



Government of Western Australia  
Department of Health

# Review of admission and discharge referral practices for the metropolitan hospital emergency departments

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**Executive Summary**

## Executive Summary

This Review is concerned with examining both pre-hospital admission and post-discharge processes, and the reasons for patient referrals to current community nursing hospital in the home services.

In total 139 people were interviewed and participated in the Review over a four-month period including:

- Area Health Service Executives
- Hospital Executives (from both public and private sectors), managers and operational staff
- Department of Health Executives and managers
- Non-Government Organisation CEOs and managers
- Health Consumer Council Representatives.

During this review it became apparent that there were a very large number of Hospital in the Home Services which duplicated activities in many geographical areas, some services were over utilised and some community based care options were under used.

It is clear that current patient referral and management processes are complex, and not coordinated. The historical development of these services appeared to arise in response to the demands of an increasing and ageing population as well as escalating pressure on hospital beds. It has now become clear to clinicians that adequate and safe care can be offered in the community when a patient's clinical condition permits and extended lengths of hospital stay are not necessary in a large range of conditions.

The acceptance of community based hospital in the home and community nursing services as referral pathways for Emergency Departments' patients is only being slowly accepted in WA. This is because of the caution of clinicians who want to be assured that safe care is provided after an initial short patient assessment and observation period in an ED.

The development of community based but hospital standard patient activity appears to have taken place in an uncoordinated manner, as each Health Service looked into and established its own requirements. At the same time one of the large providers of these services namely the not-for-profit Silver Chain Nursing Association Inc. (Silver Chain), reintroduced the Silver Chain Liaison Nurses at RPH, Fremantle Hospital, and SCGH along with Silver Chain nurses supporting secondary hospital sites. These nurses are available for liaison work, connecting hospitals with the community.

Silver Chain in Western Australia is a very large organisation which used to run Nursing Homes as well as providing community nursing including some Out Post Nursing in remote areas of the State. More recently the Silver Chain Service has devolved itself of nursing homes and directs its activities in Community Nursing.

The resources of this organisation are extensive and well organised. Currently the nursing services are overseen for clinical governance by a medical advisory committee. At this time some hospital clinicians remain loath to refer patients and use the services of this organisation because of uncertainty over clinical standards. In the Reviewer's opinion this is more perceived than real and a recommendation is made which hopefully will overcome this uncertainty.

The Priority Response Assessment Service (PRA) service run by Silver Chain provides very good clinical care under the FINE Program and works in conjunction with the Residential Care Line.

In essence the recommendations in this report support the ongoing use of the Silver Chain Service to carry out “Hospital at Home Services” (HATH) for simple conditions which should be agreed by hospital clinicians working with the medical governance of Silver Chain. The current WA public hospital based “Hospital in the Home” (HITH) program should be used to assist chronic disease management programs and those patients with complex medical and social issues who require frequent hospital admission if care is not well coordinated. This review recommends that there be improved coordination between all health services so that common clinical protocols are used across the WA health system. In particular each health service should develop protocols of work to prevent post code cross over and therefore produce a much more timely and cost efficient program to the WA community.

The Review recognises the importance of relationships at the interface between primary care and hospital providers. Recommendations within this Review focus upon these key areas.

## Recommendations

The Review notes that the existing system appears to adequately address the needs of uncomplicated patients. The need to better meet the demands of complex patients has been acknowledged by the establishment of programs such as Complex Needs Coordination Team (CoNeCT). In exploring future options, the value of and lessons from current arrangements need to be appreciated and a novel approach must seek to improve upon existing practice. The Review observed no consistency in referral practice between and within hospitals and a cacophony of community based providers, both public and private. Recommendations were formulated to streamline these approaches.

It should also be noted that the Review saw no cause to consider present clinical pathways to be inappropriate. The number of patients whose discharge from emergency departments could be further expedited is low and thus the impact upon consumption of emergency beds may be marginal. The Review did however observe the impact of chronic disease, especially when coupled with complex medical and social needs, upon patients and the health system. It is with the latter in mind that many recommendations below were formulated.

### Options

1. Maintain the existing system with refinements to ensure all suitable patients are referred from emergency to Hospital in the Home (HITH) and Silver Chain's Hospital at the Home (HATH) and staff are appropriately informed on availability of community services.
2. Create a two-tiered system whereby patients requiring short term interventions for non-complex care are referred to Silver Chain's HATH service and patients with chronic disease and complex medical and social needs are managed by North Metropolitan Area Health Service (NMAHS) and South Metropolitan Area Health Service (SMAHS) HITHs in conjunction with specialist staff and general practitioners.

In either option one or two, a central service operating from one tertiary site may be established to coordinate ambulatory adult care across the metropolitan area.

### **The principal recommendation from this Review is implementation of Option 2.**

As the outcomes of the national reforms crystallise; and Medicare Locals (MLs) mature, the roles and responsibilities of these and the Commonwealth in the care of patients outside of hospitals need to be explored and pathways for patient transitions established.

### Operation of emergency departments

It is recommended that:

1. Additional resource be allocated to Care Coordination Teams based in Emergency Departments so expansion of the nature of the cohort seen to address the needs of patients across a larger age range and socio-demographic group.
2. An assessment of the need for, and costs and benefits, of expanding after-hours access from ED to diagnostic services, especially imaging, as this has been cited as a reason for ED to admit patients to short stay units.
3. Criteria for referral of low acuity patients and clinical pathways for ongoing care should be developed.
4. Residential Care Line staff members, ED discharge coordinators and CCT Social Workers continue to work closely with low care Residential Aged Care Facilities to ensure they are in a position to accept patients back into their facility after hours.

## The relationship with Silver Chain

It is recommended that:

5. Structures are established to permit increased collaboration between hospital staff and Silver Chain to address current concerns regarding the robustness of clinical governance structures within Silver Chain. Specifically, the current medical directors of HITHs should formally be engaged in the clinical governance activities of Silver Chain's activities in these programs. In this way, shared care protocols for common patient presentations may be developed.
6. *healthdirect* Australia's protocols should be updated to include referral to Silver Chain's Priority Response Assessment service.
7. WA Health explore safety and quality mechanisms to ensure Silver Chain participates in WA Health's sentinel events reporting program.

## Operation of Hospital in the Home programs

It is recommended that:

8. Emergency departments, outpatient and in-patient services refer patients with ambulatory care sensitive conditions (such as cellulitis, deep vein thromboses, pyelonephritis) to Silver Chain's HATH.
9. HITHs provide only specialist services not appropriate for referral to Silver Chain's HATH i.e. patients with complex care needs or patients with chronic diseases.
10. HITH teams should refer patients enrolled in one HITH but living within the catchment of another HITH team to the latter. To facilitate this:
  - patient care, referral and communication protocols are developed
  - the geographical boundaries of the various HITHs are re-assessed and agreed between AHS.
11. Secondary hospitals which currently do not have a HITH should use Silver Chain's HATH for low acuity patients and a tertiary HITH for complex patients.

## The relationship with primary care

It is recommended that:

12. The location of after hours and extended hours general practices, particularly when co-located, should be readily accessible for patients awaiting care in emergency departments.
13. Where triage staff suggest to patients that they may wish to consult a GPAH or GPEH or other community provider, patient details (demographic and clinical data consistent with the detail usually obtained at triage) should be documented.
14. Information programs on the availability of alternate services are developed for both patients and healthcare professionals.
15. The feasibility and benefits of allocating reserved outpatient appointments for urgent referrals are examined.
16. The chronic disease health network, NMAHS planning teams and SMAHS clinical clusters develop protocols and clinical pathways for the referral of patients between primary care and hospital services, to avoid unnecessary emergency presentations.

## **Establishment of care teams and pathways to ensure continuity of care for chronic disease management:**

It is recommended that:

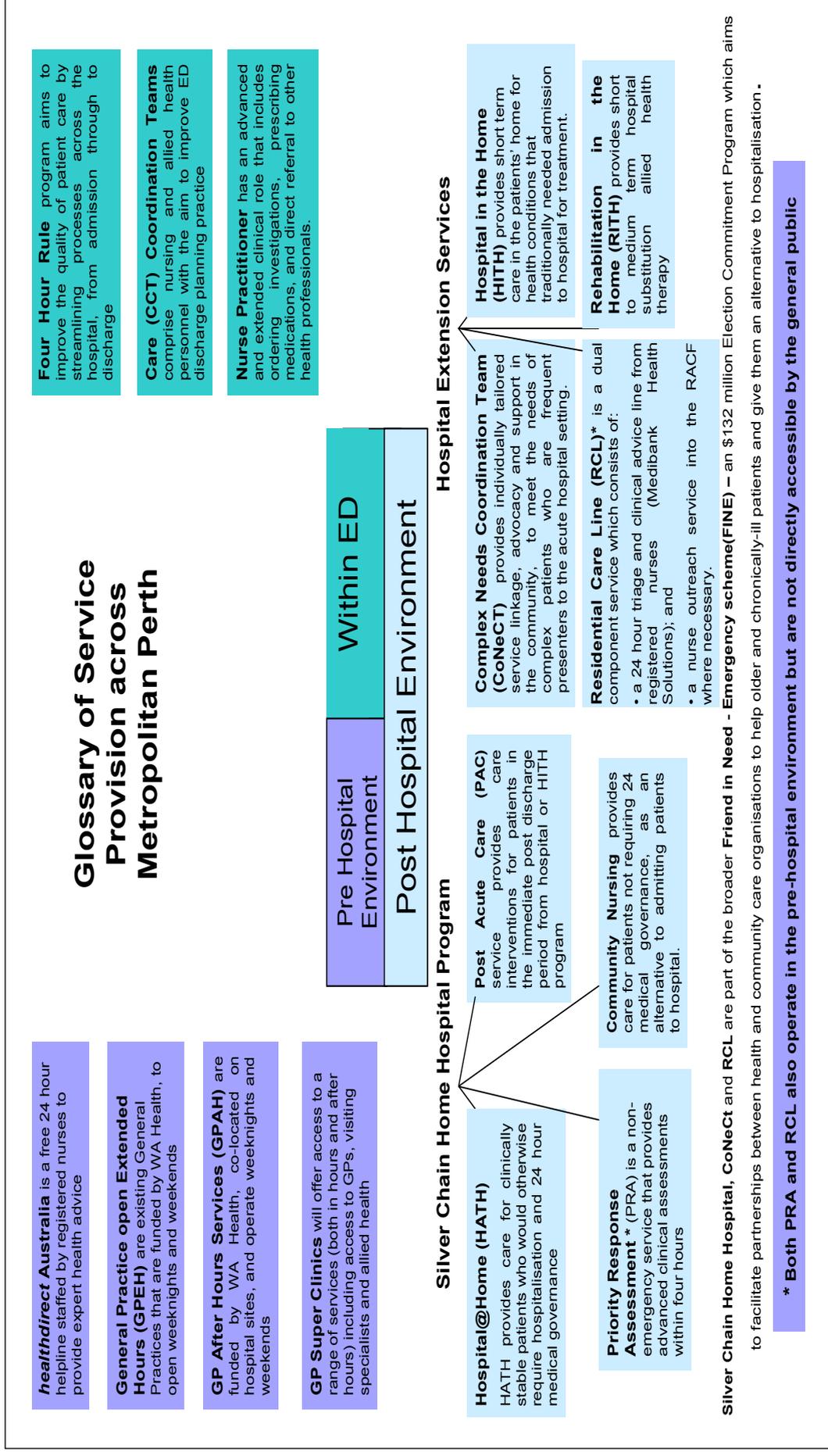
17. Hospital based HITHs, RITHs and CoNeCT teams amalgamate their FTE and resources such that medical, allied health and other support structures to patients are delivered by a single unified team operating over the AHS. A current model exists in the NMAHS Home Link structure.
18. Health services work with local primary care providers (MLs, General Practice divisions or networks) to develop referral and discharge pathways for chronic diseases including mental health. These pathways should incorporate continuity of care models which see engagement of hospital specialist nursing services with at risk patients who frequently require hospital admission while in the community.
19. Development of these pathways may be enhanced by a common membership across chronic disease health network, NMAHS planning teams and SMAHS clinical clusters, clinical lead forums in LHNs and MLs.
20. Current paradigms for the funding of inpatient and outpatient care will need to be examined to ensure that no disincentives prevent continuity of care and that care provided to patients following the acute admission is recognised.
21. The Health Information Network continues to explore all options to improve communications between WA Health hospital sites and General Practice to ensure that exchange of clinical information is safe, timely and seamless, consistent with national e-health standards and aligned to the implementation of e-health capability by General Practice.

This report should be read in conjunction with the Glossary of Service Provision across metropolitan Perth (see next page).

## Summary of Services and Providers

Numerous services and providers exist in the pre-hospital and post-hospital environs and are relevant to this Review. The schematic below seeks to explore the roles and inter-relationships between these players.

### Schematic summary of key services and providers of ambulatory care



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