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

Version 3 July 2012

improving care | managing resources | delivering quality
Foreword

Since the introduction of Activity Based Funding and Management in Western Australia (WA) in 2010, staff at every level have identified and implemented new ways of managing our health system.

A key area of reform has been the way we capture and classify the details of the services we deliver to the WA community – our activity. Accurate and timely information about the care we provide is used in many ways – including ensuring that our health services are adequately funded for the services they provide.

The Admission, Readmission, Discharge and Transfer (ARDT) Policy has been developed in collaboration with staff across WA Health to support staff as they record and classify this information. It outlines the requirements for ensuring consistent and meaningful data collection in a range of settings. The policy is updated annually.

Compliance and consistency with the ARDT Policy is highly important for two reasons. Firstly, consistent classification and tracking of activity within WA allows 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 serves to position WA in terms of the national ABF program which began in practice on 1 July 2012.

I am pleased to present the second edition of the Admission, Readmission, Discharge and Transfer Policy and look forward to its consistent implementation throughout WA Health.

Kim Snowball
Director General
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1. Policy

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 rules and criteria to enable this to occur.

WA Health is transitioning to Activity Based Funding and Management (ABF/ABM) as the principal resource allocation and funding mechanism. In addition, there is a national transition towards this method of funding. Classification and counting of 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 national hospital funding reforms.

1.2 Scope

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

1.3 Responsibilities

Hospitals are responsible for ensuring that appropriate procedures and records are maintained to facilitate accurate reporting and to justify the admission.

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.

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 decision 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.
- WA Health serves the Western 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.
2. Definitions

2.1 Admitted patient
An admitted patient is defined as a person who meets the criteria for admission to the admission category and care type, and undergoes a hospital's admission process (documented) to receive treatment and/or care for a period of time – minimum 4 hours for medical admissions.

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 4 – Same day admission categories Type E, B, C.

The criteria for all admission categories 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 decision to admit can only be made by authorised medical officer or nurse practitioner. The admission can occur in a traditional hospital setting, or in the patient’s home under specified programs such as Hospital in the Home.

2.2 Non-admitted patient
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.

Non-admitted patient categories include (but are not limited to):

- 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
- patients treated in the Emergency Department (ED) who do not meet any of the criteria for admission
- patients attending an outpatient clinic. Outpatient attendances during an admission are included as part of the overall admission. If the outpatient service event is not related to the inpatient event, then it can be counted and reported separately as a service event
- dead on arrival (no active resuscitation)
- babies who are stillborn, or show no sign of life at birth
- other non-admitted patient:
  - boarders
  - posthumous organ donor.

Refer also to: HA 215B Reporting rules and Guidelines for Non Admitted Patient Services (OD 0396/12)
3. Policy requirements

3.1 Criteria for admission

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

- the person's condition requires clinical management and/or facilities not available in their usual residential environment
- the person requires observation in order to be assessed or diagnosed
- the person requires at least daily assessment of their medication needs
- 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)
- the patient is aged nine days or less
- there is a legal requirement for admission.

Note:
The items in the above list, in isolation, may not be sufficient. Refer also to the Sections 4–7: Admission categories and classes for additional criteria specific to each admission type.

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

Severity of illness:

- sudden alteration to conscious state (unconsciousness, coma, disorientation, confusion or unresponsiveness)
- abnormally high or low pulse (pulse rate outside specified range for age)
- abnormally high or low blood pressure (above or below limit for age)
- acute loss of sight or hearing
- acute loss or ability to move major body part
- persistent fever (rectal temperature>38.3 C, or other temperature>37.8 C in Paediatric)
- active bleeding
- severe plasma electrolyte/acid-base/blood pH abnormality or low Hb or packed cell volume
- severe electrolyte or blood gas abnormality
- electrocardiogram abnormality
- wound dehiscence or evisceration
- incapacitating pain
- acute or progressive incapacity
- conditions not responsive to Out Patients or Emergency Department management*
- child abuse and non compliance with essential treatment recommendations*
- failure to thrive.*

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

- administration of parenteral medications and/or fluid replacement
- surgery or procedure scheduled within 24 hours
- equipment/facilities only available in an acute care setting
- intermittent or continuous use of a respirator
- treatment in an ICU, and/or intermittent or continuous use of a ventilator
- vital signs monitoring
- chemotherapeutic agents requiring continuous observations*
- down transfer following major specialist surgery.*

* Additional paediatric criteria

Care provided to a patient in a non-admitted hospital setting over an extended period of time does not in itself constitute an admission. A patient in a non-admitted care setting may only be admitted after at least one of the admission criteria is met and, where required, criteria specific to the admission category.

Under these criteria, the fact that treatment is undertaken in a procedure/operating room or ward does not, in itself, justify admission.

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)
- adult at risk (i.e. domestic abuse).

The admission criteria may not always be present in the following care types:

- Obstetric care – admission to manage labour and/or delivery
- Subacute and non-acute care:
  - Rehabilitation
  - Geriatric evaluation and management
  - Psychogeriatric
  - Palliative care
- Non-acute
  - Maintenance (respite) care
  - Nursing home type care
- Patients living in rural or remote areas.

The treating clinician may decide that optimal patient management requires an overnight-stay even in circumstances where none of the admission criteria are present. 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 the patient’s medical record.
3.2 Admissions for procedure/treatment not performed

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

- The admission is to be reversed where only the administrative processes have been completed, and the patient has not been admitted to the ward or received any clinical care. There should be no episode of care reported.
- Otherwise the admission continues as an episode of care and is not to be reversed. Activity is recorded in the Patient Administration System and reported through the Hospital Morbidity Data System (HMDS).
- Abandoned procedures where the procedure is aborted after arrival in theatre or similar procedural unit, after administration of pre-operative sedation or anaesthesia, or commencement of an infusion, are reported as admitted episodes of care.

Note:

- Waitlisted patients whose procedures are cancelled will need to be rebooked.
- 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 (OD 0154/08).

3.3 Admission status

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

- Elective – waitlist
- Elective – not waitlist
- Emergency admission
  - Emergency – ED admission
  - Emergency – direct admission.

3.3.1 Elective – waitlist

In the opinion of the treating clinician, care is necessary but admission can be delayed for at least 24 hours. Elective waitlist patients may include cases under investigation for a non-urgent illness, or planned non-urgent procedures.

3.3.2 Elective – not waitlist

Elective not waitlist 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.

### 3.3.3 Emergency admissions

A 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:

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

- **Direct Admission**: the patient was directly admitted to hospital without admission via the hospital’s own Emergency Department.

**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.
4. Same day admissions (Type E, B, C)

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

Decisions on whether to admit or not admit patients as same day cases are governed by explicit inclusions and exclusions for procedures/conditions set by the Commonwealth. Refer to Appendix 2: Type B admitted and Type C non-admitted procedure lists.

A patient may attend the same hospital on the same day for more than one booked procedure (e.g. chemotherapy and dialysis). Admission can only be undertaken once per day at one hospital campus.

An admitted inpatient may require a same day procedure during an overnight/multi-day admission. The same day procedure is amalgamated and coded into the overnight/multi-day admission.

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) are classified as same day admissions.

A patient should be admitted as a same day 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.

Same day admissions fall into three groups:

- same day extended medical treatment (Type E)
- same day admitted procedures (Type B)
- same day non admitted procedures (Type C) when certified. Criteria for admission for each same day admission type is outlined below.

4.1 Criteria for same day extended medical treatment (Type E)

Same day medical patients receive a minimum of four hours of continuous active management consisting of:

- regular observations (which may include diagnostic or investigative procedures).
- continuous monitoring. Continuous blood pressure and/or pulse monitoring is not considered a sufficient level of continuous monitoring for these purposes.
- mental health patients requiring a period of safe observation/assessment and discharge planning, including complex evaluation of medical and ongoing psychosocial needs.
When determining a patient’s eligibility for admission, the following factors could be taken into account:

- Observations of vital or neurological signs provided on a repeated and periodic basis during the patient’s treatment:
  - This may consist of observations at even intervals throughout the patient’s treatment, or observations that become more or less frequent over the course of the treatment, depending on the needs of the patient.
- Provision of repeated and periodic diagnostic or investigative procedures or provision of treatment:
  - A patient is assumed to be ‘observed’ when undergoing treatment administered by a clinician. Where such treatment is noted in the record, it is assumed to be a proxy for formal observations.
  - A ‘trial of void’ procedure is admissible under this criterion.
- Continuous monitoring could include:
  - continuous monitoring via ECG or similar technologies
  - continuous active supervision or treatment by clinical staff.

4.1.1 Emergency Department same day admissions
Patients admitted from the Emergency Department (ED) with the intention of being discharged on that same date are categorised as same day admissions, refer to Section 4 above. The 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.

Note:
- When an ED patient is admitted, they must meet the admission criteria for same day extended medical patients (Type E), receiving a minimum of four hours of continuous active management. Refer Section 4.1.
- An ED patient receiving a Type B procedure meets the criteria for admission as a Type B same day admission. Refer Section 4.2.
- When an ED patient is admitted, the ‘Admission Time’ is defined as the recorded time that medical treatment (continuous active management) commenced in the ED. Any intervention provided after that treatment commences should be recorded and identified as part of the admitted patient’s episode of care.
- An ED patient who does not fulfil admission criteria is to be managed as a non admitted patient and should not be admitted.

Exclusions:
- A patient should not be admitted because they are waiting for review by an admitting team, results of diagnostic tests, equipment or medications.
- Patient has been present at the hospital for more than four hours, but has not been engaged in treatment or diagnosis.
- A patient should not be admitted because they are or will be in the ED for longer than 4 hours.
A patient should not be admitted where clinical intervention/s for their condition have been provided and they require time to rest prior to discharge, which will result in a length of stay over four hours, but does not require any ongoing monitoring or care during this period by clinical staff.

Examples of ED same day admissions:
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. For example:
- When the patient requires repeated and periodic observations of vital or neurological signs. e.g. neurological observations, observation post anaphylaxis, continuous ECG monitoring.
- Where the patient requires repeated or periodic diagnostic or investigative procedures or provision of treatment. e.g. serial troponin testing, serial diagnostic investigations, continuous active treatment or supervision by clinical staff.

4.2 Same day 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 Appendix 2); and
- Receive treatment on a day-only basis.

Intravenous (IV) therapy is included on the same day 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.*

* For further information visit: Highly specialised drugs program – Western Australian Administrative Guidelines at: www.public.health.wa.gov.au/2/1303/2/highly_specialised_drugs_hsd_program.pm
4.3 Same day non-admitted procedures (Type C)

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

Refer to Appendix 2: Type B admitted and Type C non-admitted procedure lists.

Examples that would justify admitting a patient to perform a Type C procedure include:
- where general/regional anaesthesia is required
- where intravenous or inhalational sedation is required
- where the patient’s co-morbidities place the patient under high dependency
- where the Type C procedure is not the reason for admission but occurs within an eligible admission.

Under special circumstances, a Type C procedure can be performed as a same day admission where the treating medical officer provides suitable evidence to justify admission. The treating medical officer must:
- document evidence of reason for admission in the patient’s medical record
- describe the condition or circumstances under which it would compromise accepted medical practice to not provide the care under an admitted setting.

Note:
- Where the criteria and documentation are not satisfied for an admission, the admission must be reversed.
- Where practical, the reversed admission (and activity undertaken in an admitted setting) should be recorded as a non-admitted patient service event.
- Health Services may require specific documentation to justify Type C admissions. Please refer to your clinical coding or health information management teams if you are unsure.

5. Overnight admissions (Type O)

Overnight admission occurs when the patient is expected to require admission for a minimum of one night. An overnight admission must meet one or more of the admission criteria outlined in Section 3.

**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.
- Patients 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.

**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 2100 with anticipation of discharge at 0200).

5.1 Care type

Overnight admissions are also classified by care type which refers to the nature of the treatment/care provided. Care types for overnight admissions are:
- Acute
- Newborn
- Subacute
  - Rehabilitation
  - Geriatric evaluation and management
  - Psychogeriatric care
  - Palliative care
- Non-acute
  - Maintenance (respite) care
  - Nursing home type care.

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.
5.1.1 Changing care type during admission
A hospital stay may consist of more than one care type. When the care type changes, a statistical discharge must take place and a new episode of care is reported.

Activity based funding for admitted patients is linked to care type, therefore it is important that a statistical discharge is performed when a patient undergoes a change of care type during their hospital stay. This will ensure that hospitals are funded appropriately. A uniform reporting process in all hospitals is required for reporting episodes of care.

The admission criteria for the care that the patient is changing to must be met. Refer to the relevant admission category in Sections 4–7 for requirements.

When the care type changes, a statistical discharge must take place and a new episode of care is reported.

Examples:
Acute care patients where the goal of care becomes rehabilitation will need to be documented by the medical officer and statistically discharged and readmitted as rehabilitation care. The care provided must meet criteria for rehabilitation.

A care type change to Nursing Home Type Patient will occur if a patient has received 35 days of continuous hospitalisation and does not have an acute care certificate.

Note:
Change in care type must not be executed for:
- a temporary change in ward, funding source or client status
- a scheduled day procedure/treatment within the same hospital
- the recovery period of an acute episode prior to separation is not classified as a separate episode of care. It is NOT classified as subacute (for example, rehabilitation) or non-acute care.

5.1.2 Retrospective care type changes
Occasionally change of care type may need to be made retrospectively. Situations where this may occur are:
- Change is documented explicitly in the medical record. An end of care 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.
5.2 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. Includes involuntary psychiatric admissions
- perform diagnostic or therapeutic procedures.

5.2.1 Hospital in the home

Hospital in the home (HITH) is considered ‘admitted patient care’. When a patient is transferred to HITH from in-hospital based care, this is considered continuous care. The criterion for admission that applies to the hospital component of their stay is also valid for the HITH component.

It is expected that these patient types will be seen at least daily by clinical staff providing inpatient care, and receive a minimum of five service events per week.

HITH patients not seen by any staff during any day are to be placed on leave for that day. It is accepted patients may be on leave over the weekend and receiving care during weekdays. Where patients are on leave for more than two days consideration should be given as to whether the patient continues to require inpatient care.

HITH should be documented in the medical record-progress notes when the patient has been visited by clinical staff providing services to the patient.

If HITH patients are transferred to in-hospital care at another health service, the administration processes are the same as any other inter-hospital transfer. Refer to Section 10 Transfer for further information.

If HITH patients require a same day procedure, within the same hospital, a ward/bed transfer is recorded but no care type change, statistical discharge or leave is required.

If HITH patients require treatment at another hospital, and it is expected they will return within 7 days, the patient is to be placed on leave and when the patient returns continue with the HITH admission. A transfer is recorded but no care type change or statistical discharge is required.

The date of discharge from HITH is to be recorded as the last day the patient received treatment.
5.2.2 Qualified newborn (Type Q) overnight admission
A qualified newborn is a patient that 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.

5.2.3 Unqualified newborn (Type U) overnight admission
An unqualified newborn is a patient that is nine days old or less at the time of admission but does not meet any of the criteria in section 5.2.2 for a qualified newborn.

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

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

Refer also to: Neonatal care information reporting (TB 14/5, 2004) for further information.

5.2.4 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.

Boarders are not admitted but may be registered on the hospital’s patient administration system (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.

Refer to Boarders (OD 0082/07) for further information.
5.2.5 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.

5.2.5.1 Posthumous Organ Procurement
Posthumous organ procurement is where 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 care type 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 separation.
- Relevant organ procurement procedure codes are assigned as per the Australian Coding Standards.

5.2.6 Contracted care
Contracted care is 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, post operative care back at A.

**Note:**
Refer to: Reporting of contracted services for admitted patients (OD 0179/09) for further information.
6. Subacute care (Type OS)

Subacute care describes time limited, goal-orientated, individualised, multidisciplinary care. In subacute care, the predominant treatment goal is enhancement of the quality of life or functional status. Subacute care includes rehabilitation, patients receiving geriatric evaluation and management, psychogeriatric and palliative care.

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. Subacute patients 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).

The definitions of and rules regarding classification of subacute care types are outlined in the following sections.

6.1 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. 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.

Rehabilitation is 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.

Note:
Long term patients in a rehabilitation unit whose care becomes primarily respite or nursing home type should have a change in care type to non-acute care.

Refer to: Rehabilitation program— definitions and reporting requirements (OD 0025/06) for further information.
6.2 Rehabilitation in the home

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

Rehabilitation in the home (RITH) 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.

It is expected that these patient types will be seen at least daily by clinical staff providing inpatient care, and receive a minimum of seven service events per week.

RITH should be documented in the medical record progress notes when the patient has been visited by clinical staff providing services to the patient.

RITH patients not seen by any staff during any day are to be placed on leave for that day. It is accepted patients may be on leave over the weekend and receiving care during weekdays. Where patients are on leave for more than two days consideration should be given to whether the patient continues to require inpatient care.

If RITH patients are transferred to in-hospital care at another health service, the administration processes are the same as any other inter-hospital transfer. Refer to Section 10 Transfer for further information.

If RITH patients require a same day procedure, within the same hospital, a ward/bed transfer is recorded but no care type change, statistical discharge or leave is required.

If RITH patients require treatment at another hospital, and it is expected they will return within 7 days, the patient is to be put on leave and when the patient returns continue with the RITH admission. A transfer is recorded but no care type change or statistical discharge is required.

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

6.3 Geriatric evaluation and management

Geriatric Evaluation and Management (GEM) is 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. GEM includes care provided:

- in a geriatric evaluation and management unit
- in a designated geriatric evaluation and management program
- under the principal clinical management of a geriatric evaluation and management physician or, with the principal clinical intent of GEM (in the opinion of the treating medical officer).
6.4 Psychogeriatric care

Psychogeriatric care is 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, or 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.

6.5 Palliative care

Palliative care is 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 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
- where in the opinion of the treating medical officer the principal clinical intent of the care is palliation.
7. Non-acute care (Type ON)

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

Refer also to: Subacute and Non-acute care (TB 20/6, 2004) for additional information.

7.1 Maintenance care

Maintenance care is care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment. Following assessment or treatment the patient does not require further complex assessment or stabilisation, and requires care over an indefinite period.

Types of maintenance care:

- Care and support of a person in an inpatient setting whilst the patient is awaiting transfer to residential care or alternate support services or where there are factors in the home environment (physical, social, psychological) which make discharge to home inappropriate for the person in the short term.

- Patients in psychiatric units 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.

- Patients 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 (e.g. at home, in a nursing home, by a relative or with a guardian) is unavailable in the short term. 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.

- Care and support of a person with a functional impairment for whom there is no multi-disciplinary program aimed at improvement of functional capacity.

- Care Awaiting Placement: 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 but whose length of stay is less than 35 days.

7.2 Nursing home type patient

A nursing home type patient (NHTP) is a patient that has been in hospital for a continuous period exceeding 35 days and does not have a current acute care certificate.

Patients who, after day 35, remain in hospital for maintenance care only, are deemed nursing home type patients. Such patients are re-classified from acute to maintenance care. The hospital may raise the applicable NHTP charges.
Therefore, in public hospitals, a patient receiving any one of the admitted patient care types will become a NHTP if they receive 35 days of continuous hospitalisation and have neither acute care certification allowing the present type of care to continue, nor documentation in the medical record to substantiate sub-acute care.

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 a nonacute episode.

Hospitals must ensure that an acute care certificate is provided for any patient who remains in hospital, after day 35, due to the need for ongoing acute care.

A NHTP can be re-classified to acute/subacute 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.

A patient cannot be designated NHTP before 35 days of continuous hospitalisation (with a maximum break of seven consecutive days) even if an Aged Care Client Record has been signed. However, they can be Care Awaiting Placement or Other maintenance type patients.

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.
- If a NHTP is out of any hospital (other than for contracted services) for more than seven consecutive days, the 35 day count begins again.
- Refer also to Acute Care Certification (OD 0147/08)

7.2.1 Non-acute compensable and non-acute ineligible
Under current legislation, compensable and ineligible patients cannot be categorised as NHTP. If after more than 35 days of hospitalisation (public or private) they no longer require acute care they are to be admitted as maintenance type non-acute care.

7.3 Aged care in multi-purpose service and none multi- purpose service facilities
Due to differences in funding arrangements, a distinction is drawn between residential aged care services in Multi-Purpose Service (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’.
7.3.1 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 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 (i.e. permanent care unit/bed, nursing home bed).
- **Low dependency** – approved for low dependency residential care (i.e. hostel).
- **Residential respite** – approved for residential respite. Residential respite may be high dependency (i.e. permanent care unit/bed, nursing home bed) or low dependency (hostel).
- **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.

7.3.2 Aged Care (MPS and non-MPS)
This category includes any patient who has been ACAT assessed, approved for residential aged care and resides in either a:
- State Government 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 choose 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.
8. 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 a 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 either planned or unplanned. The distinction revolves around the 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.

8.1 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 treating medical officer 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.

8.2 Unplanned readmission

Unplanned readmissions include readmissions within 28 days of the previous admission that are related to the condition for which they were previously treated.

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 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 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 (i.e. be excluded from being unplanned).

Unplanned readmissions include:
- readmissions to the same hospital (or other) establishments
- 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.

8.3 Readmission within the same day
Overnight stay patients who are discharged after one or more nights in hospital then subsequently readmitted on the same day or the day following discharge, should have two separate episodes reported. This is regardless of whether the second episode is for the same or related condition.

A same day patient (admission and discharge on a given day), who is then subsequently readmitted at any time on that same day is reported as one episode only. This is regardless of whether the second episode is for the same or related condition, same day or overnight. The time away from hospital between admissions is recorded as patient leave.

Note:
Admission can only be undertaken once per day at one hospital campus.

8.4 Readmission following discharge against medical advice (includes absconding patients)
A patient who absconds or 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. Refer also to Section 9.3 Discharge against medical advice.

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.
9. 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.

Patients should be discharged from the inpatient ward not the hospital waiting areas, transit lounges and discharge lounges. These 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 below:

9.1 Formal separation

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

- is discharged to private accommodation or other residence (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 external 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.
- leaves against medical advice, and does not return for continuing treatment within seven days. Discharge date to be entered as the date the patient left.
- fails to return from leave within seven days. Discharge date to be entered as the date the patient went on leave.
- is deceased.

9.2 Statistical separation

Statistical separation is 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. Refer to Section 5.1 Care Type for further information.

9.3 Discharge against medical advice

Absconding or discharge against medical advice (DAMA) patients who do not return within seven days or who return, but 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.

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.
9.4 Patient leave

Patient leave is a temporary absence from hospital overnight, with medical approval for a period no greater than seven consecutive days.

If a patient is on leave for greater than seven days, the patient should be discharged and readmitted if/when returning from leave.

9.4.1 Same day leave

A same day patient (admission and discharge on a given day), who is readmitted at any time on that same day is reported as **one episode** only, regardless of whether the second episode is for the same or related condition, same day or overnight. The time away from hospital between admissions is recorded as patient leave.

**Note:**
Admission can only be undertaken **once per day at one hospital campus**.

**Example:**
Patient was treated in the Emergency Department (ED) in the early hours of the morning, requiring admission for several hours and was then discharged at 0900. The patient presented again at the ED at 1400 and was readmitted. The previous discharge is reversed and the patient is recorded on leave for the time between discharge at 0900 and readmission at 1400.

Patient is admitted at 0830 to the day procedure unit for planned blood transfusion and discharged at 1100. They represent at 1400 to the day-chemotherapy unit for planned anti-neoplastic treatment. After the first discharge the patient should be placed on leave, or retrospectively the previous discharge is reversed and the patient is recorded on leave, for the time between discharge at 1100 and readmission at 1400.

9.4.2 Leave with permission

Leave with permission occurs when a patient leaves the hospital temporarily, with the approval of the hospital and/or treating medical officer, with the intention that the patient will return within seven days to continue the current treatment. The reason for approval, the date and time the patient goes on leave, and is expected to return from leave, are to be documented in the patient’s medical record.

**Example:**
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.

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

Patients who do not return from their leave must be contacted to ascertain if they are returning to hospital. If they do not return they must be discharged and the mode of separation is DAMA. Refer also to Section 9.3.
9.4.3 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:
A 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.

9.4.4. 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 is the date returned from leave minus date the patient went on leave.

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\(^1\).

9.5 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.

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 live born, with no significant morbidity).

However, under the above-mentioned circumstances, documentation by a clinician of any recurring care that occurred, or is proposed, and the diagnosis requiring that recurring care is mandatory.
10. Transfer

Transfer refers 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/campus
- it is intended that the patient receive admitted care in the second hospital/campus.

10.1 Temporary transfer

If, for some unforeseen reason, a patient must receive care at another facility, a transfer must take place. However, if the intention is that the patient will return within 7 days to resume care the patient is to be placed on leave. Refer also to Section 9.4 Patient Leave.

Example B:
A patient at hospital A falls resulting in a suspected fractured hip. An 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.

10.2 Rules for transfer between hospitals/campuses

Patients who will require transfer 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
- their condition requires stabilisation, which is not possible in a non-admitted patient setting
- their condition requires extensive active monitoring or investigation which is recorded.

Note:

- The treating medical officer should decide if the formal admission process should be undertaken and must authorise the admission.
- All transfers 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.
Appendix 1: Related Publications, Policies, Technical Bulletins and Directives

This policy should be read in conjunction with:

- The Hospital Morbidity Data System (HMDS) Reference Manual.
- Neonatal care information reporting (Technical Bulletin 14/5, 2004)
- Reporting different episodes of care (Technical Bulletin 26/5, 2004)
- Hospital Morbidity Information (Technical Bulletin 10/6, 2005)
- Rehabilitation program – definitions and reporting requirements (Operational Directive 0025/06, 2006)
- Hospital in the Home care (Technical Bulletin 78/0, 2006)
- Boarders (Operational Directive 0082/07, 2007)
- Western Australian coding standards (Operational Directive 0154/08, 2008)
- Patient-level information reporting for Non Admitted Outpatient Care Services (Operational Directive 0168/2009)
- Reporting of contracted services for admitted patients (Operational Directive 0179/09, 2009)
- HA215B Reporting rules and Guidelines for Non Admitted Patient Services (OD 0396/12)
- Acute Care Certification (OD0147/08)
- Subacute and non-acute care (Technical Bulletin 20/6, 2004)
- Definitions and counting methodology for the National Partnership Agreement on Improving Public Hospital Services. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong.

This Policy supersedes the following:

- Admission, Readmission, Discharge and Transfer policy 2011-2012
- Transferred Patients (Technical Bulletin 50/0, 2002).
Appendix 2: Type B admitted and Type C non-admitted lists

Due to length these lists are web referenced alongside the ARDT policy within the Activity Based Funding and Management websites available at: http://activity (intranet) and www/health.wa.gov.au/activity/home/ (internet).
Appendix 3: Common Type C same day admissions ineligible for admission

<table>
<thead>
<tr>
<th>Principal Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>95550XX</td>
<td>Allied health intervention</td>
</tr>
<tr>
<td>96209XX</td>
<td>Loading of drug delivery device</td>
</tr>
<tr>
<td>9205801</td>
<td>Maintenance (alone) of other catheter, implanted for administration of pharmacotherapy</td>
</tr>
<tr>
<td>3120500</td>
<td>Exc lesion(s) of SSCT, other site</td>
</tr>
<tr>
<td>962000X</td>
<td>Subcutaneous administration of pharmacological agent</td>
</tr>
<tr>
<td>3154800</td>
<td>Core biopsy of breast</td>
</tr>
<tr>
<td>1393902</td>
<td>Maintenance alone vascular access device</td>
</tr>
<tr>
<td>1394202</td>
<td>Maintenance alone drug delivery device</td>
</tr>
<tr>
<td>3007100</td>
<td>Biopsy of skin and subcutaneous tissue</td>
</tr>
<tr>
<td>3153300</td>
<td>Fine needle biopsy of breast</td>
</tr>
<tr>
<td>3002600</td>
<td>Repair wound SSCT, oth site superficial</td>
</tr>
<tr>
<td>3003200</td>
<td>Repair wound SSCT face/neck superficial</td>
</tr>
<tr>
<td>1200000</td>
<td>Skin sensitivity test usg &lt;= 20 allrgn</td>
</tr>
<tr>
<td>1381501</td>
<td>Perc central vein catheterisation</td>
</tr>
<tr>
<td>9619502</td>
<td>Administration of venom protein</td>
</tr>
<tr>
<td>3453004</td>
<td>Removal of venous catheter</td>
</tr>
<tr>
<td>9211900</td>
<td>Removal other urinary drainage device</td>
</tr>
<tr>
<td>96197XX</td>
<td>Intramuscular administration of pharmacological agent</td>
</tr>
<tr>
<td>3880600</td>
<td>Insertion intercostal catheter for drain</td>
</tr>
<tr>
<td>1836000</td>
<td>Admin of botulinum toxin soft tis NEC</td>
</tr>
<tr>
<td>3561400</td>
<td>Colposcopy</td>
</tr>
<tr>
<td>3680000</td>
<td>Bladder catheterisation</td>
</tr>
<tr>
<td>3550XXX</td>
<td>Attention to IUD (insertion, replacement or removal)</td>
</tr>
</tbody>
</table>
### Appendix 4: Definitions

<table>
<thead>
<tr>
<th>Activity Based Funding</th>
<th><strong>Activity</strong>: 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, subacute care, step down care, living well when older and education, training, research and supervision. <strong>Activity Based Funding (ABF)</strong>: the way that health service providers are funded for their activity. <strong>Activity Based Management (ABM)</strong>: 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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity Based Management</td>
<td><strong>Acute Care</strong>: 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  - perform diagnostic or therapeutic procedures.</td>
</tr>
</tbody>
</table>
| Admission | **Admission**: 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. |
| Admission Criteria | 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 (see Admitted Patient). |
| **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:

- the patient’s condition requires clinical management and/or facilities not available in their usual residential environment
- the patient requires observation in order to be assessed or diagnosed
- the patient requires at least daily assessment of their medication needs
- 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)
- the patient is aged nine days or less
- there is a legal requirement for admission (for example under child protection legislation).

The items in the above list, in isolation, may not be sufficient to meet the Admission criteria. |
| **Adverse Event** | An injury that was caused by medical management or complication and not of the underlying disease and that resulted in prolonged hospitalisation or disability at the time of discharge from medical care, or both. |
| **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. |
**Cae Type**

Categories that reflect the nature, acuity and intensity of provided care:
- Acute
- Newborn
- Subacute
  - Rehabilitation
  - Geriatric evaluation and management
  - Psychogeriatric care
  - Palliative care
- Non-acute
  - Maintenance (respite) care
  - Nursing home type patient.

**Clinician**

A health care professional in the employment of the hospital/health service responsible for assessing and treating (potential) patients. Clinicians include:
- nurses
- medical officers
- occupational therapists
- pharmacists
- physiotherapists
- 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.

**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.
<table>
<thead>
<tr>
<th>Episode of Admitted Patient Care</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episode of care</td>
<td>A period of health care with a defined start and end.</td>
</tr>
</tbody>
</table>
| 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  
  - 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 (GEM) | 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. |
| **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.  
Under the Commonwealth definition, hospital in the home (HITH) is considered ‘admitted patient care’. It is expected that these patient types will be seen at least daily by clinical staff providing inpatient care, and receive a minimum of five service events per week. |
| **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 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. |
### Leave
A patient can be placed on leave for up to seven consecutive days. 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 officer, with the intention that the patient will return within seven days to continue the current treatment.

### Length of stay
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.

### 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.

### Newborn
A live-born baby (live birth) who is nine days old or less, at the time of admission.

### Non-Admitted Patient
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):

- 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.
- Patients treated in the Emergency Department who do not quality for any of the criteria for admission.
- Patients attending an outpatient clinic. Outpatient attendances during an admission are included as part of the overall admission. If the outpatient service event is not related to the inpatient event, then it can be counted and reported separately as a service event.
- Dead On Arrival (no active resuscitation).
- Babies who are stillborn, or show no sign of life at birth.
- Other non-admitted patient:
  - boarders
  - posthumous organ donor.
<table>
<thead>
<tr>
<th><strong>Nurse Practitioner</strong></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>
</table>
| **Overnight or Multi-day Stay** | An admitted patient episode of care where admission and separation from the hospital occur on different dates.  

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. |
| **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. |
| **Readmission** | Readmission is defined as an admission of a patient within 28 days to the same establishment 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 around the intention to readmit, which must be clearly documented by the treating medical officer. *(See also Recurrent Admission).* |
| **Recurrent Admission** | Recurrent admissions are routine, regular and periodic episodes of care that can be either same day or overnight admissions. |
| **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. 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.

Rehabilitation is 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. |
| **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. |
| **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 | An episode that commences and finishes on the same date

A patient should be admitted as a same day 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.

A patient cannot be both a same day patient and an overnight or multi-day stay patient at the one hospital.

Decisions on whether to admit or not admit patients as same day cases are governed by explicit inclusions and exclusions for procedures/conditions set by the Commonwealth. Refer Section 4 Same Day Admissions. |
| --- | --- |
| 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.

**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 occurring within the one hospital

Is synonymous with discharge. |
### Subacute Care

Subacute care is time limited, goal-orientated, individualised, multidisciplinary 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. Subacute 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).
- Subacute
  - Rehabilitation
  - Geriatric evaluation and management
  - Psychogeriatric
  - Palliative 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.
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.

Waitlist