Admission, Readmission, Discharge and Transfer Policy for WA Health Services

Improving care | Managing resources | delivering quality

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Delivering a Healthy WA
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Foreword

With the introduction of Activity Based Funding and Activity Based Management (ABF/ABM), our health care system is currently undergoing a major institutional reform process.

ABF/ABM is becoming the principal mechanism for funding and resourcing health care services in our State. One of the benefits of ABF/ABM is the clear link between the dollars we spend and the services we provide to patients and the community.

As custodians of taxpayer funds and providers of an essential public service, it is important that we have the appropriate policy levers to ensure ABF/ABM functions to serve our priorities and strategic intent. In order for this to occur, all of our health services, hospitals and clinics must ensure that health care activity is counted and labelled in a consistent and meaningful fashion.

The Admission, Readmission, Discharge and Transfer Policy for WA Health Services (ARDT Policy) is a key part of this process and provides the overarching framework for rules and criteria that govern counting and labelling activity across the state. It is the first policy of its kind in the State in terms of its scope and scale.

Compliance and consistency with the ARDT Policy is highly important for two reasons. Firstly, consistent classification and tracking of activity within Western Australia (WA) will allow us to distribute funds efficiently and equitably across our vast health care system, achieve value for money and deliver the most benefit to patients and the community.

Secondly, it will serve to position WA in terms of upcoming national transition to ABF, which was agreed to by the Council of Australian Governments (COAG) in February 2011.

I am pleased to present the ARDT Policy and look forward to its consistent implementation throughout WA Health.

Kim Snowball
Director General
1. Introduction

1.1 Purpose
WA health services, hospitals and health care facilities have an obligation to count and label activity in a meaningful and consistent fashion. The Admission, Readmission, Discharge and Transfer Policy for WA Health Services (the ARDT Policy) provides a framework as well as a set of detailed and clear set of rules and criteria to enable this to occur.

WA Health is transitioning to Activity Based Funding and Activity Based Management (ABF/ABM) as the principal resource allocation and funding mechanism. In addition, there is an upcoming national transition towards this method of funding. This means that labelling activity accurately and consistently is now especially important in order to:

- Ensure equitable and efficient resource allocation within WA Health.
- Position the State to align with upcoming national hospital funding reforms.

Failure to achieve these objectives carries a number of serious implications ranging from sub-optimal resource allocation and service delivery to the WA community, to sanctions and disciplinary procedures brought down by the Commonwealth.

1.2 Scope
The ARDT Policy applies to all hospitals and health care facilities where publicly funded care is delivered.

1.3 Responsibilities
The responsibility to enact the rules described in the ARDT Policy lies with the entire health care team including the following key members: clinicians, coders, ward and admissions clerks, health information staff and managers.

1.3.1 Clinicians
Clinicians (medical officers, nurse practitioners, nurses, allied health professionals) have a particularly important role in ensuring health services compliance with the ARDT Policy. It
is the clinical decisions making and, most importantly, how these decisions are communicated and documented that enables the other team members listed above to perform their duties and ensure accurate counting and labelling of activity across the system.

1.4 Principles

The following principles underpin the ARDT Policy and its implementation:

- The patient, carer and family are of paramount concern.
- The WA Health Care System serves the West Australian community.
- Rules should be applied consistently and in a standardised manner.
- Transparency and integrity in data collection and reporting are essential in producing an efficient, high-quality health service.
- Policy and decision rules should be driven by best practice, not by software capabilities or restrictions.

1.5 Review

As a minimum requirement, this policy should be reviewed annually and national health reform policies should be included in a timely manner as appropriate.

1.6 Related Policies, Technical Bulletins and Directives

This policy should be read in conjunction with the:

- The Hospital Morbidity Data System (HMDS) Reference Manual.
- Neonatal Care Information reporting (Technical Bulletin 14/5, 2004).
- Non admitted Patient services Information reporting (Operational Directive 0284/10, 2010).
- Rehabilitation – definitions and reporting requirements (Operational Directive 0025/06, 2006).
- Hospital in the Home (Technical Bulletin 78/0, 2006).
- Patient-level information reporting for Non Admitted Outpatient Care Services (Operational Directive 0168/09).
- Reporting contracted services for admitted patients (Operational Directive 0179/09, 2009).

This Policy **supersedes** the following Technical Bulletins and Operational Directive.

- Transferred Patients (Technical Bulletin 50/0, 2002).
2. Admission

A person becomes an admitted patient once they undergo a hospital’s admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in traditional hospital setting and/or in the person’s home (under specified programs such as Hospital in the Home - HITH).

A person may be admitted if one or more of the following apply:

1. The person’s condition requires clinical management and/or facilities not available in their usual residential environment.
2. The person requires observation in order to be assessed or diagnosed.
3. The person requires at least daily assessment of their medication needs.
4. The person requires a procedure/s that cannot be performed in a stand-alone facility, such as a doctor’s room without specialised support facilities and/or expertise available (for example cardiac catheterisation).
5. The patient is aged nine days or less.
6. There is a legal requirement for admission (for example under child protection legislation; or an adult at risk). Refer also to Section 2.7.9 – Exceptional circumstances for further information.

NOTE:

- The decision to admit can only be made by authorised clinicians (a medical officer or nurse practitioner).

2.1 Admission Categories and Classes

There are two broad categories of admissions:

1. same day
2. overnight.

Several classes exist within these categories, according to criteria specified below and in this Policy (refer to Section 4 – Readmission).
NOTE:

- There are no other criteria for admission.
- Care provided to a patient in a non-admitted hospital setting over an extended period of time does not in itself constitute (conversion to) an admission. A patient in a non-admitted care setting may only be admitted after at least one of the admission criteria is met.
- Under these criteria, the fact that a procedure is undertaken in a procedure room does not, in itself, justify admission.

2.1.1 Intended Length of Stay (LOS)

The criteria for all admission categories and classes reflect the intended level of treatment that the patient is to receive. The decision to admit is based on these criteria, which must be considered before a decision is made.

The clinician responsible for admission must document intended length of stay, which is either:

1. Intended same-day stay (it is anticipated that the patient will be discharged on the same day as admission); or
2. Intended overnight stay (a minimum of one night in hospital is anticipated).

NOTE:

- Intended length of stay should be assigned on admission and should not be revised in view of the actual length of stay.
- Where the intended length of stay is not known at admission, intended overnight stay is recorded.
- Refer to the HMDS Reference Manual for further information.

2.1.2 Documentation

Hospitals and clinicians are responsible for ensuring that appropriate records are maintained to facilitate accurate reporting, and to justify the admission. Periodic audits will be conducted to monitor compliance.
2.2 Admission Status

All admissions must have an urgency status assigned, to indicate if the admission occurred on an emergency or elective basis:

1. Elective – waitlist.
2. Elective – not waitlist.
3. Emergency Admission.
   a. Emergency - ED admission.
   b. Emergency - Direct admission.

2.2.1 Elective - Waitlist

In the opinion of the treating clinician, care is necessary but admission can be delayed for at least twenty-four hours. Elective Waitlist patients may include cases under investigation for a non-urgent illness, or planned non-urgent procedures.

NOTE:

- Refer to Appendix 1 - Definitions for further detail on ‘waitlist’ definition.

2.2.2 Elective - Not Waitlist

This is the same as ‘elective – waitlist’ but these patients are not entered on the centralised waitlist, however, may be entered on booking lists that have a scheduled date of admission assigned.

This may include non-urgent obstetric cases, repeat admissions for renal dialysis, chemotherapy and follow-up endoscopy.

Newborn babies in the birth episode or babies born before arrival at hospital are always elective – not waitlist admissions.

2.2.3 Emergency admissions

Admission for care or treatment which, in the opinion of the treating clinician, should occur within 24 hours.
Emergency care includes patients suffering from an acute illness or injury that requires urgent assessment and treatment. These patients are usually admitted via the Emergency Department or may be a direct admission to an Intensive Care Unit, Burns Unit or other specialty area (not necessarily a ‘specialty’ if in a rural hospital).

There are two types of emergency admissions:

i. **Emergency Department**: the patient was admitted via the hospital’s own Emergency Department.

ii. **Direct Admission**: the patient was directly admitted to hospital *without admission via the hospital’s own Emergency Department*. This includes patients admitted via the Emergency Department of another establishment.

**NOTE:**

- An admission, from a private medical practice directly to hospital, which has not been placed on a formal booking list or waitlist, is an emergency admission.
- Refer also to *Section 4.4 – Patients readmitted within 24 hours* for further information.

### 2.3 Non-admitted Patients

For the purposes of this policy and patient classification in general, it is useful to first outline the criteria for non-admitted cases.

Non-admitted patients do not meet the Admission Criteria, and do not undergo a hospital’s formal admission process. In general, non-admitted patients receive ‘simpler’, less prolonged treatment, monitoring and evaluations than same-day or overnight patients.

There are several non-admitted patient categories, including (but not limited to):

1. Emergency Department patient who does not fit admission criteria / is not admitted.
2. Outpatient.
3. Patients attending for a procedure on the Non-Admitted procedures (Type C) list, without other justification for admission documented by the treating medical practitioner in the medical record.

4. Dead On Arrival (no active resuscitation).

5. Babies who are stillborn, or show no sign of life at birth.

6. Other non-admitted patient:
   a. Boarders;
   b. Posthumous organ donor; and
   c. Cancelled, reversed (refer to Section 2.7.6 - Cancelled or abandoned treatment/procedure).

**NOTE:**
- The decision to admit does not depend solely on the amount of time spent in the ED, whether the patient occupied a bed or was attended to by a medical officer (refer to Section 2.4.4 – ED presentations for further information).
- Ambulatory Surgery and Aged / ‘flexible care’ patients are technically non-admitted patients (refer to Section 2.6.3 (ii) – Nursing home type care (NTHP).)
  - These patients, though reported via the HMDS are non-admitted. As non-admitted activity, the MBS and PBS can be accessed for portions of costs. Additional funding or cost shifting would not fully cover the associated costs with treating these types of patients / clients / consumers.
Patients

Emergency

ED Presentation

Direct Admission

Wait list

Non-wait list

Elective

NON ADMITTED
1. ED ATTENDANCE
2. OUTPATIENT SERVICES
3. COMMUNITY AND OUTREACH SERVICES
4. BOARDERS
5. CANCELLED PROCEDURES
6. REFUSED PROCEDURES
7. DEAD ON ARRIVAL
8. POSTHUMOUS ORGAN DONATION
9. STILLBORN

Emergency Elective

ED Presentation Direct Admission Wait list Non-wait list

Acute

Sub-Acute

Non-Acute

Same Day

Overnight

Admitted Procedures (Type B)

Automatically qualified for admission (Type B)

Commonwealth Legislation

Special circumstances → Clinical decision to admit becoming...certified

Contracted Care

Non-Admitted Procedures (Type C)

Admitted Procedures (Type B)

Non-Admitted Procedures (Type C) when certified

Same-day extended medical treatment (SDE)

Band 1
Band 2
Band 3
Band 4

Organ donation

Overnight Adult (OA)
16 Admission criteria

Overnight Paediatric (PA)
20 Admission criteria

Overnight Mental Health (MH)
Additional legal and social factors

Newborns <9 days old
8 criteria to distinguish b/w QN and UQN

Qualified (QN)

Unqualified (UQN)
2.4 Same-day (Day Only) Admissions

Same-day (SD) admissions can be either booked or arrive via the ED and occur when a patient is admitted and separated on the same date. There are various considerations when classifying same-day cases/patients.

Commonwealth rules dictate what procedures/conditions can and cannot be admitted as same-day cases. These considerations and resulting same-day admission classes/categories are outlined in Section 2.4.2 – Same-day admission classes.

NOTE:

- There can be exceptions based on clinical appropriateness.
- The four bands of same-day admissions are described in Section 2.4.3 – Classification for SD admissions: ‘Bands’.
- The distinction between same-day and non-admitted patients, and rules for presentation via the ED are outlined in Section 2.4.4 – ED presentations.

2.4.1 Commonwealth rules on SD classification (Type B and C)

SD admissions are generally governed by Commonwealth legislation. Decisions on whether to admit or not admit patients as same-day cases revolve around explicit inclusions and exclusions for procedures/conditions set by the Commonwealth.

Comprehensive lists covering procedures considered to be Type B and Type C are maintained, and are referred to as the:

1. Admitted procedures (Type B) list
2. Non-admitted procedures (Type C) list.

These lists can be found in Appendix 2 - 1. Admitted procedures (Type B) list and Appendix 3 - 2. Non-admitted procedures (Type C) list. These are based on Schedule 3 of the Private Health Insurance (Benefit Requirements) Rules 2010.

The list will be centrally maintained and updated in view of new or altered Type B/Type C designations. The Department of Health will review these lists annually for updates. These lists will be published throughout WA Health.
NOTE:

- Regular updates and technical bulletins will be released to minimise ambiguity regarding same-day patient classification.

2.4.2 SD admission classes

A patient should be admitted as a SD case if the *intention* or plan is to deliver and complete treatment on the same day. The final classification of patients is always done retrospectively after separation.

SD admissions fall into three groups (these groups are to assist in distinguishing procedures and not for formal classification):

A. SD extended medical treatment (SDE)
B. SD admitted procedures (Type B)
C. SD not admitted procedures (Type C) when certified

NOTE:

- SD admissions B and C, fall into **four bands**, which are described in *Section 2.4.3 Classification for SD admissions: ‘Bands’.*

Rules for each are outlined below:

A. Rules for Same-day extended medical treatment (SDE)

SDE patients receive a minimum of four hours of continuous active management consisting of:

- Regular observations (which may include diagnostic or investigative procedures); or
- Continuous monitoring.

When determining a patient’s eligibility for admission, the following factors could be taken into account:

Regular observations may include:

- Observations of vital or neurological signs provided on a repeated and periodic basis during the patient’s treatment.
• Provision of repeated and periodic diagnostic or investigative procedures or provision of treatment.

Continuous monitoring could include:

• Continual monitoring via ECG or similar technologies\(^1\).

• Continuous active supervision or treatment by clinical staff.

Hospitals are encouraged to develop local policies or guidelines as to what constitutes regular observations. These guidelines should be consistent with established clinical pathways, protocols or accepted clinical practice.

NOTE:

• **Exclusions:** Rest prior to discharge home;
  - LOS primarily consisting of waiting for results of diagnostic tests;
  - Patient has been present at the hospital for more than four hours, but has not been engaged in treatment or diagnosis.

• Non-admitted services provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode (refer to Section 2.7.4 – Outpatient episode while an admitted patient).

• When a patient is transferred from the ED to a ward (including short stay units), the ‘Admission Time’ is defined as the time that treatment was started in the ED rather than the time it was decided to transfer the patient. Any intervention provided after treatment commences should be recorded and identified as part of the admitted patient’s episode of care.

B. Rules for SD Admitted Procedures (Type B)

In order to meet this admission criterion, it must be the intention that the patient will:

• Receive at least one procedure listed on the Admitted Procedure (Type B) List (refer to Appendix 2 - Admitted procedures (Type B) list).

  **AND**

• Receive treatment on a day-only basis.

\(^1\) Continual blood pressure and/or pulse monitoring is not considered a sufficient level of continual monitoring for these purposes.
Intravenous (IV) therapy is included on the SD Admitted Procedures (Type B) list, with the following exceptions:

- Placement of an IV cannula alone.
- IV injections.
- IV therapy as part of, or given at any time during, a Type C. procedure (for example, IV contrast in radiological procedures, IV normal saline in diagnostic tests).
- IV therapy covered by the Highly Specialised Drugs Program\(^2\).

**NOTE:**

- A patient who is not *intended* to receive an admitted procedure cannot meet this criterion B. above for SD admission.
- Where a patient is expected to require treatment on an overnight or multi-day stay basis while receiving an Admitted Procedure, they should be admitted under the applicable overnight admission category (refer to Section 2.3 – Overnight Admissions).
- The Lists (and codes) for Admitted, and Not Admitted Procedures when certified, can be found in Appendix 2 - 1. Admitted procedures (Type B) list and Appendix 3 - 2. Non-admitted procedures (Type C) list. These lists are derived from Schedule 3 of the *Private Health Insurance (Benefit Requirement) Rules 2010*.

Visit:  
(Accessed 27 June 2011)

### C. Rules for SD Non-Admitted Procedures (Type C)

These are procedures that *would normally be undertaken on a non-admitted basis* and therefore *not* normally accepted as admissions in their own right. These are identified in the *Appendix 3 - Non-admitted procedures (Type C)*. These lists are derived from *Schedule 3 of the Commonwealth Private Health Insurance (Benefit requirements) Rules 2010*.

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However, under special circumstances SD admission is possible. For this to take place a patient must:

- Receive a procedure on the Non-Admitted Procedures (Type C) List

AND

- Be intended to be treated on a day-only basis

AND

- The treating medical officer must provide evidence that the patient’s special circumstances justify admission for the purpose of having this procedure. This evidence must be clearly documented in the patient’s medical record and any additional/accompanying certification must be completed.

NOTE:

- A patient who is intended to receive a procedure on the Non-Admitted Procedures (Type C) List as part of an overnight or multi-day stay should be admitted as an intended overnight stay patient (refer to Section 2.5 - Overnight admissions).

- Audits of medical records may be conducted for the purpose of ensuring that treatment of such patients in an admitted patient setting is warranted.

Visit:


(Accessed 27 June 2011)
2.4.3 Classification for Same-day admissions: ‘Bands’

Same-day admissions - patients that are admitted from categories B or C above - fall into four bands, broadly determined by the level of anaesthetic and theatre time required:

| Band 1 | This is a definitive list of procedures with no flexibility for re-classification to another band. It includes gastrointestinal endoscopy, certain minor surgical items and non-surgical procedures. Any procedures from other bands, if performed without anaesthesia, or without theatre time, default to Band 1. |
| Band 2 | Procedures (other than Band 1) carried out under local anaesthetic, no sedation. |
| Band 3 | Procedures (other than Band 1) carried out under general or regional anaesthesia or intravenous sedation. Theatre time < one hour. |
| Band 4 | Procedures (other than Band 1) carried out under general or regional anaesthesia or intravenous sedation. Theatre time one hour or more. |

NOTE:

- For further information on Bands 1-4:


2.4.4 ED presentations

The distinction between admitted and non-admitted cases warrants further explanation for ED presentations.

The following should be considered:

- Decision to admit does not solely depend on the amount of time spent in the ED, whether the patient occupied a bed or was attended to by a medical officer.
- An ED patient transferred to a holding/observation ward must meet one or more of the admission criteria (refer to Section 2.5 – Overnight admissions).

**Context:**

An **observation / holding ward** or **short stay unit** is an area of the hospital, often in close proximity to the ED, where patients may receive treatment, monitoring or evaluation.

It is used when the treating medical officer decides that appropriate treatment of the patient involves close evaluation of signs and symptoms over a period of hours before a decision is made about formally admitting the patient to a specific ward for continuing treatment or monitoring.

These wards are not a temporary ED overflow area nor used to keep patients solely awaiting an inpatient bed nor awaiting treatment in the ED.

**NOTE:**

- Other non-admitted categories such as boarders, cancellations and organ donation (posthumous) are outlined in Section 2.7 – Additional Considerations.

### 2.4.5 Multiple same-day procedures

A patient may attend two or more departments/clinics in the same hospital on the same day for a booked procedure(s) (e.g. chemotherapy and dialysis). Admission can only be undertaken **once only per day at one hospital campus**.

**NOTE:**

- Refer also to Section(s) 2.7.3 – Same-Day procedure while an admitted patient, and 2.7.4 – Outpatient admission while an admitted patient.
2.5 Overnight Admissions

Overnight admission occurs:

- when the presenting patient is expected to require overnight or multi-day hospitalisation;
- where there is a clinical and documented expectation that the patient will require ongoing admitted care.

Overnight admissions are grouped as:

1. Adult (AO)
2. Paediatric (PO)
3. Newborn/neonate
   - a. Qualified (QN)
   - b. Unqualified (UN)
4. Mental health (MH)
5. Contracted (funded) care (CC)
6. Organ donation (OD)

2.5.1 Adult Overnight Admission (AO)

For adult patients, one of the following 16 criteria related to severity of illness and intensity of service will usually be present to warrant admission:

**Severity of Illness:**

1. Sudden onset of unconsciousness.
2. Abnormally high or low pulse.
3. Abnormally high or low blood pressure.
4. Acute loss of sight or hearing.
5. Acute loss or ability to move major body part.
6. Persistent fever.
7. Active bleeding.
8. Severe electrolyte or blood gas abnormality.
10. Wound dehiscence or evisceration.
11. Incapacitating pain.

**Intensity of service:**
Due to the severity of illness (above) the need for overnight admission is anticipated for:

12. Administration of parenteral medications and/or fluid replacement.
13. Surgery or procedure scheduled within 24 hours.
14. Equipment/facilities only available in an acute care setting.
16. Intermittent or continuous use of a respirator.

**Adult overnight admission includes:**

- Patients who present to the ED, but die within a few hours, despite intensive resuscitative treatment but whose treatment plan initially included an expectation that they would require hospitalisation for a minimum of one night.
- Patients who are transferred to another hospital where the intention is that they will require hospitalisation for a minimum of one night, having received active treatment and stabilisation at the original hospital.

**Adult overnight admission excludes:**

- Patients whose treatment is expected to be concluded on the same day.
- Patients whose admitted episode includes 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).

**2.5.2 Paediatric Overnight Admission (PO)**

For paediatric patients (patients less than 16 years of age on the day of admission) there are 20 criteria:
Severity of Illness:

1. Sudden alteration to conscious state (coma, disorientation, confusion or unresponsiveness).
2. Acute or progressive incapacity.
3. Acute loss of sight or hearing.
4. Acute loss of ability to move a major body part.
5. Persistent fever, rectal temperature $>38.3$ C, or other temperature $>37.8$ C.
6. Active bleeding.
7. Wound dehiscence, evisceration, or treatment.
8. Severe plasma electrolyte/acid-base/blood pH abnormality or low Hb or PCV.
9. Pulse rate outside specified range for age.
11. Conditions not responsive to Out Patients or Accident & Emergency Department management.
13. Failure to thrive.

Intensity of Service:

Due to the severity of illness (above) the need for overnight admission is anticipated for:

14. Surgery or procedure scheduled within 24 hours.
15. Use of equipment etc. only available in an acute care hospital.
16. Treatment in an ICU, and/or intermittent or continuous use of a ventilator.
17. Vital signs monitoring every 4 hours or more often, under Medical Officer’s orders.
18. Parenteral medications and/or fluid replacement, at least 8 hourly.
19. Chemotherapeutic agents requiring continuous observations.
20. Down transfer following major specialist surgery.
Paediatric overnight admission includes:

- Paediatric patients who present to the ED, but die within a few hours, despite intensive resuscitative treatment but whose treatment plan initially included an expectation that they would require hospitalisation for a minimum of one night.
- Paediatric patients who are transferred to another hospital where the intention is that they will require hospitalisation for a minimum of one night, having received active treatment and stabilisation at the original hospital.

Paediatric overnight admission excludes:

- Paediatric patients whose treatment is expected to be concluded on the same day.
- Paediatric patients whose admitted episode includes 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).

2.5.3 Mental Health (MH) Overnight Admission

Adult or paediatric patient for whom a clinical decision is made to commence treatment for a mental health diagnosis. Treatment is anticipated to be for a minimum of one night.

NOTE:

- The criteria outlined in Section(s) 2.5.1 - Adult Overnight Admission (AO) and 2.5.2 - Paediatric Overnight Admission (PO) may or may not be present, and additional social factors may be included in the clinical decision. Other factors may include risk of self harm, harm to others.
- The reason for admitting must be clearly documented in the medical record.

2.5.4 Qualified Newborn (QN) Overnight Admission

The patient is nine days old or less at the time of admission and meets at least one of the following criteria:

- The newborn is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient.
- The newborn requires intensive or special care and is admitted to a facility approved for the purpose of provision of that care.
- The newborn is, on that day, admitted to or remains in hospital without their mother (or the mother is a boarder).

**NOTE:**
- If more than one change of qualification status occurs on a single day, the day is counted against the final qualification status.
- If the newborn continues to require acute medical care in hospital beyond 10 days of age, they remain in this classification until discharge.
- Any patient newly born in the hospital, or presenting for newborn care prior to 10 days of age, meets the admission criterion: newborn.

### 2.5.5 Unqualified Newborn (UN) Overnight Admission

The patient is nine days old or less at the time of admission but does not meet any of the criteria for QN.

UN that are still in the hospital at 10 days of age should be:

1. re-classified to Boarder status (episode of care type change); or
2. if requiring ongoing acute care, subjected to a changed client status to QN. In that case the newborn episode continues and every day of care from day 10 onwards is a qualified day.

### 2.5.6 Contracted Care

Care treatment or services purchased by one hospital from another under specific arrangement. It must be for an admitted patient (either overnight or same-day admission).

The administrative process for admission is undertaken at both hospitals/providers although physical admission occurs at one.

The **Contracted** provider/hospital/health service provides the treatment, care or service and reports the activity.
The Contracting or Funding hospital /health service requests and purchases the service from the Contracted hospital and reports the funding.

**Two examples:**

- Step down care: *postoperative management at another hospital.*
- Transitional care: *preoperative care at hospital A, procedure contracted from hospital B, postoperative care back at A.*

**NOTE:**

- Refer to **Operational Directive 0179/09** for further information.

### 2.5.7 Organ donation

There are different circumstances in which organs are donated or procured. Organ donation patients may enter hospital to donate an organ or tissues (for example kidney or bone marrow).

They will be classified as admitted patients with the episode of care ‘acute’ when the organ is removed and the patient is discharged from hospital.

**Posthumous Organ Procurement**

An admitted patient dies and becomes an organ donor in the same or another hospital:

- Such a patient’s time of statistical separation is the official time of death. The patient should undergo statistical discharge and a change in episode of care from ‘acute’ to ‘organ procurement’.
- The count of hours in ICU and/or CCU, and the Duration of Mechanical Ventilation and Non-invasive Ventilation, recorded must cease at official separation.
- The care type is changed to 'organ procurement'.
- Relevant organ procurement procedure codes are assigned as per the Australian Coding Standards.
NOTE:

- The Australian Coding Standard 0030 should be used for the recording of the different circumstances and different codes used. Circumstances may involve:
  - a live donor;
  - an organ donation following brain death; or
  - patients resuscitated and ventilated for possible organ donation.
- Patients receiving the transplanted organ are admitted patients.

2.5.8 ‘Dead On Arrival’

Patients who are dead on arrival do not qualify for admission.

2.6 Care Type

Care type refers to the nature of the treatment/care provided. Care types for overnight admissions fall into two broad categories.

- Acute Care.
- Sub-acute (with several sub-categories).
- Non-acute care (with several sub-categories).

For admitted patients, the type of care received will determine the appropriate casemix classification for the episode of care. Assigning the correct care type is critical from a cost weighting and funding perspective.

Determination and recording of the acuity of care is the responsibility of the responsible medical officer. While this responsibility rests ultimately with the most senior clinician, the task of recording acuity may be delegated to other medical officers or senior nursing staff. It must be ensured that any delegated reporting of care type is concordant with the various care type definitions.

The medical officer needs to ensure clear documentation on which of the seven care types outlined below the patient is to be classified under.
2.6.1 Acute Care

Acute care is (admitted patient) care in which the clinical intent or treatment goal is to:

- Manage labour (obstetric);
- Cure illness or provide definitive treatment of injury;
- Perform surgery;
- Relieve symptoms of illness or injury (excluding palliative care);
- Reduce severity of an illness or injury;
- Protect against exacerbation and/or complication of an illness and/or injury; which could threaten life or normal function; and/or
- Perform diagnostic or therapeutic procedures.

NOTE:

- Involuntary psychiatric admissions are a sub-category of acute care.

2.6.2 Sub-acute Care

Sub-acute care describes time limited, goal-orientated, individualised, multidisciplinary care. Its aim is to help people who are disabled, frail, chronically ill or recovering from traumatic injury to regain and/or maintain optimal function to allow people to maximise their independence and return to (or remain in) their usual place of residence.

It is available to people of all ages on an admitted or ambulatory basis and may follow an admitted episode, ambulatory care or directly from the community. Sub-acute patients generally require:

- Assessment and/or oversight of their care plan by a specialist medical consultant.
- Therapy services in accordance with individual need as identified in their care plan (for example, physiotherapy and occupational therapy).

Sub-acute care consists of the following care types:

i. Rehabilitation;
ii. Geriatric evaluation and management;
iii. Psychogeriatric care; and
iv. Palliative care.

The definitions of and rules regarding classification of these care types are outlined in more detail below:

i. **Rehabilitation**

Rehabilitation refers to care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap.

Rehabilitation is usually evidenced by a multidisciplinary rehabilitation plan comprising negotiated goals and indicative time frames which are evaluated by periodic assessment using a recognised functional assessment measure.

It includes care provided:

- In a designated rehabilitation unit;
- In a designated rehabilitation program, or in a psychiatric rehabilitation program as designated by the state health authority for public patients in a recognised hospital, for private patients in a public or private hospital as approved by a registered health benefits organisation, or
- Under the principal clinical management of a rehabilitation physician or, in the opinion of the treating medical officer, when the principal clinical intent of care is rehabilitation.

Refer to **Operational Directive 0025/06**\(^3\) for additional information.

**Acute care recovery period**

The recovery period of an acute episode prior to separation is **not** classified as a separate episode of care. It is **NOT** classified as sub-acute or non-acute care (for example, rehabilitation).

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\(^3\) This OD will become obsolete with the introduction of AN-SNAP. Additionally, RITH may see patients without fulfilling the OD criteria of a ‘multidisciplinary service’.
Example:
The final 1-2 Nights of stay (NOS) prior to discharge, following a joint replacement, are part of the acute episode. Even though the care has a lower resource intensity than the initial period, it is not rehabilitation.

Rehabilitation in the Home (RITH)
Rehabilitation may be provided in the patient’s home or place of residence as a substitution for inpatient rehabilitation.

RITH care is a substitute for inpatient rehabilitation, and may apply for part of, or the entire admission. A RITH patient must therefore fulfil the same criteria for admission as any other admitted rehabilitation patient. Ideally, RITH should be recorded when the patient has been visited in his/her home (or other residential service not providing care) by clinical staff providing services to the patient.

NOTE:
- Refer to Section 2.7.2 - Hospital in the Home (HITH) for further information.
- Long term patients in a rehabilitation unit whose care becomes primarily respite or nursing home type should have a change in Care Type to Maintenance Care.

ii. Geriatric Evaluation and Management
Care in which the clinical intent or treatment goal is to maximise health status and/or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, who is usually (but not always) an older patient. This may also include younger adults with clinical conditions generally associated with old age.

This care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. Geriatric evaluation and management includes care provided:
- in a geriatric evaluation and management unit;
- in a designated geriatric evaluation and management program; or
under the principal clinical management of a geriatric evaluation and management physician or, in the opinion of the treating medical officer, when the principal clinical intent of care is geriatric evaluation and management.

iii. Psychogeriatric Care

Care provided to an elderly person with either an age-related organic brain impairment with significant behavioural disturbance or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric disturbance or behavioural disturbance, for whom the primary treatment goal is improvement in health, modification of symptoms and enhancement in function, behaviour or quality of life.

It is evidenced by multidisciplinary assessment and/or management of complex medical psychiatric and functional conditions; and regular reassessments working towards negotiated goals within an indicative time frame.

It includes care provided:

- in a Psychogeriatric care unit.
- in a designated Psychogeriatric care program.
- under the principal clinical management of a Psychogeriatric physician.
- with the principal clinical intent of psychogeriatric care (In the opinion of the treating medical officer).

NOTE:

- Patients who are admitted for respite care in a Psychogeriatric unit should be assigned a Care Type of maintenance care.

iv. Palliative care

Care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and grief and bereavement support service for the patient and their carers/family.
Palliation provides relief of suffering and enhancement of quality of life for such a person. Interventions such as radiotherapy, chemotherapy, and surgery are considered part of the palliative episode if they are undertaken specifically to provide symptomatic relief.

Palliation includes episodes:

- in a palliative care unit;
- in a designated palliative care program;
- under the clinical management of a palliative care physician; or
- where in the opinion of the treating medical officer the principal clinical intent of the care is palliation.

2.6.3 Non-acute Care

Non-acute care is maintenance care. It includes respite care, care awaiting placement, care provided to nursing home type patients and any other care where the primary goal is maintenance of current health status in a patient with a chronic condition or disability.

Residential aged care is a non-admitted service and is not included in the definition of maintenance (non-acute) care.

i. Maintenance (including Respite) Care

Non-acute patient care includes care provided to those who:

- are Nursing Home Type Patients (NHTPs), i.e. when a person has been in hospital for a continuous period of more than 35 days and does not have a current acute care certificate; or

- are Other Non-Acute Patient⁴: These include patients with an episode of care type of Maintenance Care who do not fit the definition of a Care Awaiting Placement (CAP), Respite (RESP), Nursing Home Type Patient Awaiting Placement (NHTAP) or Nursing Home Type Patient (NHTP). They would not normally require hospital treatment but there are factors in the home environment (physical, social or psychological) which make it inappropriate for the person to be discharged to home in the short term; or

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⁴ Refer to Technical Bulletin 20/6.
are not NHTPs but are in receipt of respite care where the sole reason for admitting the person to hospital is that the care that is usually provided in another environment, for example, at home, in a nursing home, by a relative or with a guardian is unavailable in the short term; or

- are treated in psychiatric units and who have a stable but severe level of functional impairment and inability to function independently without extensive care and support and for whom the principal function is the provision of care over an indefinite period. This includes psychogeriatric patients admitted for respite care.

- Care Awaiting Placement:² where a patient who has been assessed by an Aged Care Assessment Team (ACAT) or clinician as requiring more intensive day to day care needs than what can be supported in their home environment and are awaiting placement in a Nursing Home or Hostel and does not yet meet the qualification of the 35 day rule.

Respite care patients are those with chronic conditions who are usually managed at home but who, due to factors in the home environment (physical, social or psychological), require hospital admission. The care given is for functional maintenance only.

ii. Nursing home type care (NHTP)

After 35 days of continuous hospitalisation a patient is classified as a NHT patient unless a medical practitioner certifies that the patient is in need of acute care (or Rehabilitation, Palliative Care or Geriatric Evaluation and Management).

Three examples:

- Professional attention for an acute phase of the patient’s condition.
- Active rehabilitation.
- Continued management, for medical reasons as an admitted patient.

A patient cannot be designated NHT before 35 days of continuous hospitalisation (with a maximum break of seven consecutive days) even if an Aged Care Client Record (ACCR) has been signed.

However, they can be Care Awaiting Placement (CAP) or Other Non-Acute Patients (ONAP).
Non-acute compensable and non-acute ineligible

- Under current legislation, compensable and ineligible patients cannot be categorised as Nursing Home Type. However, where such a patient has been admitted in one or more hospitals (public and private) for a continuous period of more than 35 days with a maximum break of seven consecutive days and who, if not a compensable/ineligible patient would be deemed to be a Nursing Home Type patient, then the patient is deemed to be Non-Acute.

- Following 35 days of continuous hospitalisation a patient becomes NHT/Non-Acute unless the patient continues to receive acute care.

- Nursing Home Type Patient Awaiting Placement: See Technical Bulletin 20/6 A Nursing Home Type Patient as per the Health Insurance Act 1973 (see NHTP) who has been assessed by ACAT or clinician as awaiting placement in a residential aged care facility.

In public hospitals

- For public patients, a medical practitioner or their delegate must provide certification that the patient requires acute care after 35 days of continuous hospitalisation.

- For private and compensable patients, a medical practitioner must provide certification that the patient requires acute care after 35 days of continuous hospitalisation.

- Therefore, in public hospitals, a patient receiving any one of the admitted patient Care Types will become a NHT/Non-Acute patient if they receive 35 days of continuous hospitalisation and do not have certification allowing the present type of care to continue.

- The decision for a patient to continue to receive acute care following 35 days of continuous hospitalisation is a clinical one, which needs to be clearly documented then communicated to the relevant staff who report data on admitted episodes of care. This enables the identification of episodes that continue to be acute beyond 35 days and thus do not require statistical separation from an acute episode and a statistical admission to commence an NHT/Non-Acute episode.
NOTE:

- 35 days of hospitalisation can be accrued across hospitals when a patient is transferred. Continuity is not broken by normal leave or when a patient is out of hospital for no more than seven consecutive days.

Example:

A patient receives admitted patient care in a hospital for 20 days and is then transferred to another hospital. On the 16th day of the second admission, the patient becomes a Nursing Home Type patient (if acute care certification does not exist). If, in this example, the patient was on normal leave for two days during the accrual period, the change to Nursing Home Type would not occur until the 18th day of the second admission (two days later).

- If a NHT patient is out of any hospital (other than for contracted services) for more than seven consecutive days, the 35 day count begins again.

Long Stay Patients

Patients, who remain in hospital for more than 35 days, in order to receive ongoing acute or sub-acute care, remain classifiable as Other Admitted Patients (not NHTP).

They are not deemed NHTP until such time as the clinician authorises a change in care type to Maintenance (non-acute) Care. NHTP patients can be re-classified to acute/sub-acute care if there is a revision of the medical officer’s opinion regarding the acuity of care required, such as may occur where the patient develops a secondary condition requiring medical attention.

It is expected that NHTP will not actually remain in hospital unless part of a Multi-purpose Site Agreement but will be transferred to a nursing home, or allocated an appropriate care type bed for their ongoing care.

iii. Aged care in Multi-Purpose Service (MPS) and non-MPS facilities

Due to differences in funding arrangements, a distinction is drawn between residential aged care services in MPS sites and residential aged care services in non-MPS sites. At MPS sites these services are flexible in both delivery and funding arrangements and are therefore referred to as ‘flexible care’.
Flexible care (in MPS Facilities)

Flexible care is only provided at MPS sites and only to non-private patients.

A patient becomes eligible for flexible care if they are:

- Assessed by the Aged Care Assessment Team (ACAT) or their clinician; and
- Approved for residential aged care.

In addition, there are four different sub-classifications:

- **High dependency** - approved for high dependency residential care (ie permanent care unit/bed, nursing home bed);
- **Low dependency** - approved for low dependency residential care (ie hostel);
- **Residential respite** - approved for residential respite. Residential respite may be high dependency (ie permanent care unit/bed, nursing home bed) or low dependency (hostel); and
- **Resident Awaiting Placement** - Flexible care type residents who, after approval for residential care, are awaiting placement in a designated residential aged care bed.

**NOTE:**

- Private patients who have been in hospital for more than 35 days and do not have an acute care certificate continue to be reported as Nursing Home Type Patients. Some MPS sites may have privately insured clients who are classifiable (below) as aged care residents.

**Aged Care (MPS and non-MPS)**

This category includes any patient who has been ACAT assessed, approved for residential aged care and is a resident of a:

- Nursing Home; or
- Hostel.

This includes patients who have been ACAT approved for residential respite in these facilities but excludes residents of a fully Commonwealth-funded unit.
For MPS sites, this category, if applicable, would comprise private clients only. Non-private residents at an MPS are Flexible Care Type Residents.

**NOTE:**

- Where a Residential Aged Care (RAC) reporting establishment has been created (effective 1 August 2006) these residents should be recorded against the RAC rather than the hospital. Patients who chose to use their Private Health Insurance even if assessed and approved for residential aged care should be recorded against the Hospital establishment and classified according to the business rules for Non-Acute/Respite/Maintenance Care/Nursing Home Type Patients.

### 2.6.4 Changing care type during admission

An admission service may consist of more than one care type. The classification and distinctions become highly important when care type is changed. A uniform reporting process in all hospitals is required for reporting episodes of care.

**When the care type changes a new episode of care should be reported.**

**Example:**
Acute Care patients who during their care become palliative will need to be statistically discharged and readmitted as Palliative Care.

**NOTE:**

- Change in type must not be executed for a change in ward, funding source or client status.

### 2.6.5 Temporary Care type escalation

An admitted patient may require increase in acuity of care.

**Example:**
A patient admitted for rehabilitation requires, or is scheduled for a procedure that warrants an acute episode during the hospital stay (i.e. within the same hospital or campus).
A statistical discharge must take place and a new episode is reported5.

2.6.6 Retrospective care type changes
Occasionally change of care type may need to be made retrospectively. There are three situations when this may occur:

- Change is documented explicitly in the medical record but no episode of care (EOC) form has been completed.
- The EOC form has been completed but has not been entered onto the patient administration system (PAS).
- A change in the acuity of care is indicated in the medical progress notes and requires confirmation by the clinician that a change in care type occurred.

2.7 Additional Considerations

2.7.1 Haemodialysis (HD)/Renal Dialysis
Renal or haemodialysis (refer to Appendix 1 - Definitions) can be performed in a variety of settings, including the patient’s home, depending on clinical need. It is considered a high-cost and high volume service, and therefore it is critical that renal dialysis delivery is coordinated and efficient as possible.

Patients should always be dialysed in a setting/modality that meets their minimum clinical and social requirements. However, the final decision on the appropriate setting/modality for dialysis always rests with the treating medical officer.

There are four settings/modalities as follows (refer to Appendix 1 - Definitions):

1. In-centre HD;
2. Satellite HD;
3. Home HD; and

Refer to Technical Bulletin 4/5 for further information.

5 To avoid double counting the bed days, any same day episodes so generated, should be excluded from length of stay/ bed-day figures.
NOTE:

- Haemodialysis is NOT a separate care type. It is classified as acute care.
- Home HD and CAPD are classified as non-admitted episodes.
- Contracting arrangements between providers may exist for this service. Rules regarding contracted care (refer to Section 2.5.6 – Contracted care) apply to such situations.

2.7.2 Hospital in the Home (HITH)

Under the Commonwealth definition, HITH is considered ‘admitted patient care’. It is usual that these patient types are seen at least daily, by clinical staff providing inpatient care, however it is recognised that this may not always be the case.

Ideally, HITH patients not seen by any staff during any day, are on leave for that day.

HITH patients admitted to another hospital are treated as any other inter-hospital transfer.

As admitted patient care, HITH provided by one hospital, on behalf of another hospital, will fall within the ambit of contracted services reporting (refer to Operational Directive 0179/09 for further detail on contracted services).

NOTE:

- Refer to Technical Bulletin 78/0, Operational Procedure 2021/06 for further information.

2.7.3 Same-day episode while an admitted patient

An admitted (in)patient may require a same-day procedure during an overnight/multi-day admission. The same day procedure should be amalgamated into the longer admission (i.e. a separate episode should not be recorded for the same-day procedure) unless it involves temporary care type escalation – (refer to Section 2.6.6 – Temporary Care type escalation).

NOTE:

- Exceptions: Satellite dialysis.

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5 Sourced from the National Health Data Dictionary – ‘Hospital-in-the-home care’.
2.7.4 Outpatient episode while an admitted patient

Outpatient (non-admitted) episodes during another (overnight) admission should be included as part of the overall admission. If the Outpatient service event is not related to the inpatient event, then it can be counted separately (to the inpatient event).

Example:
A Chronic Obstructive Pulmonary Disease (COPD) patient has a physiotherapy outpatient appointment for knee rehabilitation.

NOTE:
- Refer to Operational Directive 0168/097 for further information.

2.7.5 Recurrent Admissions

Recurrent admissions are planned, regular and periodic episodes (either same-day or overnight). Examples include:

- Dialysis.
- Chemotherapy and IV treatment.

For these patients, every episode of care must have a formal admission and discharge. This does not apply to HITH and RITH patients as they are already admitted patients.

Same-day procedures can occur on consecutive days.

NOTE:
- Readmissions are addressed in Section 4 - Readmission.

7 Please note that this OD is currently under review.
2.7.6 Cancelled or abandoned treatment / procedure

Reporting of cancelled and abandoned procedures

In elective admissions for a booked procedure which is cancelled prior to commencement the following reporting rules apply:

1. When only the administrative processes have been completed, the admission should be reversed.

2. Where a clinician spends time counselling or assessing a patient, the admission should be reversed and that time should be recorded as a non admitted service event.

3. *Abandoned procedures (see definition below) remain inpatient episodes of care and are reported through the HMDS.

4. For systems not able to reverse, or when, for internal purposes, a coded record of the attendance is desired, the outpatient event should still be recorded. The coded episode will be excluded from the inpatient data\(^8\).

5. Waitlisted patients whose procedures are cancelled or abandoned will need to be rebooked.

For reporting purposes the booked procedure commences with:

- the administration of pre-operative sedation or anaesthesia; or
- arrival in theatre or similar procedural unit (for example, endoscopy suite); or
- commencement of any infusion, transfusion or dialysis.

Cancellations beyond this point are regarded as abandoned procedures and continue to be reported as inpatient episodes of care using the following guidelines:

- *Abandoned procedures - where the procedure is aborted after arrival in theatre, after administration of pre-operative sedation or anaesthesia or after commencement of any booked infusion, transfusion or dialysis, the procedure is regarded as abandoned. Such cases continue to be reported as admitted (inpatient) episodes of care.

\(^8\) refer to WA Coding Standards – Operational Directive 0154/08 for further information.
- **Continuing admissions** - an elective procedure may be cancelled, yet inpatient care continues for monitoring, investigation, or treatment of some other symptom or condition, under medical officer’s orders. Such cases continue to be reported as admitted (inpatient) episodes of care.

**NOTE:**

- The level of same-day admissions involving cancelled procedures is continually monitored.
- Refer also to the WA Coding Standards- Cancelled Procedures, for details of clinical codes assigned (under Operational Directive 0154/08).

### 2.7.7 Patients who present, then refuse admission

In the event of a patient presenting to hospital then changing their mind and consequently refusing admission:

- If the clerical procedures have been completed but the patient refuses to be admitted - the admission should be cancelled.
- Any time spent by the clinician counselling or encouraging the patient to be admitted should be recorded as a non-admitted service event.

### 2.7.8 Boarders

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

There are several types of boarders, determined by circumstances (refer to Operational Directive 0082/07 for further detail).

Boarders are not admitted but may be registered on the hospital's PAS. However, boarders must be excluded from patient and episode counts.

Boarders must stay a minimum of one night.

Babies in hospital at age nine days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either a qualified or unqualified day.
Changes under webPAS:
Commencing in 2011, webPAS will gradually replace other PAS used in WA. webPAS will provide capability to register non-admitted individuals without having to create an admission for them and that registration can occur without creating an episode of care.

Currently, hospitals should continue to 'admit' boarders as the sole means of registration.

2.7.9 Exceptional circumstances

There will be exceptional circumstances under which a decision to admit is made to ensure a person’s welfare. There may also be legal/social factors such as:

- Child at risk (Department of Child Protection orders, suspected child abuse); and
- Adult at risk (ie domestic violence).

The treating clinician must consider the full clinical details of each patient as well as any specific individual circumstances that exist. Exceptional cases which do not meet the admission criteria, but which the treating medical officer decides require overnight stay or a same day admission, should have the exceptional reasons documented clearly.

In addition, the admitting criteria may not always be present in the following care types:

- Obstetric care – admission to manage labour and/or delivery.
- Sub-acute and non-acute care:
  - Rehabilitation.
  - Palliative care.
  - Psychogeriatric care.
  - Maintenance (non-acute) care (ie Nursing Home Type Care).

Patients living in rural or remote areas may not always meet any one of the listed criteria for adult or paediatric patients. The treating clinician may decide that optimal patient

9 Some of these are addressed in Section 2.5.3 - Mental Health Overnight Admissions.
management requires an overnight-stay even in circumstances where none of the criteria are present.

**Two examples:**
The admission of a patient to monitor a suspected premature labour however labour is not confirmed. The patient remained in hospital overnight and was discharged in the morning; **OR**
Patient presents with confusion. An admission is authorised for assessment of the underlying cause(s).

If special circumstances influence the clinician’s decision to admit a patient, the reasons should be documented in the patient’s medical record.

The hospital’s admission protocols aim to meet both the patient’s need to be provided with high quality care in a professional and compassionate manner, as well as management needs for efficient use of limited hospital resources.
3. **Discharge (Separation)**

A patient is separated at the time the hospital ceases to be responsible for the patient’s care and the patient is discharged from hospital accommodation.

Hospital waiting areas, transit lounges and discharge lounges are not considered hospital accommodation unless the patient is receiving care or treatment in these areas.

A separation may be formal or statistical and is further explained as follows:

**Formal separation** - the administrative process by which a hospital records the cessation of treatment and/or care and/or accommodation of a patient.

Where the patient meets one of the following criteria:

- Is discharged to private accommodation or other residence (no intention to return to the hospital within seven days for the continuation of the same treatment).
- Is transferred to another hospital, health service or other health care accommodation.
- Is transferred to other health care accommodation (unless there is an intention to return to this campus within seven days for continuation of the same treatment - in which case the patient should be placed on leave).
- Is discharged following a procedure from the Admitted Procedure (Type B) List (even if the patient is returning within seven days for another treatment).
- Dies.
- Leaves against medical advice, and does not return for continuing treatment within seven days.
- Fails to return from leave within seven days. The patient is discharged effective from the date upon which their failure to return was noted.

Refer to **Section 4 - Readmission** for guidance related to situations where a patient is separated, then deteriorates and returns to the hospital and is subsequently re-admitted.

**Statistical separation** - the administrative process by which a hospital records the completion of treatment and/or care and accommodation following a change of Care Type within one hospital stay.
3.1 Patient Transfers

Transfers refer to situations where patients are moved between different hospitals OR hospital campuses where:

- They were assessed or received care and treatment in the first hospital; and
- It is intended that the patient receive admitted care in the second hospital.

3.1.1 Rules for transfer between hospitals/campuses

Patients who are to be transferred to another hospital should only be admitted to the first hospital if:

- the treating medical officer authorises the admission.

And where subject to this authorisation:

- they meet admission criteria; or
- their condition requires stabilisation, which is not possible in a non-admitted patient setting; or
- their condition requires extensive active monitoring or investigation which is recorded.

NOTE:

- The treating clinician should decide if the formal admission process should be undertaken and must authorise the admission.
- All admissions require a discharge summary completed by the medical officer responsible for care. The MR1 Form (Emergency Department Notes) is not a substitute for a discharge summary.

3.2 Patient Leave

A patient can be placed on leave from care for a range of purpose or reasons outlined below for up to seven consecutive days.

Examples are provided in this section to assist in the application of this discharge type.
3.2.1 Leave with permission

Leave with permission occurs when an overnight or multi-day patient leaves the hospital temporarily with the approval of the hospital and/or treating medical practitioner, with the intention that the patient will return within seven days to continue the current treatment.

Same-day patients cannot be placed on leave.

Newborns cannot be placed on Leave with Permission unless the newborn is transferred to another hospital with clinical intent to return within seven days.

**Example A:**
Nursing home type patient at hospital A needs a hip replacement at hospital B. It is all planned with expected return in 5 days. Hospital A should place the patient on leave and when the patient returns, continue the previous admission, and record the time out as leave days.

3.2.2 Leave without permission

Where a patient absconds or leaves against medical advice, if it is still the intention of the medical practitioner that the patient return within seven days to continue the current treatment (refer to Section 4.4 – Readmission following Discharge Against Medical Advice (includes Absconding patients) for further information).

3.2.3 Leave vs. Transfer

As stated above, leave entails the intention that a patient will return to resume care and is most often planned. If, for some unforeseen reason, a patient must receive care at another facility, a transfer must take place.

**Example B:**
Nursing home type patient at hospital A falls out of bed with a suspected fractured hip. Urgent transfer to hospital B is required for further management. There are no firm plans to return as future clinical course is indeterminate. Therefore, hospital A records a transfer (no leave). If and when the patient returns it is a new admission, regardless of the number of days that have elapsed.

3.2.4 Calculation of leave days

A leave day is counted if the patient is on leave from the hospital overnight. The sum of the length of leave (date returned from leave minus date went on leave) for all periods
within period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type.

This will be the same number of days recorded for accounting purposes.

The following rules apply in the calculation of leave days:

- The day the patient goes on leave is counted as a leave day.
- The day the patient is on leave is counted as a leave day.
- The day the patient returns from leave is counted as a patient day.
- If the patient is admitted and goes on leave on the same day, this is counted as a patient day, not a leave day.
- If the patient returns from leave and then goes on leave again on the same day, this is counted as a leave day.
- If the patient returns from leave and is separated on the same day, the day should not be counted as either a patient day or a leave day.

NOTE:

- For specific treatment/calculation of leave days refer to the HMDS Reference Manual under the Total Leave Days sub-section of the manual\(^{10}\).

3.3 Additional Considerations

3.3.1 Discharge summaries

All admissions require a discharge summary completed by the medical officer responsible for care. The MR1 Form (Emergency Department Notes) is not a substitute for a discharge summary.

A signed discharge summary or coding sheet is required to be completed for all records submitted to the HMDS. This signed summary of the admission is an attestation that the narrative description of the principal and secondary diagnoses, principal and other significant procedures are accurate and complete in accordance with reporting standards to the best of the treating medical officer’s knowledge.

The discharge summary must be completed at discharge.

The summary sheet should be filed in the patient medical record where it is readily available for subsequent reference.

For day-case procedures, the operation record will suffice as long as all critical details required for clinical coding are present.

A signed discharge summary is not mandatory for the following:

- Day only patients admitted for haemodialysis, where no complications arise, where no other treatment is provided and where the record creation process is automated.
- Day only chemotherapy patients when no complications arise and where the record creation is automated. The clinician (not necessarily a medical officer) who is providing the treatment may complete a summary sheet, which documents the service provided.
- Unqualified newborns (single liveborn, with no significant morbidity).

However under the above-mentioned circumstances, whether or not the record creation is automated and where there is no signed discharge summary, documentation by a clinician of any recurring care that occurred, or is proposed, and the diagnosis requiring that recurring care is mandatory.

For further information refer to the following:

- Clinical Handover Policy; and
- Clinical documentation policy/manual
4. **Readmission**

Readmission is defined as an admission of a patient **within 28 days** to the **same** establishment and if **one** of the following is true:

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

Day stay patients are included in this indicator if they meet the above criteria.

Readmissions are classified as:

1. **Planned**; or
2. **Unplanned**.

The distinction revolves around the clinical intention to readmit, which is detailed below. Also outlined in this section are (a) the National Safety and Quality Indicators pertaining to readmissions (b) same-day readmissions, and (c) readmissions following discharge against medical advice (DAMA).

**Clinical intention to readmit**

Information on the intention to readmit should be clearly recorded by the treating medical officer at the time of separation to indicate whether the patient would and/or may be admitted to the same or other hospital / facility as part of ongoing treatment / care, even if the actual date is yet to be confirmed.

A subsequent admission may be for treatment of a condition related to the one for which the patient was originally hospitalised, a complication thereof or for another reason. This must be **clearly** documented.
NOTE:

- The intention to NOT readmit must also be clearly documented.
- The distinction is important as unplanned / unexpected readmission rates can provide a flag for quality of care during admission. In a casemix environment this is an important consideration, and regular audits will be undertaken to ensure that intention to readmit is based solely on clinical circumstances.
- Refer also to Section 4.3 – National Safety and Quality Indicators.

4.1 Planned Readmission

Planned readmissions apply when patients who, when they were discharged, were expected to be readmitted to the same (or other) establishment within 28 days for further treatment of the condition for which they were previously hospitalised.

The intention of the responsible clinician was to readmit the patient at either a specified or unspecified time following separation/discharge.

This may include staged procedures or ongoing treatment such as recurring cases of chemotherapy and dialysis.

4.2 Unplanned Readmission

These include unplanned and unexpected readmissions within 28 days of the previous admission and related to the condition for which they were previously treated.

Unplanned readmissions require that there was NO intention to readmit for treatment of the same or related condition as the previous admission. It is the clinician who is responsible for determining whether readmissions are unexpected, and therefore unplanned.

Patients with progressive or chronic conditions (for example, advanced cancer, back pain or renal disease) may be expected to return to the hospital at some stage although the admission date is not planned. These groups of patients should not routinely be classified as planned readmissions (ie be excluded from being unplanned).
The decision should be based on whether there were complications or adverse events related to treatment during the previous admission. Note again, that the key clinical criterion is that the admission should be unplanned and unexpected.

Unplanned readmissions include:

a. Readmissions to the same hospital (or other) establishments.

b. Readmission of patients where the intent was for an outpatient appointment only.

Unplanned readmissions most often follow formal, but sometimes also statistical separations or transfers.

**Three examples:**

Infection of a surgical site requiring hospitalisation.

Exacerbation of COPD resulting in a fall at home or Residential Aged Care Facility.

Medication prescription or dispensing error resulting in misdosing/omission requiring consequent hospitalisation.

### 4.3 Patients Re-admitted Within 24 Hours

**Overnight stay** patients who are discharged, then subsequently readmitted on the same day or the day following discharge, for the same or related condition, should have **two separate episodes reported**.

This is a departure from the previous *Admission Policy for WA Hospitals (2002)* and will facilitate the reporting of the key performance indicator on readmissions.

A **same-day patient** who is discharged, then re-admitted later in that same day, should have **one episode only reported**, regardless of whether the second episode is same-day or overnight.

Admission on a given day, with re-admission at any time on that same day, is reported as one episode only.
4.4 Readmission Following Discharge Against Medical Advice (Includes Absconding Patients)

A patient who discharges against medical advice (DAMA) and re-presents any time within seven days for resumption of current treatment will be regarded as having one continuous admission, with the time out of hospital being leave days.

Absconding or DAMA patients who (within seven days):

- do not return; or
- return for other treatment (i.e. not under the original clinician or specialty)

- are to be discharged (The time of discharge is backdated to their time of departure. The mode of separation is reported as DAMA).

The leave reported for those who do return, can be regarded as ‘leave without permission’.

It does not require the hospital to hold a bed. It is statistical leave and is reported retrospectively should the patient be re-admitted to resume care.

‘Leave without permission’ is reported no differently from normal leave and follows the rules for counting leave days (Refer to Section 3.2.4 – Calculation of leave days).

NOTE:

- Attempts to contact absconding patients should still be made as per the demands of duty of care, particularly for psychiatric patients.
- This is to be determined by the treating clinician on a case-by-case basis.
- Refer also to the HMDS Reference Manual under Patient not returning from leave Section 6/96.
## Appendix 1 – Definitions

| Activity Based Funding | Activity: everything that the health system does for, with and to patients, residents, clients and their families and carers, and the community. Activity can include community care grants, chronic disease programs, preventative health programs, shared maternity care, sub-acute care, step down care, living well when older and education, training, research and supervision.  

**Activity Based Funding (ABF):** the way that health service providers are funded for their activity.  

**Activity Based Management (ABM):** the management approach used by WA Health to plan, budget, allocate and manage activity and financial resources to ensure delivery of safe high quality health services to the WA community. |
<table>
<thead>
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<tbody>
<tr>
<td>Activity Based Management</td>
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</table>

| Acute Care | Acute Care is (admitted patient) care in which the clinical intent or treatment goal is to:  
- Manage labour (obstetric);  
- Cure illness or provide definitive treatment of injury;  
- Perform surgery;  
- Relieve symptoms of illness or injury (excluding palliative care);  
- Reduce severity of an illness or injury;  
- Protect against exacerbation and/or complication of an illness and/or injury; which could threaten life or normal function; and/or  
- Perform diagnostic or therapeutic procedures. |
|---|---|
| Admission | Admission is the process whereby the hospital accepts responsibility for the patient’s care and/or treatment.  
Admission follows a clinical decision based upon specified criteria that a patient requires same-day or overnight care or treatment.  
An admission may be *formal* or *statistical*.  

**Formal Admission:**  
The administrative process by which a hospital records the commencement of treatment and/or care and/or accommodation of a patient.  

**Statistical Admission:**  
The administrative process by which a hospital records the commencement of a new episode of care, with a new care type, for a patient within one hospital stay. |
<table>
<thead>
<tr>
<th>Admission Criteria</th>
<th>A set of requirements, reflecting the intended level of treatment that the patient is to receive, in order for admission under all patient classifications to occur (<em>See Admitted Patient</em>).</th>
</tr>
</thead>
</table>
| Admitted Patient    | A patient who undergoes a hospital’s admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in traditional hospital setting and/or in the person’s home (under specified programs such as Hospital In The Home). The patient may be admitted if one or more of the following apply:  
  1. The patient’s condition requires clinical management and/or facilities not available in their usual residential environment.  
  2. The patient requires observation in order to be assessed or diagnosed.  
  3. The patient requires at least daily assessment of their medication needs.  
  4. The patient requires a procedure/s that cannot be performed in a stand-alone facility, such as a doctor’s room without specialised support facilities and/or expertise available (for example cardiac catheterisation).  
  5. There is a legal requirement for admission (for example under child protection legislation).  
  6. The patient is aged nine days or less.  
The items in the above list, in isolation, may not be sufficient to meet the Admission criteria. (*See also non-admitted patient*) |
| Admitted Patient Hospital Stay | The period of admitted patient care and/or accommodation between a formal or statistical admission and a formal or statistical separation, characterised by only one care type. (*See also Episode of admitted patient care*) |
| Adverse Event       | An injury that was caused by medical management or complication instead of the underlying disease and that resulted in prolonged hospitalization or disability at the time of discharge from medical care, or both. (1)  
An incident in which harm (*death, disease, injury, suffering and/or disability*) resulted to a person receiving health care. |
| Ambulatory Care      | Medical, nursing or professional paramedical care or treatment to patients in their own homes or in (non-health) residential institutions. Domestic or housekeeping assistance is not considered ambulatory care.  
Synonymous with domiciliary care.  
*NOT* synonymous with Hospital in the Home (HITH).* |
**Boarder**

A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care. A boarder thus defined is **not** admitted to the hospital.

**Care**

Medical / clinical intervention, treatment or procedure.

Synonymous with health care

**Care Type**

Categories that reflect the nature, acuity and intensity of provided care:

- A. ACUTE
- B. Psychogeriatric (acute)
- C. Sub-ACUTE
  1. Rehabilitation,
  2. Geriatric evaluation and management
  3. Palliative care
- D. Non-acute
  1. Maintenance (respite) care.
  2. Nursing home type care (NHTC)

**Clinical intervention**

An intervention carried out to improve, maintain or assess the health of a person, in a clinical situation.

Clinical interventions include invasive and non-invasive procedures, and cognitive interventions.

Invasive:
- Therapeutic interventions where there is a disruption of the epithelial lining generally, but not exclusively, with an implied closure of an incision (e.g. operations such as cholecystectomy or administration of a chemotherapeutic drug through a vascular access device);
- Diagnostic interventions where an incision is required and/or a body cavity is entered (e.g. laparoscopy with/without biopsy, bone marrow aspiration).

Non-invasive:
Therapeutic or diagnostic interventions undertaken without disruption of an epithelial lining (e.g. lithotripsy, hyperbaric oxygenation; allied health interventions such as hydrotherapy; diagnostic interventions not requiring an incision or entry into a body part such as pelvic ultrasound, diagnostic imaging).

Cognitive:
An intervention which requires cognitive skills such as evaluating, advising, planning (e.g.
<table>
<thead>
<tr>
<th><strong>Dietary Education</strong></th>
<th>dietary education, physiotherapy assessment, crisis intervention, bereavement counselling)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(See also Procedure)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Record</strong></td>
<td>(See Medical Record)</td>
</tr>
</tbody>
</table>
| **Clinician**        | A health care professional in the employment of the hospital / health service responsible for assessing and treating (potential) patients. Clinicians include:  
1. nurses  
2. medical officers  
3. occupational therapists  
4. pharmacists  
5. physiotherapists  
6. speech pathologists  
(See also Medical Officer) |
| **Contracted care / services** | Care treatment or services purchased by one hospital from another for an admitted patient (either overnight or same-day admission).  
The Contracted provider/hospital / health service provides the treatment, care or service.  
The Contracting or Funding hospital /health service requests and purchases the service from the contracted hospital. Original admission takes place there. |
| **Dialysis (Renal)** | (See Haemodialysis)                                                                         |
| **Discharge**        | (See separation)                                                                             |
| **Domiciliary care** | (See ambulatory care)                                                                        |
| **Emergency department** | The dedicated area in a public hospital that is organised and administered to provide emergency care to those in the community who perceive the need for or are in need of acute or urgent care.  
An emergency department provides triage, assessment, care and/or treatment for patients suffering from medical condition(s) and/or injury. |
| **Emergency department stay** | The period between when a patient presents at an emergency department and when that person departs. |
| **Episode of Admitted Patient Care** | The period of admitted patient care and/or accommodation between a formal or statistical admission and a formal or statistical separation, characterised by only one care type: |
|---|
| **Episode of care** | A period of health care with a defined start and end.  
*(See also Occasion of Service)* |
| **Flexible Care** | The type of aged care provided to non-private patients at Multi Purpose Service (MPS) sites is called ‘flexible care’. Flexible care is aged care provided to non-private patients who are resident in a MPS site who have been:  
- Assessed by Aged Care Assessment Team or their clinician; and  
- Approved for residential aged care; and  
- Have been placed in a residential aged care bed; or  
- Who are awaiting placement in a residential aged care bed/unit or an aged care facility elsewhere. |
| **Geriatric evaluation / management** | Care in which the clinical intent or treatment goal is to maximise health status and/or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, who is usually (but not always) an older patient. This may also include younger adults with clinical conditions generally associated with old age.  
This care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. Geriatric evaluation and management includes care provided:  
- in a geriatric evaluation and management unit;  
- in a designated geriatric evaluation and management program; or  
- under the principal clinical management of a geriatric evaluation and management physician or, in the opinion of the treating medical officer, when the principal clinical intent of care is geriatric evaluation and management. |
| **Haemodialysis** | A procedure used to maintain a patient with end stage renal failure by using an artificial kidney machine (or "dialysis machine") to replace the excretory function of the failed kidneys. Blood from the patient is pumped from the patient to the dialysis machine, where it travels through the dialyser and back to the patient.  
The procedure is usually carried out three times per week and takes four to five hours.  
**In-centre (Hospital) Haemodialysis**  
This is carried out at a suitably equipped hospital. Hospital Dialysis is best reserved for... |
those with serious medical problems who need immediate access to medical care during dialysis or who, for clinical reasons, are not suitable to receive their dialysis in a satellite centre.

Patients are also admitted for training or while waiting placement in a satellite. Hospital haemodialysis may also be called in-patient haemodialysis.

**Satellite Haemodialysis**
The dialysis procedure is carried out in a non-tertiary hospital or self care facility. Satellite units may be wholly operated and staffed by a tertiary hospital, or staffed and run by another hospital.

**Home Haemodialysis**
Home dialysis is the preferred option for many patients. If home haemodialysis is chosen, the individual is fully trained to manage their own dialysis with the assistance of a partner or spouse, parent or friend. In conventional home haemodialysis, patients dialyse for 4-5 hours, three times per week during daytime hours.

**Nocturnal Home Haemodialysis**
Nocturnal home haemodialysis occurs overnight while the patient sleeps. Patients are trained to self-care at home and do not need a carer or family member to assist. Patients will dialyse for up to 8-10 hours either every second night or 6 times per week while they sleep.

**Continuous Ambulatory Peritoneal Dialysis (CAPD)**
In peritoneal dialysis the dialysing fluid is inserted into the peritoneal (abdominal) cavity at regular intervals, and the waste products diffuse into it. The peritoneum is the membrane that lines the abdominal cavity and it is across this membrane that the chemical exchange between the blood capillaries and the dialysing fluid takes place. After a period of time the dialysing fluid is drained from the cavity.

CAPD is usually performed four times per day. Each exchange takes about 30 minutes to perform, and can be done almost anywhere, provided a clean area is available. In between each exchange the patient is free to undertake the regular activities of daily living.

**Automated Peritoneal Dialysis (APD)**
This requires a machine to regulate the movement of fluid into and out of the peritoneal cavity. The patient is attached to the machine at night before going to sleep, and while they sleep the machine performs 6-8 exchanges. During the day, solution is left in the peritoneal cavity so that dialysis can still occur slowly.
| **High dependency Unit (HDU)** | A High Dependency (HDU) is a separate and self-contained critical care unit that is configured and equipped to ICU and/or HDU standards. This unit must be capable of providing basic multi-system life-support for a period of usually less than 24-hours. An HDU bed is staffed for not less than 1:2 nursing care and is fully configured to cater for an HDU patient.

High Dependency Care is delivered in one or more of the following circumstances:

- Single organ system monitoring and support but excluding advanced respiratory system support;
- General observation and monitoring: More detailed observation and the use of monitoring equipment that cannot safely be provided on a general ward, which may include extended post-operative monitoring for high risk patients; and/or
- Step-down care: Patients who no longer require intensive care but who are not well enough to be returned to a general ward. |

| **Hospital** | A health care facility established under Commonwealth, State or Territory legislation as a hospital or a free-standing day procedure unit, and authorised to provide treatment and/or care to patients.

A hospital may be located at one physical site or may be a multi-campus hospital located across one or more different sites within the State.

For the purposes of these definitions, ‘hospital’ includes satellite units managed and staffed by the hospital and private homes used for service provision under the Hospital in the Home program.

This includes private hospitals treating public patients under government contract.

Nursing homes and hostels which are now approved under the Aged Care Act 1997 (Commonwealth) are excluded from the definition, as are supported residential services registered under the Health Services Act 1988, as amended.

*(Can be synonymous with health service, or provider).* |

| **Hospital in the home (HITH)** | Provision of care to hospital admitted patients in their place of residence as a substitute for traditional hospital accommodation. Place of residence may be permanent or temporary.

Place of residence includes residential facilities such as nursing homes, hostels or other forms of supported accommodation.

HITH is considered a ward within the hospital.

*(NOT synonymous with domiciliary care).* |
### Hospital Morbidity Data System

The Hospital Morbidity Data System (HMDS) is a database containing information concerning all inpatient discharge summary data from all public and private hospitals in Western Australia. The HDMS is a key information source used throughout the Department of Health and public and private hospitals to meet the mandatory and statutory reporting requirements.

### Hospital stay

The period of time between a formal admission and a formal separation.

A hospital stay may comprise more than one episode of care where:

- The episodes occur at one hospital campus; and
- Where the first episode has a statistical Separation Mode and the subsequent episode(s) has a statistical Admission Source.

In practice, hospital stay refers to the time elapsing between a patient entering the hospital campus and leaving the hospital campus, excluding leave periods.

### Intensive Care Unit

An intensive care unit (ICU) is a designated ward of a hospital that is specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises the skills of medical, nursing and other staff trained and experienced in the management of these problems.

There are five different types and levels of ICU, details of which are listed below:

- Adult intensive care
- Paediatric intensive care
- Neonatal intensive care

As defined, ICUs do not include Special Care Nurseries, Coronary Care Units, High Dependency Units, Intensive Nursing Units or Stepdown Units.

All types of ICU must substantially conform to appropriate guidelines of the Australian Council on Healthcare Standards (ACHS).

### Leave

**Leave with permission**

Leave with permission occurs when an overnight or multi-day patient leaves the hospital temporarily with the approval of the hospital and/or treating medical practitioner, with the intention that the patient will return within seven days to continue the current treatment.

Newborns are not permitted to go on Leave with Permission.
| **Leave without permission** | Where a patient absconds or leaves against medical advice.  
As it is still the intention of the medical officer that the patient return within seven days to continue the current treatment, follow Leave with Permission guidelines and reporting. |
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Length of stay</strong></td>
<td>The length of stay of an admitted patient is measured in patient days. A same day patient should be allocated a length of stay of one patient day. The length of stay of an overnight or multi-day stay patient is calculated by subtracting the Admission Date from the Separation Date and deducting total leave with and without permission days.</td>
</tr>
</tbody>
</table>
| **Medical Officer** | A medical doctor under the employment of a hospital/health service.  
*(Synonymous with Medical Practitioner).* |
| **Medical Record** | A medical record is a systematic clinical documentation of a single patient’s individual care and medical history. Entries into the medical record are generally made by clinicians. The medical record can be paper based or electronic. |
| **Neonate** | A live birth less than 28 days old. |
| **Newborn** | A live-born baby (live birth) who is nine days old or less, at the time of admission. |
| **Non-Admitted Patient** | A patient who:  
a. does not meet the Admission Criteria, and  
b. does not undergo a hospital’s formal admission process.  
There are three categories of non-admitted patient: Emergency Department patient, outpatient, and other non-admitted patient (treated by hospital employees off the hospital site —includes community/outreach services).  
Non-Admitted patients include, but are not limited to:  
- Patients treated in an Emergency Department who do not qualify for any of the Criteria for Admission. These patients may be treated or observed by a medical officer but are not admitted to a holding ward. These patients will present with the types of conditions which could be treated in a doctor’s surgery or which may require more extensive treatment than that available in a doctor’s surgery, but do not require treatment as an admitted patient;  
  *Note: the length of time spent in the ED does NOT influence the decision to admit.*  
- patients presenting for pre-admission work-up/testing, including attendance at a pre-admission clinic; |
- patients attending an outpatient clinic (who may also be admitted patients at the same time);
- other patients which include patients treated by hospital employees not on the hospital site and community and outreach services provided by the hospital;
- patients attending for a procedure on the Non-Admitted Procedures (Type C) List, without other justification for admission documented by the treating medical practitioner in the medical record;
- babies who are still-born, or show no sign of life at birth (refer to the definition of Stillbirth).

The term non-admitted can be synonymous with the term ambulatory or domiciliary. 
(See also: admitted patient; admission criteria)

<table>
<thead>
<tr>
<th>Nurse Practitioner</th>
<th>Nurse practitioners are registered nurses with the education and extensive experience required to perform in an advanced clinical role. A nurse practitioner's scope of practice extends beyond that of the registered nurse.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occasion of service</td>
<td>Any examination, consultation, treatment (or both consultation and treatment) or other service provided to a patient by medical, nursing, allied health or other hospital employees.</td>
</tr>
<tr>
<td>Overnight or Multi-day Stay</td>
<td>An admitted patient episode of care where admission and separation from the hospital occur on different dates.</td>
</tr>
</tbody>
</table>

The category of overnight or multi-day stay is determined retrospectively; that is, it is not based on the intention to admit for one night or more.

Therefore, a booked same day patient who is subsequently required to stay in hospital for one night or more is an overnight patient; a patient who dies, is transferred to another hospital or leaves of their own accord on their first day in the hospital is a same day patient, even if the intention at admission was that they remain in hospital at least overnight.

Unless the patient is on leave with or without permission, an overnight or multi-day stay patient in one hospital cannot be concurrently an overnight or multi-day stay patient in another hospital.

| Palliative Care | Care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and grief and bereavement support service for the patient and their carers/family. |
| **Patient** | A person for whom a hospital accepts responsibility for treatment and/or care. 
There are two categories of patient: admitted patient and non-admitted patient. 

**Paediatric Patient:** 
A patient under 16 years of age when admitted to hospital. 
*(Boarders are not patients).* |
| **Patient Day** | A day or part of a day that a patient is admitted to receive hospital treatment. The patient day is the unit of measurement for the length of stay of an episode of care. 
The term ‘patient day’ is synonymous with the term ‘bed day’ as used in hospitals. |
| **Post acute care** | Post acute care is hospital–organised therapy or nursing care provided following an episode of acute illness with the principal intent of reducing the length of hospital stay and restoring function. It is time limited. |
| **Principal Diagnosis** | The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code. 
The principal diagnosis must be determined in accordance with the ICD-10-AM Coding Standards. 
It is derived from and must be substantiated by clinical documentation. |
| **Procedure** | A clinical intervention that: 
- Is surgical in nature; and/or 
- Carries a procedural risk; and/or 
- Carries an anaesthetic risk; and/or 
- Requires specialised training; and/or 
- Requires special facilities or equipment only available in an acute care setting. |
| **Readmission** | Readmission is defined as an admission of a patient usually for a condition either the same or related to one for which the patient has previously been admitted or hospitalised (unless clearly documented by the treating clinician at time of separation). 

Readmission can be **planned**, **unplanned** and **unexpected**. The distinction revolves principally revolves around the **intention to readmit**, which must be clearly documented by the treating medical officer. 
*(See also Recurrent Admission).* |
<table>
<thead>
<tr>
<th>Recurrent Admission</th>
<th>Recurrent admissions are routine, regular and periodic episodes of care that can be either same-day or overnight admissions.</th>
</tr>
</thead>
</table>
| Rehabilitation      | Care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap. It is usually evidenced by a multi-disciplinary rehabilitation plan comprising negotiated goals and indicative time frames which are evaluated by periodic assessment using a recognised functional assessment measure.  

The Department of Health Rehabilitation Program excludes Nursing Home Type/Non-Acute patients and Geriatric Evaluation and Management patients. |
| Rehabilitation in the Home (RITH) | Rehabilitation in the Home care is a substitute for inpatient rehabilitation, and may apply for part of, or the entire admission. RITH patients must therefore fulfil the same criteria for admission as any other admitted rehabilitation patients. Rehabilitation may be provided in the patient’s home or place of residence. |
| Renal Dialysis      | See dialysis (Renal) |
| Residential stay / Care | Care for patients with chronic conditions who are usually managed at home but who, due to factors in the home environment (physical, social or psychological), require hospital admission. The care given is for functional maintenance only. The episode of care recorded for these patients will be maintenance care. |
| Same Day Patient / episode | A patient who is admitted and separated on the same date  

An episode that commences and finishes on the same date  

A same day patient may be either a booked or an emergency patient.  

A patient cannot be both a same day patient and an overnight or multi-day stay patient at the one hospital. Thus emergency treatment provided to a patient who is subsequently classified as an overnight or multi-day stay patient in the same hospital shall be regarded as part of the overnight or multi-day stay patient episode of care.  

The category of ‘same day’ is determined retrospectively; that is, it is not based on the intention to admit and separate on the same date. Therefore, patients who die, transfer to another hospital or leave of their own accord on their first day in the hospital are included. Booked same day patients who are subsequently required to stay in hospital for one night or more are excluded. |
| Separation           | The process by which an episode of care for an admitted patient ceases.  

A patient is separated at the time the hospital ceases to be responsible for the patient’s care and the patient is discharged from hospital accommodation. Hospital waiting areas, transit lounges and discharge lounges are not considered hospital accommodation unless the patient is receiving care or treatment in these areas. |
A separation may be formal or statistical.

**Formal separation**: the administrative process by which a hospital records the cessation of treatment and/or care and/or accommodation of a patient.

Where the patient meets one of the following criteria:

- Is discharged to private accommodation or other residence (no intention to return to this campus within seven days for continuation of the same treatment).
- Is transferred to another hospital campus of the same service.
- Is transferred to other health care accommodation (unless there is an intention to return to this campus within seven days for continuation of the same treatment, in which case the patient should be placed on leave).
- Is discharged following a procedure from the Admitted Procedure (Type B) List (even if the patient is returning within seven days for another treatment).
- Dies.
- Leaves against medical advice, and does not return for continuing treatment within seven days.
- Fails to return from leave within seven days. The patient is discharged effective from the date upon which their failure to return was noted.

**Statistical separation**: the administrative process by which a hospital records the completion of treatment and/or care and accommodation following a change of Care Type (transfer between Care Types) occurring within the one hospital stay (for example, transfer from Acute to Nursing Home Type care or transfer from Acute to Rehabilitation care in a designated rehabilitation program).

Where two episodes are created by a statistical separation, the Admission Time of the second episode must be one minute after the Separation Time of the first episode.

Is synonymous with discharge.

| Stillbirth | A still birth is the death prior to the complete expulsion or extraction from its mother of a foetus of 20 or more completed weeks of gestation or a birthweight of 400gms or more. The death is indicated by the fact that after such separation, the foetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. |
| Sub-acute Care | Sub-acute care is time limited, goal-orientated, individualised, interdisciplinary care that aims to help people who are disabled, frail, chronically ill or recovering from traumatic injury to regain and/or maintain optimal function to allow as many people as possible to maximise their independence and return to (or remain in) their usual place of residence. It is available |
to people of all ages on an admitted or ambulatory basis and may follow an admitted episode, ambulatory care or directly from the community. Sub-acute patients generally require:

- Assessment and/or oversight of their care plan by a specialist medical consultant.
- Therapy services in accordance with individual need as identified in their care plan (for example, physiotherapy and occupational therapy).

All admitted patients with episodes in the following Care Types are considered sub-acute:

- Rehabilitation Care.
- Geriatric Evaluation and Management.
- Psychogeriatric Care.
- Palliative Care.
- Maintenance Care.

### Transfer

Transfer refers to patients moving between different hospitals or hospital campuses where:

- They were assessed or received care and treatment in the first hospital; and
- It is intended that the patient receive admitted care in the second hospital.

### Transition Care

Transition Care is a jointly funded program between the Department of Health and the Department of Health and Ageing which targets older people at the conclusion of a hospital episode who require more time and support in a non hospital environment to complete their restorative process, optimise their functional capacity and finalise and access their longer term care arrangements.

Services provided include:

- Those that further improve functioning thereby improving the person's capacity for independent living
- Those that actively maintain the individual’s functioning while assisting them and their family/carers make appropriate long-term care arrangements.

Services may be provided in a bed-based environment or at the person's home.

Eligible people will be separated from hospital.

### Waitlist

The centralised list of patients requiring care that is managed by the DoH, cases may or may not have a scheduled admission date assigned. Patients on the waiting list are assigned a Clinical Urgency status to prioritise the urgency with which they require elective hospital care.
Appendix 2: Admitted procedures (Type B) list

Due to its length, Appendix 3 will be web referenced alongside the ARDT policy on a webpage within the Activity Based Funding and Management websites available at: http://activity/ (intranet) and http://www.health.wa.gov.au/activity/home/ (internet).

It is a Microsoft Excel spreadsheet which has been adjusted from the Australian Classification of Health Interventions, 7th Edition- National Centre for Classification in Health, 2010.
Appendix 3: Non-admitted procedures (Type C) list

Due to its length, Appendix 3 will be web referenced alongside the ARDT policy on a webpage within the Activity Based Funding and Management websites available at: http://activity/ (intranet) and http://www.health.wa.gov.au/activity/home/ (internet).

It is a Microsoft Excel spreadsheet which has been adjusted from the Australian Classification of Health Interventions, 7th Edition- National Centre for Classification in Health, 2010.