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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. The Reference Manual is a related document under the mandated Admission Policy for the WA Health System.

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

This manual shall be read in conjunction with the Admission Policy and other guidelines and policy documents 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 admission processes. The manual is set out in sections:

- Section 2, Admitted and non-admitted care definitions
- Section 3, Admitted care requirements
- Section 4 - 9, Admitted care 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 the policy or manual please complete the query submission form in Appendix 5 and email to royalstreetdatareviewgroup@health.wa.gov.au.
2 Admitted vs non-admitted care

2.1 Admitted care

Admitted care is care which qualifies for admission as set out in Section 3.1 and meets criteria specific to same day or overnight admission and the relevant care type. The patient must undergo 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.

To ensure data integrity for a wide range of uses, only valid inpatient activity must be reported as admitted care.

Activity that meets admission criteria makes the patient eligible to be considered for admission. However, this does not mean that this activity is automatically reported as admitted care. It may be reported as non-admitted care.

An episode of care must not be reported as admitted if the care is provided entirely in a non-admitted setting such as an Emergency Department (ED). This excludes admissions to an ED short stay unit (SSU).

Still born babies and patients who are dead on arrival to the hospital with no active resuscitation are not reported 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
- 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
- patients who receive their entire care within the ED (excludes ED SSU admissions)
- care provided by hospital staff outside of the hospital, for example community or outreach services
- care provided by community mental health services to admitted patients
- care provided in the patient’s home (except hospital in the home - see Section 6.3)
- patients who receive their care during an outpatient or other non-admitted service event

All activity should be recorded however activity must not be reported to the Department as both an admitted episode of care and a non-admitted service event. This applies to all admitted episodes of care, including HITH.
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 a patient for admitted care must be made and documented by an authorised and registered health professional.

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 unit¹ (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 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)
  • the patient requires observation to prevent self-harm.

• 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).

V. Due to national reporting standards, a patient must not have more than one planned admitted episode of care reported on the same day at the same hospital.² Only one patient day may occur per 24 hour period from 00:00 - 23:59.

VI. 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.

¹ Admission to a virtual or administrative ward, with very few exceptions, is not valid admitted care. See Section 6.3.
² For further information see section 7.3
3.2 Documentation

Medical practitioners must complete the Health Service Provider’s documented admission process.

The documentation for an admitted episode of care must also include:

- admission status (refer to the Hospital Morbidity Data System (HMDS) Reference Manual for data definitions)
- reason for admission
- indications for treatment
- factors/ exceptional patient circumstances contributing to the admission
- treatment plan
- conditions treated and care provided
- clearly delineated sections for admitted and non-admitted care.

3.3 Financial election

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

Refer to Section G24 of the National Health Reform Agreement and the WA Health Fees and Charges Manual.
4 Same day vs overnight admissions

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 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 three categories:

(i) 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).
- The patient must receive treatment on the same day.

A same day admitted procedure may commence in ED and continue in the short stay unit (SSU) or other inpatient ward, for example:

- IV infusion commenced in ED and continuing in SSU.

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 alone
- 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)
- IV infusions of immunomodulators under the highly specialised drugs program, for example, Infliximab, Natalizumab and Tocilizumab.
(ii) Same day non-admitted procedure exceptions

Procedures on the WA health system Type C same day non-admitted procedure list are normally performed as non-admitted care.

Admission for the purpose of providing a procedure on the Type C same day non-admitted procedure list may only occur if:

- there are exceptional 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 treating medical practitioner documents suitable evidence to justify the admission in the medical record and/or completes a certification form for admission for a non-admitted procedure. The documentation must:
  - describe the reason for the patient requiring admitted care
  - describe the circumstances under which it would compromise accepted medical practice to not provide the care under an admitted setting
  - be completed and signed by a medical practitioner.

Certification is applicable to the individual patient and documents a condition or circumstance that is present at the time of the decision to admit. Universal non patient-specific certification is unacceptable.³

Please refer to the Private Health Insurance (Benefit Requirements) Rules 2011 for documentation 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. The decision to admit must be based on the criteria above.

(iii) 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 of the care provided:

- The patient requires an essential period of safe observation and/or psychiatric assessment.
- The patient requires life sustaining intensive care only available in an inpatient ward or unit.
- 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 (continuous blood pressure or pulse monitoring is insufficient)

³ Health Service Providers and Contracted Health Entities seeking reclassification of a specific procedure on the Type C same day non-admitted procedure list should complete an application for procedure reclassification (Appendix 3).
• continuous or regular treatment approved by a medical practitioner. Generally this management should align with established clinical protocols.

Admissions from the Emergency Department

Admissions from the ED to a short stay unit must meet the criteria for same day medical treatment, a same day admitted procedure, or a same day non-admitted procedure.

Patients in ED awaiting transfer to another hospital may only be admitted if they meet the applicable admission criteria (see Section 3).

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

To allow for delays in bed availability, the calculation of four hours continuous active management may include the time continuous active management commenced in ED, and continued in an inpatient setting, with the following qualifications:

• calculation of four hours may only commence after the decision to admit has been made and documented
• the patient must arrive in the short stay unit or inpatient ward with a clear treatment plan for ongoing inpatient management
• the admission time is to be reported as the time the patient physically leaves the clinical area of the ED for transfer to an inpatient ward or unit.
• not applicable to patients who are awaiting transfer to another health service for their ongoing care or admission.

Example

A patient presents to the ED with chest pain. After initial examination, investigations were ordered by the emergency medical practitioner, which returned normal results. However, the medical practitioner made the decision to admit the patient and provide continuous monitoring via ECG. ECG monitoring was initiated in the ED and continued for two hours before the patient was transferred to the ED short stay unit. After two hours of continuous ECG monitoring in the short stay unit, the patient was discharged with a follow-up appointment in the outpatient clinic.

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 excludes intended short stay admissions that incidentally span midnight (refer to Section 4.1).

An overnight admission must meet the definition of admitted care in Section 2.1 and the requirement for admitted care as set out in Section 3.
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. The allocated care type determines the Activity Based Funding (ABF) classification that applies to the episode of care.

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 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.
An overnight patient may receive more than one type of care during a period of hospitalisation. If so, 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.

5.1 Care type changes

A patient’s care type is changed when the focus of clinical care provided meets the criteria for a different type of care. The care type of the new episode of care is determined and authorised by the medical practitioner, with specialised expertise where required, who will be responsible for, or informs, the management of the new type of care for the patient.

To change a patient’s care type, a new episode of care is reported 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 to subacute or non-acute care, and requires a change care type back to acute, 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.

Change of care type 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 a temporary interruption due to a change in patient condition
- for a same day procedure or 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 organises a 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 of a treatment plan in the medical record only
• for transfers to HITH where there is no change in the primary clinical purpose of care
• from newborn to acute care type.

Documentation
In order to initiate a care type change, the following documentation must be completed in the medical record:
• actual time the care type change is effective
• 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.

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
• 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).

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 hospital level of care documented in the patient’s medical record prior to day 35.
5.3 Newborn care

Newborn care is initiated when the patient is born in hospital, or when not admitted from birth, the patient is nine days old or less on admission. Newborn care type may be extended beyond ten days of age when the patient requires ongoing acute care.

Patients may change between qualified and unqualified during the episode of care.

Refer to the HMDS Reference Manual for instruction on the reporting of qualified and unqualified newborns and calculation of qualified and unqualified newborn days.

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:

- they require intensive or special care and are admitted overnight to a Level 2 Special Care Nursery (SCN2) or Neonatal Intensive Care (NICU) facility approved for the purpose of provision of that care.1
- newborn is the second or subsequent live born infant of a multiple birth
- newborn remains in hospital where the mother is a boarder, is discharged or transferred to another hospital
- newborn is admitted to a hospital without its mother being admitted to the same hospital.

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

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.

Unqualified newborn

An unqualified newborn is a patient who is nine days old or less at the time of admission but does not meet any of the admission criteria for a qualified newborn.

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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 in order for the admission to be reported 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 evidenced by an individualised formal mental health assessment or the implementation of a documented mental health plan during the episode of care
- requires the mental health phase of care and relevant clinical measures to be reported.

A patient transferred to another facility for same day electroconvulsive therapy (ECT) may have the clinical measures and phase of care recorded at the transferring hospital.

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

Scope

Mental health care is best 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.

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. The transferring medical facility is responsible for completion of the clinical measures not the facility providing the ECT.

Mental health legal status

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

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4 Requires referral to a specialised mental health medical practitioner who provides shared care or oversees the provision of the mental health care including the formal mental health assessment and mental health plan.

5 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 medical practitioners and the client and/or carers. A copy of the mental health plan must be kept in the patient’s medical record as evidence to inform audit. Refer to State-wide.

6 Clinical measures refers to the clinician-rated measure from the National Outcome Casemix Collection (NOCC).
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)**

HITH rules in **Section 6.3** apply to mental health HITH.
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 and over may, where applicable, qualify for subacute care.

Subacute care comprises of the following care types:

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

Admission criteria

The following requirements must be met in order for the admission to be reported as a subacute episode of care.

- Subacute care is always delivered under the management of or informed by a medical practitioner with specialised expertise in the subacute care type.
- Where the management plan is being informed by a medical practitioner with specialised expertise, this is documented in the patient’s medical record, describing who is providing the shared care.
- An individualised multidisciplinary management plan must be documented in the patient's medical record and contain all of the following:
  - a series of documented and agreed initiatives or treatments which are established through multidisciplinary consultation and consultation with the patient and/or carer(s)
  - the physical, psychological, emotional and social needs of the patient
  - specific program goals, actions and timeframes.
- The subacute patient is required to be admitted for overnight care for at least one night.
- The applicable clinical and functional assessments must be completed and reported.
- 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. Any waiting period before the planned care commences should not be included in the new episode of care.

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

Data collection and reporting requirements for all subacute care types are contained in the SANADC Reference Manual.

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7 This requires a referral to a subacute specialist medical practitioner who provides shared care or oversees the provision of the subacute care including the clinical assessment and development of the management plan.
5.5.1 Rehabilitation care

Rehabilitation care 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.

5.5.2 Geriatric evaluation and management care

Geriatric evaluation and management (GEM) is care 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.

5.5.3 Psychogeriatric care

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

5.5.4 Palliative care

Palliative care 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 is a specialised care type and excludes acute admitted patients receiving end of life palliation not managed or informed by a palliative care specialist medical practitioner.

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 subacute admission criteria in Section 5.5.
5.6 Maintenance care

Maintenance (or non-acute) care 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 often require care over an indefinite period. Paediatric patients aged 10 days and over may qualify for maintenance care.


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 number of 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. 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 reported.

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. However, boarders are excluded from activity counts.

Refer also to the WA Health Fees and Charges Manual.
6 Additional considerations

6.1 Hospital in the home

Hospital in the home (HITH) is acute or mental health inpatient care provided by hospital clinical staff in the patient’s home or usual place of residence. HITH is overnight care with the exception of patients admitted under an approved homebirth program.

If the care to be provided to the patient does not require inpatient admission, then provision of that care in the patient’s home does not qualify for a HITH admission and cannot be reported as HITH days of care; for example, post-acute care.

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

Admission criteria

A HITH admission is governed by the same admission criteria and other rules that apply to in-hospital admitted care in Sections 2-5.

As HITH is a substitute for inpatient care it is expected that patients receive direct clinical care at least every second day.

A HITH day of care is only to be reported where hospital based clinical staff visit the patient in their home to provide the equivalent of admitted care.

A HITH patient must be put on ‘leave’ for each day that they are not receiving admitted care in the home.

Care provided in a setting other than the patient’s home, or the provision of non-admitted care, is not eligible to be reported as a HITH day of care; for example, attendance at outpatient or community health clinics.

Continuation of admitted care by transfer to a HITH program is to be recorded as an internal ward transfer not a new admission.

The hospital medical record is maintained for HITH care provided to the patient.

Designated psychiatric facilities reporting HITH activity must report both HITH days and Psychiatric days.

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

6.2 Contracted care

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.
It is noted that current PAS limitations restrict the ability to put the patient on leave during the contracted event, resulting in multiple admitted care episodes, even on the same day.

6.3 Virtual wards

Admitted care must occur within a physical inpatient ward or unit (see Section 3). Admission to a virtual ward is not valid admitted care and must not be reported.

Admissions to funding wards (prefixed by ‘ZZ’), and HITH are accepted.

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

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.

Patients must not be discharged from virtual wards except for HITH, discharge/transit lounges (if still receiving care) and contract funding episodes.

6.4 Cancelled elective procedures

When a patient is admitted for a booked procedure and the procedure is subsequently cancelled, the admission must not be reported 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 age or distance reasons, a patient is admitted on the day prior to their scheduled procedure and the procedure is subsequently cancelled then the admission must be reported.

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.

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.

Patients with progressive or chronic conditions may return to the hospital within 28 days of discharge. Although these admissions are not planned, they are not unexpected and hence must not be classified as unplanned readmissions.

7.3 Readmissions within the same day

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

Patients may be readmitted on the same day of discharge where the second admission is unplanned (e.g. an emergency) and have two separate episodes reported. Where two inpatient events occur on the same day, with the first being unplanned and the second being planned, the two admissions should be merged and only one admission reported.

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

It is noted that current PAS limitations restrict the ability to put the patient on leave during a contracted event, resulting in more than one admitted care episode on the same day.

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 (excludes patients on leave)
- is transferred to another hospital, health service or other external health care accommodation (excludes patients on leave)
- leaves against medical advice
- fails to return from leave within seven days, or 21 days for patient admitted on an Involuntary Treatment Order under the Mental Health Act and are placed on leave
- has deceased.

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 cease treatment against the advice of the treating medical practitioner 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 continue.

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 by the medical practitioner.

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

Planned leave

Leave is recorded when a patient leaves the hospital, with the approval of the treating medical practitioner, with the intention that the patient will return within 7 days to continue the current treatment. This includes inpatients transferred to another hospital for treatment. The reason for approval, and the date and time of leave must be documented in the patient’s medical record.

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 21 days.

Patients who are transferred to another hospital with no expectation of returning should be discharged.

If during leave a decision is made to discharge the patient, this is reported as “discharged from leave”. The discharge date should not be backdated to when the patient left the hospital.

If a patient fails to return from leave within seven days, the patient is discharged and is reported as “discharged against medical advice”.

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.

Refer to Section 6.4 for HITH leave reporting requirements.

Overnight leave is not applicable to patients admitted under the same day admission criteria.

Patients receiving a series of treatments 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.

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

Unplanned leave

When patients leave the hospital against the advice of the treating medical practitioner and it remains unclear whether they intend to return, they may be placed on leave. Refer to Section 8.3 DAMA.
### 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. |
| **ED short stay unit** | A ‘short stay unit’ is:  
- designated and designed for the short term inpatient treatment, observation, assessment and reassessment of patients initially triaged and assessed in the emergency department (ED)  
- a unit with specific admission and discharge criteria and policies  
- designed for short term stays no longer than 24 hours  
- physically separated from the ED acute assessment area  
- a unit with a static number of beds with oxygen, suction, patient ablution facilities  
- not a temporary ED overflow area nor used to keep patients solely awaiting an inpatient bed nor awaiting treatment in the ED. |
<p>| <strong>Health Professional</strong> | As per the <em>Health Services Act 2016</em>, a health professional registered under the <em>Health Practitioner Regulation National Law (Western Australia)</em>, other than as a student. |
| <strong>Medical Practitioner</strong> | As per the <em>Health Services Act 2016</em>, a medical practitioner is a person registered under the <em>Health Practitioner Regulation National Law (Western Australia)</em> in the medical profession. |
| <strong>Non-admitted procedure</strong> | Procedures that would normally be undertaken on a non-admitted basis. |
| <strong>Recorded</strong> | 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. |</p>
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<td>For purposes of this policy, reported means submitted to the Department as per applicable data collection 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.</td>
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11 Appendices

Appendix 1: Reference manuals, policies and supporting information

Reference manuals and mandatory policies


Supporting information

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

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
- child abuse and noncompliance with essential treatment recommendations
- failure to thrive.

Intensity of service

Due to the severity of illness the need for overnight 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

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9 Additional paediatric criteria.
Appendix 3: Request to review same day non-admitted procedure status

Same day non-admitted procedures are procedures that would normally be undertaken on a non-admitted basis and therefore **not** accepted as a reason for admission in their own right.

Requests for a change in a procedure’s status must include a brief overview describing the clinical circumstances justifying the reclassification to a same-day admitted procedure for all patients.

Factors that must be considered when applying for reclassification:

- benchmarking against a comparable same day admitted procedure
- best national practice
- resource consumption
- existing classification in existing systems, for example AR-DRG
- other – please specify

Please forward this request to: royalstreetdatareviewgroup@health.wa.gov.au

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Appendix 4: Cancelled procedure flowchart

1. Admission is booked for a procedure which is cancelled?
   - NO: Admission is reported as per relevant section of ARDT manual.
   - YES: Proceed to the next step.

2. Despite the procedure being cancelled, the admission continued for some other treatment or circumstance, under clinician's orders and meeting admission criteria?
   - NO: Admission is not reported.
   - YES: Proceed to the next step.

3. Procedure is dialysis/infusion/transfusion or apheresis?
   - NO: Proceed to the next step.
   - YES: Procedure commenced?
     - NO: Admission is not reported.
     - YES: Proceed to the next step.

4. Patient is already in theatre or procedure room e.g. endoscopy procedure room, cardiac cath lab, radiology i.e. where procedure is performed under CT guidance?
   - NO: Admission is not reported.
   - YES: Patient has received pre-medication i.e. Emla gel/cream, eye drops, iodine lotion, IV saline, anxiolytics and antiemetics or anaesthesia has been administered?
     - NO: Admission is not reported.
     - YES: Proceed to the next step.

5. Patient admitted on the same day as booked procedure?
   - NO: Admission is reported.
   - YES: Admission is not reported.
Appendix 5: Admission policy reference manual query submission

Please document your query that relates to the current Admission policy and/or Reference manual in the area below. You may include relevant de-identified data or supporting documentation with your query. This documentation must be sent in a secure and encrypted manner. If further information is required about your query, we will make contact with you. Please send your completed query and associated documentation to the AADAG at the following email address: royalstreetdatareviewgroup@health.wa.gov.au

The AADAG do not endorse educational material generated by Health Service Providers (HSPs) or Contracted Health Entities (CHEs). The AADAG will however answer queries related to admitted activity that may be contained in such material.

Query Details:

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De-identified data: This is information that does not contain a person’s name(s) or date of birth.