Policy No.: G0106

Direct Admission to a Hospital Inpatient Unit Policy Guideline

Version No.: 2.0
Approval date: 17 May 2018

Government of South Australia

SA Health

Contents

1. Policy Statement

SA Health is committed to providing the South Australian community with timely and equitable access to health services and ensuring the efficient use of available resources in public hospitals. Historically there has been an over-reliance on the Emergency Department (ED) to manage the admission of many patients, including transfers from other sites, where a medical review has already occurred. Consequently, some patients receive multiple reviews which may result in treatment delays and contribute to ED overcrowding.

The *Direct Admission to a Hospital Inpatient Unit Policy Guideline* (the Policy Guideline) enhances patient care by establishing a streamlined process for the management of safe and timely hospital admission for those patients considered suitable to be directly admitted to a hospital inpatient unit rather than via the ED.

Direct admission to a hospital inpatient unit is underpinned by the following principles:

1. Direct admission is the preferred pathway for patients being transferred as approved hospital inpatient admissions via SA Ambulance Service (SAAS), MedSTAR and Royal Flying Doctor Service (RFDS). A direct admission via SAAS should not result in a delayed transfer of care at the receiving hospital. Transfer of care should occur at an agreed designated location (preferably the hospital inpatient unit) within 15-30 minutes of arrival at the receiving hospital. Patients should not remain in ambulances for extended periods of time.
2. Timely and efficient handover of clinical care is essential for the safe care and treatment of each patient and for maintaining effective hospital operations.
3. Direct admission to an inpatient unit, where appropriate, promotes improved patient outcomes and patient experience, and reduces demand on EDs.
4. Clear pathways support streamlined transfer of care processes.
5. Recognition and response to clinical deterioration requires effective communication, documentation and multi-disciplinary teamwork.
6. SA Health is committed to the ongoing review and implementation of evidence-based practices that promote effective and efficient patient admission processes. Accordingly, SA Health will regularly evaluate and update this Policy Guideline.

This Policy Guideline applies to all SA Health staff involved in the management and facilitation of direct admission of a patient to an SA Health public hospital inpatient unit.

This Policy Guideline does not cover:

- hospital inpatient admission resulting from an ED presentation to the same hospital
- arranged elective admission to hospital, for example, for booked surgery
- established direct admission pathways for specific patient cohorts or clinical specialities within Local Health Networks (LHNs).

2. Roles and Responsibilities

Chief Executive Officers, LHNs are responsible for:

- promoting compliance with this Policy Guideline
- nominating an executive sponsor to lead the Policy Guideline implementation, including the development of:
    - a local interim treatment plan form,
    - protocols for recognising interim treatment plans originating from other LHNs; and
    - any required local processes for responding to referrals received and/or patients arriving after hours.
- referring any significant strategic issues to the Department for Health and Wellbeing.

Chief Operating Officers, LHNs are responsible for promoting service provision in accordance with this Policy Guideline

Referring clinicians are responsible for:

- identifying patients requiring transfer to another hospital for inpatient admission
- initiating the admission process as outlined in this Policy Guideline
- informing patients of the admission process and admission details
- arranging an appropriate mode of transport as required
- providing a comprehensive clinical handover, including expected date and time of arrival, and a 4 hour interim treatment plan (or for an appropriate period of time as agreed between the referring and receiving clinicians), to the receiving medical clinician
- escalating any significant issues to the relevant senior clinician, Director or Head of Unit.

Receiving Consultants are responsible for:

- considering the clinical need of the request for admission
- when a request for admission has been accepted, determining whether the patient can be admitted directly to the inpatient unit or whether the patient's clinical condition requires ED assessment
- ensuring that all patient information, including expected date and time of arrival, is communicated to relevant inpatient team members
- ensuring that patients received via direct admission receive treatment in a safe and timely manner
- escalating any significant issues to the relevant Director or Head of Unit.

Patient Flow Coordinators are responsible for:

- managing patient flow and effective bed utilisation in accordance with this Policy Guideline
- escalating any issues as per local processes.

SAAS are responsible for:

- coordinating requests from referring clinicians to transfer patients eligible for direct admission
- notifying the requesting hospital of any unexpected delays in transport
- monitoring the patient's clinical condition during transfer and alerting the receiving hospital to any clinical deterioration that may impact on the patient's eligibility for direct admission.

Administrative Officers are responsible for completing the administrative processes by which a hospital commences and records the admission of a patient.

3. Policy Requirements

3.1 Overview

Direct admission is a process whereby patients are admitted directly to a hospital inpatient unit rather than via the hospital's ED. The process, summarised in Attachment 1, is coordinated between the referring clinician, the receiving Consultant, the Patient Flow Coordinator and the transporting clinician.

3.2 Referral process

The process commences when a hospital-based clinician identifies a patient requiring further inpatient care or treatment that cannot be provided at the originating hospital. The referring clinician determines the proposed receiving hospital taking into consideration the receiving hospital's characteristics (for example, the availability of diagnostic and therapeutic facilities) and proximity to the patient's home. The referring clinician should contact the relevant Consultant at the proposed receiving hospital via the hospital switchboard, advising the switchboard operator that they are seeking to initiate a patient transfer and admission, and require a discussion with a Consultant of the appropriate specialty. If a patient is already known to a treating medical team and the current diagnosis or clinical condition is relevant, that team should be the point of contact.

From time to time, operational circumstances may result in a Consultant being unavailable. An LHN or hospital may therefore allow delegation by a Consultant to a Senior Registrar or Fellow acting under the clinical supervision of the Consultant. The Consultant retains responsibility and accountability for clinical decision making in regard to patient transfer and admission requests.

The proposed receiving hospital Consultant should consider the following factors in determining whether the patient is suitable for admission:

- the patient's clinical condition
- urgency
- clinical actions required on arrival or during admission
- any other treatments and referrals that may be required.

N.B. In some circumstances the direct admission process may be initiated by a referring clinician who may not be hospital-based or have direct admitting rights to the intended hospital, i.e. a Primary Care Provider General Practitioner (GP), Specialist or Nurse Practitioner. In these circumstances the above referral process is to be followed.

3.2.1 Approval for admission

If the patient cannot be treated at the originating hospital and is clinically suitable for transfer and admission to the receiving hospital, the receiving Consultant is to request a clinical handover from the referring clinician (see 3.4). The receiving Consultant decides whether the patient will be admitted to the inpatient unit or requires assessment via the ED and confirms this with the receiving hospital Patient Flow Coordinator.

Direct admission to an inpatient unit is the expected pathway for all patients accepted for admission who are transferred by SAAS, Medstar and RFDS to SA Health public hospitals. These patients should bypass the ED unless the receiving Consultant has determined there is a clinical reason for presentation to the ED for assessment or investigation that cannot be provided on the receiving ward, or the patient's clinical condition deteriorates en route and urgent clinical assessment in the ED is required.

N.B. Medicare ineligible patients must be informed that hospital billing will occur in line with relevant guidelines for management of Medicare ineligible inpatient admissions to hospital, including SA Health Fees and Charges Manual requirements.

3.3 Direct admission transfer process

Patients approved for admission are transferred in accordance with the following processes:

1. *The receiving Consultant (or their delegate, e.g. Registered Nurse or Nurse Manager)* contacts the Patient Flow Coordinator of the receiving hospital to discuss:
    - proposed date and time for admission to occur (patients should not be transported until bed availability is confirmed and admission should occur during business hours wherever possible)
    - bed availability
    - estimated length of stay
    - any known special or additional requirements, for example, bariatric patient, infectious status, security requirements, and minor being admitted to a general hospital.

The receiving Consultant should ensure that all patient details, including expected date and time of arrival, where possible, is communicated to all other relevant inpatient team members prior to the arrival of the patient.

2. The *Patient Flow Coordinator* at the receiving hospital contacts the referring clinician to confirm the admission and any relevant information.

3. The *referring clinician* is responsible for:
    - advising the patient and/or significant others of the admission
    - preparing a four hour interim treatment plan (or for an appropriate period of time as agreed between the referring and receiving clinicians), including accepted clinical parameters, for the receiving hospital
    - coordinating the patient transport booking, including advising the transport provider that the patient is to be admitted directly to an inpatient unit
    - ensuring all relevant clinical information and documentation is conveyed with the patient or transmitted securely otherwise
    - escalating any undue delay to patient transport to the Chief Operating Officer or delegate, as per local processes, in order to escalate the issue with SAAS.

4. *SAAS/RFDS/MedSTAR* are responsible for:
   - coordinating requests from referring clinicians to transfer patients for admission
   - notifying the requesting hospital of any unexpected delays in transport
   - providing timely clinical handover to receiving clinicians
   - monitoring the patient's clinical condition during transfer and alerting the receiving hospital to any clinical deterioration as this may impact on the patient's eligibility for direct admission.

5. *The Administrative Officer* at the receiving hospital inpatient unit is responsible for completing the administrative process by which a hospital commences and records the admission of a patient.

6. *Bed availability*
In the event that the receiving facility does not have a bed available within the required timeframe, the following steps should be taken:
   - The receiving Patient Flow Coordinator should consult with the referring and receiving clinicians to determine whether the direct admission can be delayed until a bed is available.
   - The referring and receiving clinicians should consider the suitability of alternative options, for example, the patient can safely return home with elective admission the following day, or whether the direct admission can occur at another hospital.
   - If the above options have been exhausted and the direct admission is considered urgent, the most senior receiving medical clinician should escalate the issue to the relevant Divisional Director or Chief Operating Officer to enact local escalation processes. This should occur as soon as the issue is identified to enable timely action and resolution of the situation.

3.4 Clinical handover

Clinical handover is integral to the delivery of safe patient care. It is the responsibility of the clinicians involved to ensure that timely and effective clinical handover occurs on every occasion of transfer of clinical responsibility during the direct admission process and in accordance with SA Health policies and guidelines including the *Clinical Handover Policy Directive* and the *Clinical Handover Policy Guidelines*.

3.5 Patient arrivals

3.5.1 Patient suitable for direct admission on arrival

Patients whose clinical condition is unchanged or who remain suitable for direct admission on arrival should bypass ED and be transferred to the agreed designated location in consultation with the receiving medical clinician or Patient Flow Coordinator for the receiving hospital. Transit lounges should be utilised, where available, to facilitate efficient turnaround times for ambulance crews.

When the patient arrives at the agreed designated treatment area, the nursing team leader (or delegated clinician) immediately contacts the receiving medical clinician to confirm arrival. To ensure patient safety, LHNs must have mechanisms in place to confirm that patients who are admitted directly to inpatient unit beds are clinically appropriate for direct admission once they have arrived at the hospital. A member of the receiving inpatient medical team should review the patient as soon as possible and **within 1 hour of arrival*** at the receiving hospital. In the event of any delay to patient review by the receiving medical team, the team leader should escalate concerns in accordance with local processes.

If at any time there are concerns regarding the patient's condition and inpatient unit staff are unable to initiate a response from the receiving Consultant (or delegate), standard local medical emergency procedures must be followed, adhering to the SA Health *Recognising and Responding to Clinical Deterioration Guidelines*.

In the event, following review of the patient at the receiving hospital, that the Consultant or inpatient team disagrees that the patient requires admission to the respective specialty or unit, the Consultant (or delegate) should follow local processes to refer on to the alternate specialty or unit. Clinical responsibility for the patient remains with the receiving team until a transfer has been actioned, including timely clinical handover and a timeframe for which the patient should be

reviewed. If the issue cannot be resolved, the situation should be escalated to the Medical Director for a timely clinical decision.

*****This timeframe may be extended in special circumstances (for example, a patient being admitted to a country hospital where the receiving clinician is not hospital-based) if the referring and receiving clinicians agree that it is clinically safe to do so.

3.5.2 Patient's condition deteriorates en route

Where the patient's clinical condition deteriorates en route and the patient is no longer considered suitable for direct admission, the receiving hospital should be notified as soon as possible that the patient requires urgent assessment on arrival. The transporting clinician contacts the receiving hospital's ED to advise that the patient has clinically deteriorated en route and requires assessment to determine whether direct admission is still appropriate. The patient should be transferred directly to the ED or, where prearranged, to the appropriate Intensive Care Unit/specialist unit.

On arrival at the ED, the patient is assessed by the ED triage nurse or appropriate ED clinician and a determination is made as to whether the patient is suitable for direct admission or requires admission to the ED or an alternative inpatient specialist unit.

Patients assessed as suitable for direct admission are transferred to the pre-arranged receiving area of the hospital and standard direct admission processes are followed (see 3.5.1). Information about the ED assessment and any change to the interim treatment plan should be included in the clinical handover.

4. Implementation and Monitoring

Chief Executive Officers of LHNs and SAAS are responsible for nominating an executive sponsor to lead the Policy Guideline implementation.

Chief Operating Officers of LHNs and Director Service Performance and Improvement, SAAS, are responsible for establishing local monitoring and reporting processes to ensure the active management and review of direct admission processes. Hospitals must ensure that appropriate records are maintained to facilitate accurate reporting.

Directors and Heads of Units are responsible for oversight of direct admission processes.

Clinicians who experience any issues that impact on patient quality of care should report this via the Safety Learning System, where appropriate, using keywords 'Direct Admission' and/or 'Transfer'.

5. National Safety and Quality Health Service Standards

National Standard 1 Governance for Safety and Quality in Health Care	National Standard 2 Partnering with Consumers	National Standard 3 Preventing & Controlling Healthcare associated infections	National Standard 4 Medication Safety	National Standard 5 Patient Identification & Procedure Matching	National Standard 6 Clinical Handover	National Standard 7 Blood and Blood Products	National Standard 8 Preventing & Managing Pressure Injuries	National Standard 9 Recognising & Responding to Clinical Deterioration	National Standard 10 Preventing Falls & Harm from Falls
☒	☐	☐	☐	☐	☒	☐	☐	☒	☐

6. Definitions

In the context of this document:

- **Clinical deterioration** refers to a change in a patient's physiological status that has the potential to lead to either morbidity or mortality. Clinical deterioration may be anticipated in the context of end of life care.

- **Clinical handover** is the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.

- **Delegate** means an employee authorised by a senior clinician to represent them for a specific responsibility, for example a Senior Registrar or Fellow may be authorised by the Consultant to consider a request for a direct admission and a Registered Nurse or Nurse Manager may be authorised by the Consultant to contact the Patient Flow Coordinator to plan a patient admission.

- **Direct admission** means the admission of eligible patients directly to a hospital ward under the care of a responsible medical team, whether:
    - as an inter-hospital transfer within SA Health hospitals, or from a private hospital to an SA health hospital, or as an inter-state hospital transfer into an SA health hospital; or
    - from a community based practitioner who does not have direct admitting rights to the intended hospital, i.e. Primary Care Provider GP, Specialist or Nurse Practitioner.

- **Interim treatment plan** means documented directions for the individualised care of the patient (including, as necessary, the appropriate national inpatient medication chart, instructions for acceptable clinical parameters and frequency of monitoring, diet, fasting orders, etc.) that provide continuity of care for the period of time from when the patient leaves the care of the referring clinician until the patient has been reviewed by the receiving Consultant (or delegate).

- **Receiving Consultant** means a hospital doctor of the highest rank who is an expert in a particular area of medicine or, where a hospital is not staffed by Consultants (for example a country hospital), a lead medical officer.

- **Referring clinician** means a senior hospital based medical clinician, i.e. Consultant, Senior Registrar or Fellow, or an appropriately qualified community based practitioner, i.e. Primary Care Provider GP, Specialist or Nurse Practitioner.

7. Associated Policy Directives / Policy Guidelines & Resources

- Acute Medical Units Policy Guideline (2009)
- Clinical Handover Policy Directive (2010)
- Improving Access to SA Health Services Policy Directive (2011)
- Recognising and Responding to Clinical Deterioration Policy Directive (2012)

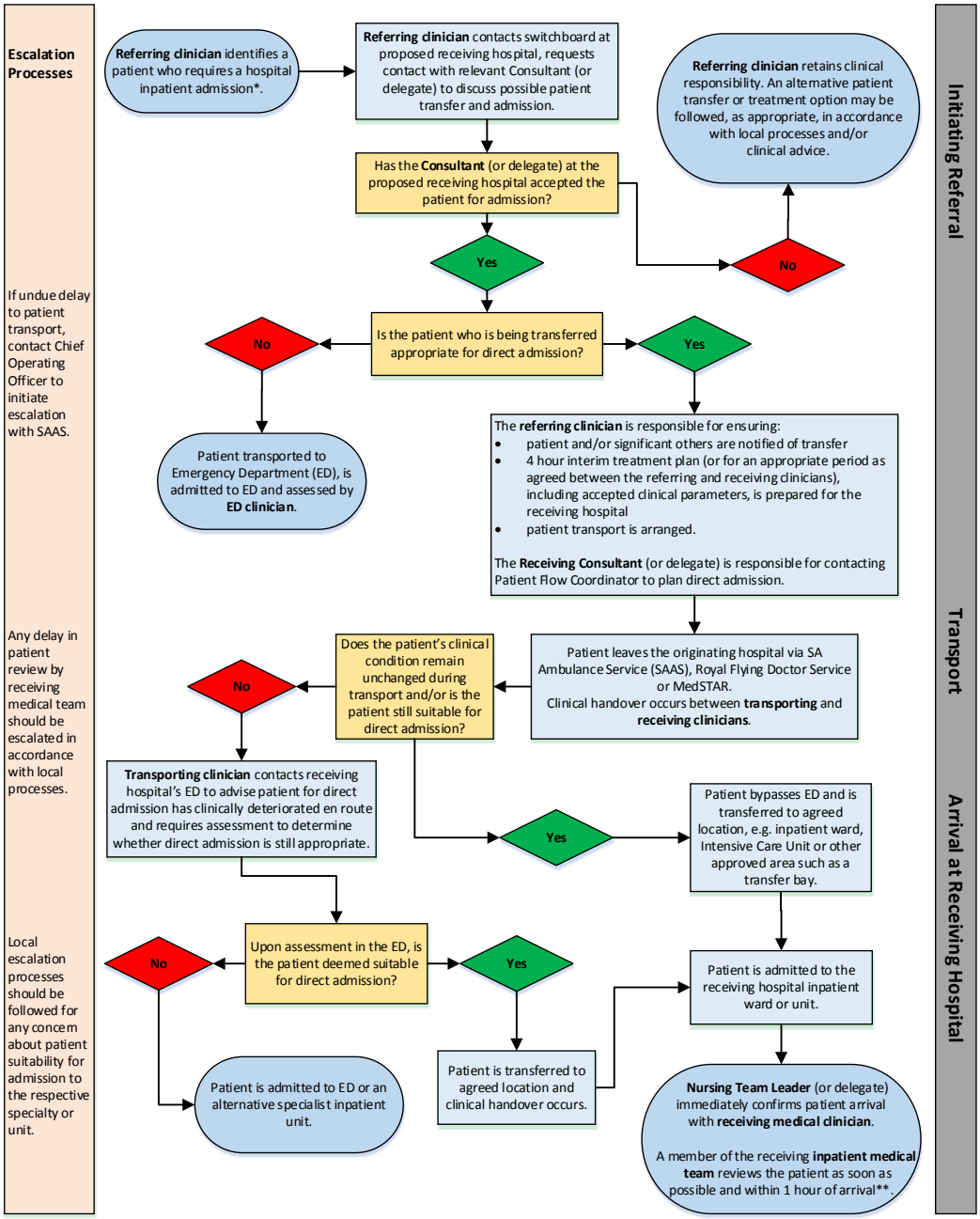
8. Document Ownership & History

Document developed by: Operational Service Improvement and Demand Management
File / Objective No.: 2017-10741 | A496001
Next review due: 31 May 2022
Policy history: Is this a new policy (V1)? **N**
Does this policy amend or update and existing policy? **Y**
If so, which version? **1.0**
Does this policy replace another policy with a different title? **N**

ISBN: 978-1-74243-986-0

Approval Date	Version	Who approved New/Revised Version	Reason for Change
17/05/2018	V2	SA Health Policy Committee	Formally reviewed.
16/06/11	V1	Portfolio Executive	Original version.

Patient Transfer and Direct Admission Process



*In some circumstances the direct admission process may be initiated by a referring clinician who may not have direct admitting rights to the intended hospital, i.e. a Primary Care Provider GP, Specialist or Nurse Practitioner. In these circumstances the above referral process is to be followed.
**This timeframe may be extended in special circumstances if the referring and receiving clinicians agree that it is clinically safe to do so.