes Scales (HoNOS) to inform AN-SNAP classification.

5.6. Maintenance care type

Maintenance (or non-acute) care type is care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition. Following assessment or treatment the patient does not require further complex assessment or stabilisation. Patients with a care type of maintenance care may require care over an indefinite period. Paediatric patients aged 10 days and over may qualify for maintenance care type.

Maintenance care type requires completion of a clinical assessment using the Resource Utilisation Group Activities of Daily Living (RUG-ADL) measures to enable the activity to be classified using the Australian National Subacute and Non-Acute Classification (AN-SNAP).

Data collection and reporting requirements for maintenance care are contained in the SANADC reference manual.

Admission criteria

A patient may be admitted with a care type of maintenance for a few purposes. These are listed below.

Convalescence

Convalescence is provided when, following assessment and/or treatment, the patient does not require further complex assessment or stabilisation but continues to require care over an indefinite period. Under normal circumstances the patient would be discharged but due to factors in the home environment, such as access issues or lack of available community services, the patient is unable to be discharged. Examples may include patients waiting:

- completion of home modifications essential for discharge
- provision of specialised equipment essential for discharge
- rehousing
- supported accommodation such as hostel or group home bed
- for whom community services are essential for discharge but are not yet available.

Respite

An episode of respite occurs where the primary reason for admission is the short-term unavailability of the patient's usual carer. See also Section 3.2. Examples may include:

- admission due to carer illness or fatigue
- planned respite due to carer unavailability
- short term closure of care facility
- short term unavailability of community services.

Other maintenance

This refers to patients other than those already stated. This includes patients that have been assessed as requiring more intensive day-to-day care than can be provided in the home environment and who are awaiting aged care services, including placement in a residential care facility, for example:

- Commonwealth-subsidised permanent Residential Aged Care
- Commonwealth-subsidised Home Care Packages

Nursing home type patient

Maintenance care must be selected for all patients with a client status of nursing home type.

A nursing home type patient is a patient who has been in one or more hospitals (public or private) for a period of more than 35 days of continuous care, and who is now remaining in hospital for nursing care and accommodation as an end in itself.

5.7. Posthumous organ procurement

Posthumous organ procurement is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead.

At the time of death, the patient must be discharged as deceased; this is the official time of death. A separate admission for posthumous organ procurement is to be recorded.

5.8. Hospital boarder

A hospital boarder is a person who is receiving food and/or overnight accommodation at the hospital but for whom the hospital does not accept responsibility for treatment and/or care.

Boarders do not receive admitted care but may be registered on the hospital's patient administration system. Boarders are excluded from ABF activity counts by the Department of Health in reporting.

Refer also to the WA Health Fees and Charges Manual.

5.9. Medi-hotel

Admission classification and reporting requirements for Medi-hotels are under development.

6. Additional considerations

6.1. Hospital in the home

Hospital in the home (HITH) is the provision of acute or mental health overnight/multiday 'admitted care' provided in the patient's home or usual place of residence as a substitute for hospital accommodation.

Models of care that are alternative to inpatient care do not automatically qualify for HITH. HITH programs must be endorsed for classification as admitted care by the Department of Health.

If the care being provided to the patient would not otherwise require in-hospital admission, then provision of that care in the patient's home does not qualify for HITH and cannot be recorded as admitted care activity. For example, post-acute and community outreach care.

HITH care may sometimes initiate from a direct referral as a substitute for an inpatient hospital admission or facilitate early discharge with continuation of admitted care in the patient's residence.

Private patients must not be discharged and then readmitted as public HITH patients[8].

Home births may be recorded as eligible HITH admissions when provided under an approved home birth program and in accordance with the WA Department of Health Home Births mandatory policy; in development to supersede: *WA Health Policy for Publicly Funded Home Births OD 0482/1*.

Admission criteria

A HITH admission is governed by the same rules that apply to in-hospital admitted care and must meet:

- the definition of admitted care in Section 2.1
- qualify for admission as set out in Section 3.1.
- meet the applicable admission criteria Sections 4-5

HITH care is the equivalent of admitted care services provided by hospital based medical practitioners or nursing staff in the patient's usual place of residence.

Exclusions:

A HITH admission must not be recorded for:

- same day care (with the exception of home births).
- care not provided in the patient's residence
- telehealth only (non-admitted) care
- the purpose of referral and assessment only, without provision of ongoing HITH care
- care provided entirely by non-hospital based clinicians or external providers

[8] See Section 4.3 WA Health Fees and Charges Manual

HITH days of care reporting criteria

The movement of patients between hospital and HITH must be recorded as internal ward transfers within a single episode of care. The patient is not to be discharged and readmitted. Any days between leaving hospital and commencement of HITH are to be recorded as leave days.

A HITH day of care can only be recorded when the patient has been visited in their place of residence by HITH staff providing admitted services to the patient.

As HITH is a substitute for inpatient care it is expected that patients receive direct clinical admitted care in the home daily or at least every second day.

A HITH patient must be put on 'leave' for each day that they are not receiving admitted care in the home. HITH leave must not exceed 2 consecutive days in duration.

If scheduled care is cancelled, or the patient is not home when HITH staff visit, a leave day is to be recorded.

HITH clinicians must document leave days and the clinical care provided for a recorded HITH day in the hospital medical record to evidence provision of admitted care.

Care provided in a setting other than the patient's residence is not eligible to be recorded as a HITH day of care; for example, telephone consultation, attendance at community health clinics are all non-admitted care.

Care provided that would not qualify for admission and would be classified as non-admitted care, e.g. allied health consultation, is not a day of admitted care and cannot be recorded as a HITH day.

If the patient returns to the hospital, at which they are a current HITH inpatient, for care that cannot be provided in the patient's residence, e.g. specialist medical review, or an Emergency Department (ED) attendance, HITH days may be recorded for this contact. This care is included as part of the single admitted care episode. Where ED attendance is at another hospital Refer to 9.4 Patients on Leave Presenting to an Emergency Department.

Designated psychiatric facilities recording HITH activity must record both HITH days and Psychiatric Care days.

The date of discharge from HITH is to be recorded as the last day the patient received treatment.

Refer to the HMDS Reference Manual for instruction on the calculation and reporting of HITH days.

6.2. Contracted care

At the time of revising this manual the recording and reporting processes for contracted care was under review. The Information and Performance Governance Unit is currently evaluating and assessing the risks of the recommended changes which will be reflected in subsequent editions of this manual.

Current processes apply in the interim.

Contracted care is treatment or services purchased, under agreement, from another hospital/Contracted Health Entity, for example:

- dialysis provided by a contracted hospital for a hospital patient
- use of a private hospital, under contract, when facilities are unavailable at the public hospital.

For instructions on how to collect and report data for contracted care please refer to the HMDS Reference Manual.

6.3. Virtual beds/wards

A virtual bed is a term used to denote a nominal location which the patient is held against in the hospital's patient administration system. Admission to a virtual bed with very few exceptions, is not valid admitted care.

Virtual beds are used for administration purposes only, for example, to facilitate patient movements such as internal transfers.

It is only acceptable to admit a patient to or discharge a patient from a virtual ward in the following scenarios:

- to admit patients who have gone to OR directly into Theatre from the Emergency Department when a ward has not yet been allocated.
- hospital in the home - ward code/name to include 'HITH'
- discharge/transit lounges
- contract funding ward code/name to be prefixed by 'ZZ'

All other admitted care must occur within a physical inpatient ward or unit (see Section 3),

Patients still being cared for in the ED and waiting to be allocated/transferred to an inpatient bed must not be admitted to a virtual ward.

Admitted patients who deteriorate and require care within who deteriorate and require transfer for care within the location of an Emergency Department can be transferred to an ED Virtual Ward for bed movement tracking purposes.

6.4. Cancelled or abandoned elective procedures

When a patient is admitted for a booked procedure and the procedure is subsequently cancelled, the admission must not be recorded unless:

- the procedure is for dialysis, infusion, transfusion or apheresis and the procedure has already commenced
- the patient is already in the operating theatre or procedural unit. A procedural unit includes endoscopy procedure room, cardiac catheter laboratory, radiology
- the patient has received pre-medication such as Emla gel/cream, eye drops, iodine lotion, IV saline, anxiolytics and anti-emetics

- anaesthesia has already been administered
- despite the procedure being cancelled, the admission is continued for some other treatment or circumstance, under the medical practitioner's orders and meeting admission criteria.

If, for non-clinical reasons, a patient is admitted on the day prior to their scheduled procedure and the procedure is subsequently cancelled then the admission must be recorded.

Establishment of Intravenous access only prior to commencement of a procedure, without administration of anaesthesia, is be considered cancelled not abandoned.

For recording of cancelled/abandoned procedure activity as a non-admitted service event refer to the Non-admitted activity reporting reference manual.

Refer to Appendix 4 for cancelled elective procedures flow chart.

7. Readmission

A patient admitted within 28 days of discharge is only considered a readmission if it is for:

- further treatment related to the same condition for which the patient was previously hospitalised
- treatment of a condition related to the one for which the patient was previously hospitalised
- a complication of the condition for which the patient was previously hospitalised (this may include mechanical complications).

Readmissions are classified as either planned or unplanned based on the clinical intention to readmit. The intention to readmit must be clearly documented by the treating medical officer at the time of discharge.

7.1. Planned readmission

A planned readmission is when the patient is readmitted at a time following discharge, on the advice of the treating medical practitioner. This may include staged procedures or ongoing treatment such as recurring cases of chemotherapy and dialysis.

Patients discharged from an unplanned admission (e.g. short stay unit) with a plan for readmission within 7 days, (e.g. returning for a scheduled procedure or other admitted care) must not be discharged and instead be placed on leave as per Section 9.2 Planned leave.

7.2. Unplanned readmission

Unplanned readmission is an unexpected admission of a patient within 28 days of discharge to the same establishment. This is where there is no intention of the treating medical practitioner to readmit for treatment of the same or related condition as the previous admission.

7.3. Readmissions within the same day

A patient may be scheduled to attend the same hospital on one day for more than one planned admission (for example, a day procedure on the same day as scheduled dialysis) however only one admitted episode must be recorded. See Section 3 requirements for admitted care.

Patients that are readmitted on the same day of discharge where the second admission is unplanned (e.g. an unrelated emergency) may record the second admission.

Patients that are readmitted on the same day of discharge where the second admission is planned must not record a second admission.

Should two inpatient events occur on the same day, with the first being unplanned only one admission must be recorded, and the patient is recorded as on leave in between. For example, Patients discharged from an unplanned admission (e.g. short stay unit) with a plan for readmission later in the day for a scheduled procedure or other intended care, must not be discharged and instead be placed on leave as per

Section 9.2 Planned leave.

A second admission must not be recorded when the patient is recalled by the medical practitioner to continue the same inpatient treatment on the same day as discharge.

A patient may not be readmitted on the same day for the purpose of changing the financial election or transfer to HITH. See also Section 6.1 HITH.

7.4. Readmission following discharge against medical advice

See Section 8.3 discharge against medical advice.

8. Discharge

Discharge is the process by which an admitted patient completes an episode of care.

8.1. Formal discharge

Formal discharge is the administrative process, by which a hospital records the cessation of treatment and/or care and/or accommodation of a patient, where the patient:

- is discharged to private accommodation or other residence
- is transferred to another hospital, health service or other external health care accommodation
- leaves against medical advice
- fails to return from leave
- has deceased.

Refer to MP 0095/18 *Clinical Handover Policy* Section 3.4 In-patient Discharge Planning, for mandatory discharge summary requirements.

8.2. Statistical discharge

Statistical discharge is an administrative process that completes an admitted patient episode of care when there is a documented change in the clinical intent of treatment (for example, from acute care to palliative care). For each statistical discharge, there must be a corresponding statistical admission.

8.3. Discharge against medical advice

Discharge against medical advice (DAMA) is when the patient chooses to leave the hospital before the completion of treatment against the advice of the treating medical practitioner.

When patients leave the hospital and it remains unclear whether they intend to return, it is a clinical decision whether to place the patient on leave or to discharge the patient. Medical practitioners may allow patients to remain on leave up to a maximum of 7 days and if the patient returns during this time, the admission can resume. See Section 9 Leave

The medical practitioner may decide to discharge the patient during the patient's unauthorised absence from hospital. The mode of separation must be recorded as DAMA, not discharged from leave.

The decision to place the patient on leave or discharge against medical advice is to be documented in the patient's medical record by the medical practitioner.

If the patient represents after being discharged as against medical advice and they require admission, they may be readmitted (new admission).

9. Leave

It is essential to record leave to ensure the reporting of an accurate length of stay.

Leave is defined as temporary absence from Hospital with the expectation that the patient will return to resume care.

A patient may be placed on leave for up to 7 days. If a patient fails to return from leave within seven days without explanation, the patient must be discharged and recorded as 'discharged against medical advice'. If the reason for not returning is known to be death of the patient the discharge destination would be recorded as 'deceased'.

If the patient is an involuntary patient in an authorised, specialised mental health service, then in accordance with the *Mental Health Act* they may be placed on leave for up to, but not exceeding, 21 days.

A HITH patient may be placed on 'leave' for no more than 2 consecutive days, that they are not receiving admitted care in the home. Refer to Section 6.1 for further information on HITH leave days.

The reason for leave, the date and time leave commenced, and if known, the expected return date, are to be documented in the patient's medical record.

A patient may be placed on leave for a variety of reasons. For example:

- during treatment at another hospital
- during a gap in treatment
- pending a scheduled procedure
- day, overnight or weekend leave
- trial leave at home or other place of residence
- left against medical advice

9.1. Hospital leave

Patients may be placed on leave when transferred to another hospital, for planned or emergency care, and it is expected they may return to continue their care. However, patients who are transferred to another hospital with no expectation of returning should be discharged.

If whilst on leave receiving care at another hospital it is determined that the patient will not be returning, the discharge is recorded as a 'transfer to another hospital' on the date the patient was transferred to the other hospital.

9.2. Planned leave

Planned leave applies where there is an expectation that the patient will return to resume the current care. For example, returning for a scheduled procedure or continuation of current care.

Patients discharged from an unplanned admission (e.g. emergency short stay admission) with a plan for readmission, for a scheduled procedure or continuation of current care, must not be discharged and are placed on leave. This becomes an overnight admission.

Overnight leave is not applicable to planned (elective/booked) same day admissions. For example, a patient cannot be admitted (administratively only) and sent on leave for a planned same day admission scheduled for the following day. This inappropriately classified the admission as an overnight admission.

Patients receiving a series of same day treatments (>2 admissions) which meet the definition of same day care in Section 4 are not to be recorded as one multiday admission with periods of leave in between.

If during planned leave it is determined that the patient will not be returning to continue their care, and a decision is made to discharge the patient, this is to be recorded as "discharged from leave" on the date the decision is made. The discharge date is not backdated to when the patient left the hospital.

If the patient is admitted to another hospital while on leave, communication should occur between the two hospitals to ensure that admission dates and times do not overlap.

9.3. Unplanned leave

Patients who leave the hospital against the advice of the treating medical practitioner and it remains unclear whether they intend to return may be placed on leave. Refer to Section 8.3 DAMA for further information

9.4. Patients on leave presenting to an ED

A patient on leave that presents to the emergency department of the hospital to which they are currently admitted is not to be discharged and then readmitted. The patient is to have an ED Type of Visit of 'Current Admitted Patient Presentation' recorded.

Patients on leave that present to the emergency department of another hospital and are admitted to that hospital may remain on leave and return to the first hospital to continue their care. See Section 9.1 Hospital Leave. The second hospital must inform the first that they have admitted the patient.

For information on calculation and reporting of leave days refer to the HMDS Reference Manual

10. Definitions

Admitted care	Patient care which meets the criteria for admission, and the patient undergoes the hospital's documented admission process to receive inpatient treatment and/or care for a period of time. Admitted care is provided in a hospital inpatient ward or unit, or in the patient's home under specific admission criteria within Hospital in the Home programs. Admitted care may also be referred to as inpatient care.
Medical Practitioner	As per the *Health Services Act 2016*, a medical practitioner is a person registered under the *Health Practitioner Regulation National Law (Western Australia)* in the medical profession.
Non-admitted procedure	Procedures that would normally be undertaken on a non-admitted basis.
Recorded	The action of registering or capturing information publicly or officially that allows for future access, reproduction or transformation. This is generally a manual process of setting down the "raw" or "initial" information in writing or electronically for example, keyboard entry, imaging, scanning, and can include text, images or sound. The registering of information can include the manual coding and classification of the information at input stage.
Reported	For purposes of this manual, reported means submitted to or by the Department as per applicable data collection and submission requirements. The production of information organised in a narrative, graphic, or tabular form, prepared on ad hoc, periodic, recurring, regular, or as required basis, spoken or written (printed or electronic), of something that has been observed, heard, done or investigated based on the transformation of recorded information with the aim of summarising, identifying issues or to obtain an understanding of recorded information for decision making and communication purposes. These can include standardised electronic data submissions/extracts, edit reports, textual material for example briefing notes, analyses, tabulations, graphs and presentations.

11. Appendices

Appendix 1: Related documents and supporting information

Mandatory related documents

- Admission Policy for WA Health Services. Available from: https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Information-Management
- Type B admitted procedures list and Type C non-admitted procedure list. Available from: https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Information-Management/Mandatory-requirements/Collection/Admission-Readmission-Discharge-and-Transfer-Policy
- Non-Admitted Activity Recording and Reporting Manual for WA Health Services. Available from: https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Information-Management/Mandatory-requirements/Collection/Non-Admitted-Activity-Recording-and-Reporting-Policy
- SANADC Reference Manual. Available from: https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Data%20collection/PDF/SANADC%20Manual%202016_2017.ashx
- The Hospital Morbidity Data System Reference Manual. Available from: https://ww2.health.wa.ov.au/Articles/A_E/Data-Quality-Team
- National Health Reform Act 2011. Available from: https://www.legislation.gov.au/Series/C2011A00009
- WA Health Policy for Publicly Funded Home Births OD 0482/13. Available from: https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Services-Planning-and-Programs/Mandatory-requirements/Maternity/WA-Health-Policy-for-Publicly-funded-Home-Births

Supporting information

- Access to Endorsed Midwives into Public Maternity Units Policy. Available from: https://ww2.health.wa.gov.au/-/media/Files/Corporate/Policy-Frameworks/Clinical-Governance-Safety-and-Quality/Policy/Access-for-Endorsed-Midwives-into-Public-Maternity-Units/MP93-Access-for-Endorsed-Midwives-into-Public-Maternity-Units.pdf
- Australian Mental Health Care Classification (AMHCC). Available from: https://www.ihpa.gov.au/what-we-do/mental-health-care
- Elective Surgery Access and Waiting List Management Policy. Available from: https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Services-Planning-and-Programs
- Health Insurance Act 1973. Available from: http://www5.austlii.edu.au/au/legis/cth/consol_act/hia1973164/
- Health Services Act 2016. Available from: https://www.legislation.wa.gov.au/legislation/statutes.nsf/main_mrtitle_13761_homepage.html

- Mental Health Act 2014. Available from: https://www.legislation.wa.gov.au/legislation/statutes.nsf/main_mrtitle_13534_homepage.html
- National Health Reform Agreement. Available from: http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/national-agreement.pdf
- The National Healthcare Agreement 2012. Available from: http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/healthcare_national-agreement.pdf
- Performance Management Policy. Available from: https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Performance/Mandatory-requirements/Performance-Management-Policy
- Private Health Insurance (Benefit Requirements) Rules 2011. Available from: https://www.legislation.gov.au/Details/F2020C00415
- State-wide Standardised Clinical Documentation for (SSCD) for Mental Health Services OD: 0526/14. Available at: State-wide-Standardised-Clinical-Documentation.pdf
- WA Health Fees and Charges Manual. Available from: https://healthpoint.hdwa.health.wa.gov.au/FinanceGroup/Pages/FACM.aspx
- WA Health Clinical Services Framework 2014-2024. Available from: https://ww2.health.wa.gov.au/Reports-and-publications/WA-Health-Clinical-Services-Framework-2014-2024

Appendix 2: Severity and intensity of illness circumstances relating to admission[9]

One of the following circumstances related to severity of illness and intensity of service will usually be present to warrant admission.

Severity of illness

- sudden alteration to conscious state
- abnormally high or low pulse (pulse rate outside specified range for age)
- abnormally high or low blood pressure (above or below limit for age)
- acute loss of sight or hearing
- acute loss or ability to move major body part
- persistent fever
- active bleeding
- severe plasma electrolyte/acid-base/blood pH abnormality or low Hb
- severe electrolyte or blood gas abnormality
- electrocardiogram abnormality
- wound dehiscence or evisceration
- incapacitating pain
- acute or progressive incapacity
- conditions not responsive to outpatient or ED management[10]
- child abuse and noncompliance with essential treatment recommendations[9]
- failure to thrive[9].

Intensity of service

Due to the severity of illness the need for admission is anticipated for:

- administration of parenteral medications and/or fluid replacement
- surgery or procedure scheduled within 24 hours
- equipment/facilities only available in an acute care setting
- intermittent or continuous use of assisted ventilation
- treatment in an ICU
- vital signs monitoring
- chemotherapeutic agents requiring continuous observations[9]

[9] Based on Esmail A. Development of the Paediatric Appropriateness Evaluation Protocol for use in the United Kingdom. J Public Health Med. 2000;22(2):224–30. [PubMed] and
Gertman PM, Restuccia JD. The appropriateness evaluation protocol: a technique for assessing unnecessary days of hospital care. Med Care. 1981;19(8):855–71. [PubMed]

[10] Additional paediatric criteria.

Appendix 3: Emergency Department - Short Stay Admission Flowchart

The decision to admit must be documented in the medical record and can only be made by an authorised medical practitioner. Admission to a virtual ward prior to transfer to an inpatient ward/unit is not permitted.

Option 1: Does the patient require a procedure?

NO

DO NOT ADMIT

Admitted Procedure

*Is the reason for admission is to receive a **procedure** on the admitted procedures list as a hospital inpatient?*

Excludes procedures completed during the ED attendance. The procedure must occur or continue during an inpatient admission

- Sedation/Anaesthesia
- Infusion/transfusion of blood/blood products
- Reductions of fracture or dislocations
- Intravenous infusion pharmacological agent.
- Incision & drainage of abscess
- Arrest nasal haemorrhage
- Exc. debridement skin & subc tissue
- ***NB.*** *IV therapy is the administration by intravenous infusion of a pharmacological/ therapeutic agent to treat a diagnosed condition. Excludes ancillary, preparatory and line maintenance procedures*

Non-admitted Procedure

*Is the reason for admission is to receive a **procedure** on the Type C **non-admitted** procedure list and the patient has a condition or special circumstance that justifies inpatient admission?*

Excludes procedures completed during the ED attendance.

- Where the patient's co-morbidities place the patient under high dependency

NB. *The medical record must include documentation to evidence provision of and need for admission. A medical practitioner must document the reason for requiring admission. Private patients require a Type C certificate.*

This chart is a summarised guide to the admission category and criteria. See also the requirements in section 2.1, 3.1 & 4 of the Admission Policy Reference Manual .

Reference: *MP 005817 - Admission Policy and Reference Manual* **Information Management Policy Framework**

NO

*Option 2: Does the patient require 4 or more hours of continuous active management? **

Medical Admission

Identify which of the following is the reason for admission and document a clinical management plan for a minimum of 4 hours regular and continuous clinical care.

MANAGEMENT	DOCUMENTATION REQUIRED
Serial tests/investigations	• Tests Required & intervals • Results and actions documented
Regular periodic observations Excludes: routine BP / pulse / temperature monitoring only	• Required observations, intervals and duration • 4 hours of observation must be documented
Continuous monitoring	• Type of monitoring
Active treatment (and review)	• Nature of treatment • Time of planned review

NB. Admitted care (admission time) commences when the patient physically leaves the clinical area of ED for transfer to an inpatient unit or operating theatre/procedure room. *The calculation of four hours duration can include continuous active management provided within the ED after the time of the decision to admit but this care **must** continue after the patient is formally admitted to the inpatient ward/unit.

PLEASE NOTE an admission must not be recorded for the following reasons:

- Where the entirety of care occurs within the ED
- The patient is being transferred to another Hospital for ongoing care
- The patient will be in the Emergency Department for longer than 4 hours
- To avoid breaching a measured performance threshold target
- The patient is transferred to a short stay ward but does not meet admission criteria
- The care requires facilities/equipment located in the ED e.g. Resuscitation
- The patient has a length of stay > 4hours primarily consisting of waiting for:
  - *review by a specialist practitioner*
  - *diagnostic tests or results*
  - *equipment or medications*
  - *transport home/other health service*

Appendix 4: Classification of Newborn Admitted Care Guide

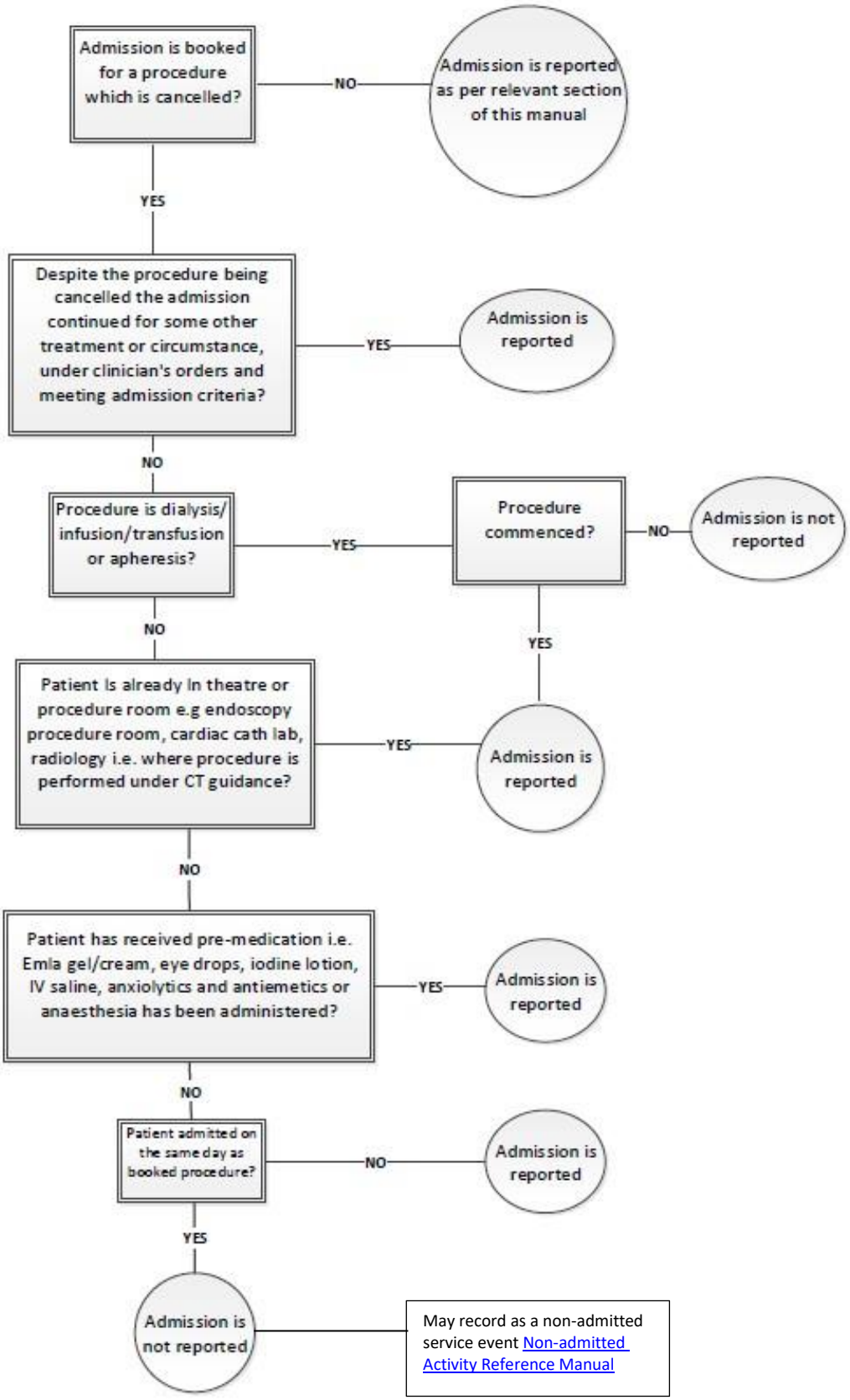
BIRTH EPISODE

1 2 3 4 5 6 7 8 9 — 10 days onwards until discharge

Day →

SCENARIO	CLIENT STATUS	CARE / PATIENT TYPE		SCENARIO	CLIENT STATUS	CARE / PATIENT TYPE
Baby born and not requiring any acute care	**Unqualified**	**Newborn**	⇨	Baby remains in hospital rooming with the mother who is patient	Change from Unqualified to **Boarder**	Change from Newborn to **Boarder**
Baby born requiring SCN NICU acute medical care	**Qualified**	**Newborn**	⇨	Requires ongoing acute medical care until discharge day 13	Remains **Qualified**	Remains **Newborn**
Baby born goes to SCN on day 2 until day 8, when is well enough to go back to ward. Mother still a patient.	**Qualified** Day 8 changed to **Unqualified**	**Newborn** Day 8 remains **Newborn**	⇨	Baby remains in hospital accompanying mother who is patient until day 13	Statistically discharged from Unqualified. Admit as **Boarder**	Statistically discharged from Newborn Admit as **Boarder**
A Twin 2 (or second onwards of multiple birth) born in hospital Past first born multiple paris	**Qualified**	**Newborn**	⇨	Twin 2 remains in hospital with mother	Remains **Qualified** until discharge	Remains **Newborn** until discharge
Newborn requiring SCN NICU and on the same day is transferred to another hospital	**Qualified**	**Newborn**	⇨			
Newborn, not requiring acute care. Mother unwell and transferred to another hospital or requires intensive acute care at day 3 until day 6 returning.	Days 1 – 2 **Unqualified** Day 3 – change to **Qualified** Day 6 – change to **Unqualified**	**Newborn**	⇨	Remained in hospital with mother who is patient until day 13.	Statistically discharged. Readmit as **Boarder**	Statistically discharged. Readmit as **Boarder**
Baby readmitted requiring acute care and < 10 days old.	**Qualified**	**Newborn**	⇨	Continues to require acute medical care until discharge	Remains **Qualified** until discharge	Remains **Newborn** until discharge
Birth episode different hospital				Baby admitted day 10 from another hospital SCN/NICU	**Acute**	**Admitted patient**
Birth episode different hospital				Baby admitted with mother who is patient Day 11	**Boarder**	**Boarder**

Appendix 5: Cancelled or abandoned procedure flowchart



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