Government of **Western Australia**
Department of **Health**

Admitted Patient Activity Data
Business Rules

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Links to:	Information Management Policy Framework https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Information-Management

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Abbreviations

ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
AN-SNAP	Australian National Subacute and Non-acute Patient
COF	Condition Onset Flag
DAMA	Discharge Against Medical Advice
ECG	Electrocardiogram
ECT	Electroconvulsive Therapy
ED	Emergency Department
FIM	Functional Independence Measure
GEM	Geriatric Evaluation and Management
HITH	Hospital in The Home
HMDC	Hospital Morbidity Data Collection
HST	Highly Specialised Therapy
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
IHACPA	Independent Health and Aged Care Pricing Authority
MCFD	Medically Cleared For Discharge
MFAU	Maternal Fetal Assessment Unit
MHCT	Mental Health Care Type
MHLS	Mental Health Legal Status
NICU	Neonatal Intensive Care Unit
NOCC	National Outcomes and Casemix Collection
PAS	Patient Administration System
RUG-ADL	Resource Utilisation Groups - Activities of Daily Living
SCN2	Special Care Nursery – level 2
SPC	Specialist Palliative Care
SSU	Short Stay Unit
URTT	Unplanned Return to Theatre
VAD	Voluntary Assisted Dying
WA	Western Australia

1. Purpose

The purpose of the *Admitted Patient Activity Data Business Rules* is to outline criteria to correctly record, count and classify admitted patient activity data within the Western Australian (WA) health system.

The *Admitted Patient Activity Data Business Rules* is a related document mandated under *MP 0164/21 Patient Activity Data Policy*.

These Business Rules are to be read in conjunction with this policy and other related documents and supporting information as follows:

- *Hospital Morbidity Data Collection Data Specifications*
- *Hospital Morbidity Data Collection Data Dictionary*
- *Patient Activity Data Policy Information Compendium*.

2. Background

Business rules ensure that the collection of admitted activity is standardised across the WA health system to ensure that Health Service Providers (HSPs) and Contracted Health Entities (CHEs) record, count and classify activity correctly for the services they provide. High quality information is required to inform the planning, monitoring, evaluation and funding of health services.

Only admitted activity which meets the requirements outlined in this document must be recorded, independent of funding arrangements, local work practices or other policies and content.

These Business Rules are revised annually, with reference to national policy and legislation, to ensure relevance and currency. Revisions are made following extensive consultation with stakeholders.

3. Contact details

Queries and feedback on the Business Rules can be submitted to the Department of Health via DoH.AdmittedDataCollection@health.wa.gov.au.

4. Scope

The scope of the *Admitted Patient Activity Data Business Rules* includes acute, subacute, non-acute, mental health and newborn admitted activity.

The following activities are excluded from being classified and recorded as valid admitted activity:

- admission to a virtual or administrative ward
- a baby classified as stillborn
- patients who are dead on arrival (other than admissions for organ procurement)
- an episode of care provided entirely in a non-admitted setting, for example:
    - Emergency Departments (ED)
    - outpatient clinics
    - telehealth or other virtual non-admitted care

- community based clinics
- patient's home (unless the criteria for Hospital in the Home (HITH) is met)
- service areas other than an inpatient ward or unit (e.g. community or outreach services)

- residential aged care or flexible care.

4.1 COVID-19

In order to accurately capture COVID-19 episodes of care and COVID-19 related hospital activity, the Independent Heath and Aged Care Pricing Authority (IHACPA) has issued national classification and reporting rules to ensure this activity is captured on a nationally consistent basis.

IHACPA has developed Australian Coding Standard (ACS 0113 Coronavirus Disease 2019 (COVID-19)) for Twelfth Edition, which provides guidance on how to classify COVID-19 in admitted episodes and supersedes all previous advice related to COVID-19.

How to classify COVID-19 guidance released by IHACPA, and COVID-19 Activity Data Recording Guidelines developed and published by the Department of Health brings together all advice related to the classification of COVID-19. These documents provide guidance and frequently asked questions (FAQs) to assist in the recording and coding of COVID-19. All WA health entities must comply with the business rules and requirements in the COVID-19 Activity Data Recording Guidelines.

5. Requirements for admitted activity

5.1 Admitted Activity

Admitted activity is defined as care which qualifies for admission and meets admission criteria specific to the admission category and the applicable care type. The patient must undergo a formal documented admission process to receive qualified inpatient treatment and/or care.

Admitted activity may also be referred to as inpatient care and involves care in a hospital inpatient ward or unit, or in the patient's place of residence under specific admission criteria as part of HITH programs.

An episode of care must not be recorded as admitted activity if the care is provided entirely in a non-admitted clinical area, e.g. an Outpatient, Emergency Department or other non-admitted service. This activity must be recorded as non-admitted care following the *Non-Admitted Activity Data Business Rules* and the *Emergency Department Patient Activity Data Business Rules.*

The NHRA and the *Health Insurance Act 1973* requires all components of care (including non-admitted care) provided to an admitted public patient to be provided free of charge as a public hospital service, regardless of the setting. This includes any care provided to the patient by Contracted Health Entities.

5.2 Qualification for admission

The following criteria must be met to qualify for inpatient admission as part of providing admitted activity services:

- clinical assessment that a patient requires same day/short stay or overnight

inpatient (admitted) care, which:

  - meets the definition of admitted activity
  - is documented in the patients' medical record

- is authorised by a medical, dental, nurse or midwife practitioner, credentialled to admit the patient under their care and management the care meets the admission criteria for the applicable admission category and care type. The patient must meet at least one of the following qualifications:
  - the patient requires expert clinical management and facilities that are only available in an inpatient ward or unit
  - the patient requires at least daily assessment of their medication needs
  - the patient is aged nine days or less
  - the patient requires management of labour and/or delivery
  - the patient has died after admission to an inpatient ward or unit
  - there are other circumstances necessitating admission.

5.2.1 Admission caveats

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

All elective procedures performed in the WA health system must meet an identified clinical need to improve the health of the patient. A list of excluded procedures is provided in the *MP 0169/21 Elective Services Access and Management Policy*.

5.3 Other admission circumstances

There may be exceptional circumstances under which a decision to admit is made to ensure a person's welfare or there may be legal or social factors such as:

- child at risk (for example, a child under state protection, suspected child abuse)
- adult at risk (for example, domestic abuse, or inadequate level of social support to safely leave the hospital)
- short-term unavailability of the patient's usual carer (care type: maintenance-respite)
- a patient approaching end of life who will be transferred to another site on social and cultural grounds, and subsequently passes away.

For exceptional cases which do not meet admission criteria, but the medical practitioner determines that an admission is required, the reason or circumstances requiring admission must be documented in the patient's medical record and the care must be provided in an inpatient ward or unit.

5.3.1 Voluntary Assisted Dying

Under the *Voluntary Assisted Dying Act 2019*, voluntary assisted dying services are available in Western Australia. Due to the sensitivity of the data there are specific requirements to be used when recording this activity.

Activity related to Voluntary Assisted Dying (VAD) typically does not qualify for admission, except in the following specific circumstances:

- the patient was already an admitted patient prior to the decision for VAD; or
- fFollowing administration of a VAD substance where death does not occur and the patient required clinical management meeting qualifications for admission (as per section 5.2 Qualification for admission); or
- in cases where all of the following criteria are met:
    - the patient died after admission to an inpatient ward or unit (as per section 5.2 Qualification for admission); and
    - other circumstances necessitated the admission – such as social or legal factors (as per section 6.1.4 Same day medical treatment); and
    - admission was required to provide accommodation to a patient due to other circumstances (as per section 7.4 Acute care).

If an admission is recorded due to the above factors, the separation date and time must be reported as the date and time of death. Any time following death is not considered part of the admitted episode.

The circumstances necessitating an admission for VAD must be clearly documented in the medical record and visible on audit. Same-day HITH admissions must not be recorded for VAD, refer to section 8 - Hospital in the Home, as HITH admission must not be recorded for same day care and must meet admission criteria under a relevant care type, as a substitute for inpatient care.

5.4 Documentation

5.4.1 Medical record

Medical records are formal collections of information regarding an individual's healthcare plan, medical history, assessments and other health related documentation.

Medical records can exist in a physical, digital and/or electronic form. It is typically a record created when a patient first presents to a healthcare facility and is used to document care in all subsequent care and/or admissions. Where an electronic record is made as a substitute for a physical record, it is to be viewed and treated in a similar manner to the physical record.

While the medical record primarily serves the patient as a documented history by documenting patient care interactions, for the purposes of patient activity data reporting, it is a necessary evidentiary record for mandatory audit purposes and to meet legislated funding agreements and record keeping requirements.

5.4.2 Requirements

All admissions must be supported by documentation and a record of treatment and/or care that includes:

- administrative documentation (e.g. registration on the Patient Administration System (PAS) and financial election forms)
- documentation in the medical record by a medical practitioner or authorised clinician to evident compliance with the definition of admitted activity, including:
    - the decision to admit and time made
    - the reason for admission
    - the intended clinical treatment plan for admitted activity
    - factors/exceptional patient circumstances contributing to the admission
    - conditions identified and treated/care provided
    - the date and time of discharge from the hospital
    - specific documentation requirements of the admission category and care type.

Information not written or recorded within a conventional paper-based or digital medical record but captured electronically via a supporting administrative and/or clinical application (e.g. EDIS, EBM, iCM) may, by definition, be considered an extended part of the medical record. Where such an application is used to document any decision in relation to the admission (e.g. a decision to admit and/or decision time to admit), local procedures must evidence this as standard practice and the information must be documented consistently. Documentation must be clearly delineated, with information recorded according to the type of activity being undertaken.

5.5 Financial election change

Patients must not be discharged and readmitted for the purposes of changing their financial election. Refer to the National Health Reform Agreement and the WA Health Fees and Charges Manual.

6. Admission categories

6.1 Same day admissions

Same day admissions occur when a patient is admitted and discharged on the same day. Short stay admissions which span midnight, but otherwise meet the medical criteria below, are included as 'same day' for the purposes of determining applicable admission criteria.

A same day admission must meet the definition of admitted activity and qualify for admission. Patients receiving the entirety of care within a non-admitted clinical area e.g. an Outpatient, Emergency or Allied Health Department are not eligible for same day admission. This activity must be recorded as non-admitted care following the *Non-Admitted Activity Data Business Rules* or the *Emergency Department Patient Activity Data Business Rules.*

Same day admissions are split into the following subcategories:

6.1.1 Procedures eligible for same-day admission

Patients may be admitted for a procedure if that procedure is eligible for same-day admission based on the list of Same-day ACHI Procedure Codes.

Intravenous therapy may only be included as a same day admitted procedure in select circumstances. Refer to the user guide in the Same-day ACHI Procedure Codes.

6.1.2 Procedures not eligible for same-day admission

In select circumstances patients may be admitted for a procedure that is not eligible for same-day admission based on the list of Same-day ACHI Procedure Codes.

Patients having these procedures in an operating/procedure room, inpatient ward or same-day care unit, are not automatically eligible for same-day admission.

An admission is permitted if at the time of the decision to admit, there are exceptional medical or patient circumstances requiring an altered treatment protocol for the procedure, resulting in an increased level of care and clinical management only available as admitted care. This must be evidenced in the patient's medical record by:

- clinical documentation to demonstrate the provision of increased level of care and management
- documentation by the Medical Practitioner outlining the exceptional condition or circumstances necessitating admission
- a Type C certification form for admission for a non-admitted procedure is acceptable and is required for privately insured patients.

Provision of generic, non-patient-specific documentation is not acceptable.

If, after admission, an eligible procedure cannot be performed and is replaced with a procedure that is not normally eligible the admission is still deemed compliant as long as the above evidence in the medical record is present.

6.1.3 Changing eligibility of same day procedure codes

Application to change the eligibility of the same day ACHI procedure codes can be made via e-mail to coding.query@health.wa.gov.au, stating:

- current work practices
- business case for change
- possible risks (for both re-allocating and not re-allocating codes), including risks to patient care.

6.1.4 Same day medical treatment

The same day medical category excludes booked procedures. Admissions for same day medical treatment must meet at least one of the following three criteria, with documented evidence in the patient's medical record:

- a minimum of four hours of continuous active management is provided to the patient, in the form of one or more of the following:
    - regular observations or monitoring of vital or neurological signs undertaken on a repeated and periodic basis, such as continuous monitoring via electrocardiogram (ECG) or similar technologiesRoutine continuous blood pressure or pulse monitoring is an insufficient level of care for this purpose
    - continuous active treatment by clinical staff as prescribed by a medical practitioner
    - the patient requires an essential period of mental health observation, assessment and management
- a social (for example domestic violence) or legal requirement or other circumstances placing the patient at risk and necessitating admission
- providing the patient life sustaining intensive care only available in an inpatient ward or unit.

An admission can be classified as same day even if the patient discharges against medical advice as long one of the above criteria is met.

6.1.5 ED short stay admissions

Patients admitted from the ED to a Short Stay Unit (SSU) with the intention of being discharged on that same day are categorised as same day admissions. This includes patients whose admitted episode spans midnight, but who otherwise would have been regarded as an intended short stay admission. For example, admission at 20:00 hours with discharge at 01:00 hours.

6.1.5.1 ED Short Stay Unit

An ED SSU may also be known as Clinical Decision Unit, Emergency Observation Unit, Urgent Care Clinic.

The purpose of an ED SSU is to:

- provide evidence-based, high-quality, intensive short-term observation and treatment for selected ED patients
- reduce inappropriate admissions to inpatient beds and associated

healthcare costs

- improve patient flow by providing timely assessments and treatment, thereby allowing patient discharge in the shortest, clinically appropriate time.

As per clause C48 of the National Health Reform Agreement - National Partnership Agreement on Improving Public Hospital Services, the Standing Council on Health, the Commonwealth and states and territories have agreed to implement the following definition of an emergency department short stay unit, or equivalent, with the following characteristics[1]:

- are designated and designed for the short-term treatment, observation, assessment and reassessment of patients initially triaged and assessed in the ED
- have specific admission and discharge criteria and procedures
- are designed for short term stays no longer than 24 hours
- are physically separate from the ED acute assessment area
- have a static number of available treatment spaces with oxygen, suction and patient ablution facilities
- are not a temporary ED overflow area, nor used to keep patients solely awaiting an inpatient bed, nor awaiting treatment in the ED.

Note: The SSU must not be used to avoid breaching a measured performance threshold.

For use of virtual wards in ED, please refer to the section on virtual wards.

6.1.5.2 ED short stay admission criteria

Patients who attend the ED and are admitted to the ED SSU or equivalent, must meet:

- the definition of admitted activity
- the patient qualifies for admission
- the admission criteria for one of the same day admission categories.

Patients may also meet the criteria for admission due to social, legal or other circumstances necessitating admission.

6.1.5.3 ED short-stay admissions - procedures eligible for same-day admission

Patients may be admitted for an ED short-stay admission for a procedure eligible for same-day admission based on the list of Same-day ACHI Procedure Codes if the procedure commences in the ED and:

- continues in the SSU. For example, a patient who has intravenous infusion of a pharmacological agent, as therapy for an established diagnosis, commenced in the ED and continued in the SSU
- the care associated with the procedure continues in the SSU. For example, a patient who has sedation administered for a procedure

[1] National Health Information Standard - ED SSU (METeOR 525112)

performed in ED and who recovers from the sedation in the SSU.

6.1.5.4 Same day medical admissions

In addition to complying with Section 6.1.4 Same day medical treatment, Health Service Providers must develop and implement local procedures and processes for determining patient compliance for admission to the SSU. For example, guidelines for medical admissions of common ED presentations and how this care constitutes continuous active management. These guidelines are to be consistent with established clinical pathways, protocols or accepted clinical practice.

To allow for delays in availability of an SSU bed, where the patient is ready for admission, the calculation of four hours continuous active management may include the time continuous active management commenced in ED, with the following qualifications:

- the calculation of the four hours commences from the time of the decision to admit, with decision, date and time documented in the medical record
- admitted care must be provided to the patient during their stay in the SSU (not only in ED), with continuous active management continuing after the patient is admitted. Admitted care provided entirely in the ED must be recorded as an ED non-admitted episode of care only
- the patient must arrive in the SSU with a documented admitted care management plan
- the admission time is recorded as the time the patient physically leaves the clinical area of the ED
- the recorded admitted care episode commences once the patient has left the ED[2] not the time of the decision to admit.

Note: this only applies to patients awaiting admission to a SSU and is not applicable to patients who are awaiting transfer to another health service for their ongoing care or admission.

6.1.5.5 Exclusions

If a short stay admission absconds/leaves at own risk and the termination of care results in the failure to meet the admission criteria the admission must be cancelled.

Activity for patients who are transferred into an SSU but not formally admitted or the SSU admission is cancelled/reversed, must be counted and recorded as part of the ED non-admitted attendance. This includes if a short stay admission leaves without notice. Refer to the *Emergency Department Patient Activity Data Business Rules* for more information.

Patients awaiting transfer to another hospital are only to be admitted if their condition requires care that meets the same day admission criteria.

An admission must not be recorded for the following reasons:

- where the entirety of care occurs within the ED (these are ED non-

[2] Treatment provided entirely in ED is not reported in the clinical coding for the inpatient admission.

admitted patients)

- for no other reason than the patient remaining in the ED for longer than four hours
- to avoid breaching a measured performance target threshold
- where the patient has been provided with clinical intervention/s for their condition and requires time to rest prior to discharge home
- where the patient's treatment, regardless of length of stay, primarily consists of waiting for:
    - allocation of an inpatient bed
    - review by a specialist medical practitioner
    - diagnostic tests e.g. medical imaging or results of diagnostic tests
    - equipment or medications
    - transport home or transfer to another health service facility.

6.2 Maternal Fetal Assessment Unit (MFAU) short stay admissions

A MFAU is an Immediate Care Clinic - Non-admitted service, similar to an ED attendance for the following purpose:

- to allow a pregnancy to be monitored outside normal clinic appointments
- to detect any abnormalities that may arise between antenatal clinic appointments
- to identify complications of pregnancy and initiate a change in management.

An attendance at the MFAU may be planned or unplanned and usually consists of an initial 'triage' midwife (or medical practitioner if midwife is not available) assessment and prioritisation of care.

In addition to the provision of non-admitted assessment and treatment (clinic), the MFAU may also have a co-located short stay inpatient ward. If there is a need for more intensive care and/or a high risk necessitating inpatient care, the patient may be admitted to the MFAU SSU directly or after assessment in the clinic.

Health Service Providers are to:

- develop protocols to inform 'triage' of patients presenting to the MFAU in determining their non-admitted or admitted care pathway
- record non-admitted care provided in the MFAU as per the *Non-Admitted Activity Data Business Rules*
- only admit patients to MFAU SSU who meet the admission criteria for same day admissions.

6.2.1 Admission criteria

Admissions to the MFAU SSU must:

- meet the definition of admitted activity
- must be authorised and meet qualification for admission criteria
- meet the criteriafor one of the same day admission categories

- ensure there is sufficient documentation to evidence:
    - the provision of admitted care that meets admission criteria
    - the decision to admit and date/time made
    - authorisation by a medical practitioner.

In addition to the same day medical admission criteria, Health Service Providers must develop and implement protocols and processes for determining patient compliance in meeting the admission criteria. For example, guidelines for admission of common obstetric presentations and how this care constitutes continuous active management.

These guidelines must be consistent with established clinical pathways, protocols or accepted clinical practice. Patients with social, legal or other circumstances may also qualify for admitted care.

A patient may be admitted to the MFAU SSU prior to transfer (not discharged) to an inpatient ward/unit for ongoing multi-day care.

6.2.2 Planned Readmissions

Where a patient is discharged from the MFAU SSU with the intention that the patient will return for admission within 24 hours for continuation of the current care (e.g. once labour has progressed, for induction of labour or for elective caesarean section), then the patient must not be discharged but placed on leave and returned from leave in accordance with planned leave protocols.

6.3 Overnight/Multi-day admissions

An overnight or multi-day admission occurs when it is intended that a patient will be admitted for a minimum of one or more nights.

An overnight admission must:

- meet definition of admitted activity
- qualify for admission
- meet the admission criteria for the applicable care type.

6.3.1 Exclusions

Overnight/multi-day activity does not include the following scenarios:

- patients whose treatment meets the criteria for same day admission (i.e. same day procedures can still span midnight – this does not automatically make them an overnight admission)
- a patient cannot be administratively pre-admitted and sent on leave for a planned same day procedure/treatment scheduled for a future date (e.g. following day)
- ED short stay admission whose admitted episode spans 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)
- boarders are excluded from this definition (see Section 7.16 Hospital Boarders).

7. Care types

An episode of care refers to a phase of treatment and is designed to reflect the overall nature of a clinical service, the changing diagnosis and/or primary clinical intent and purpose of care. The episode care type is determined and authorised by the medical practitioner who will be responsible for the management of the patient's care.

Correct assignment of care type for admitted patient episodes will ensure that each episode is classified appropriately for Activity Based Funding. This is vital as the classification will determine how the episode is counted, reported and funded.

An overnight patient may receive more than one type of care during a period of hospitalisation. In this case the period of hospitalisation is broken into episodes of care, one for each type of care.

The specialist medical practitioner responsible for the management of care may not necessarily be located in the same facility as the patient. In these circumstances, a medical practitioner at the patient's physical location may also have a role in the care of the patient. The expertise of this medical practitioner does not affect the assignment of care type.

Valid care types include:

- acute
- newborn
- mental health
- mental health rehabilitation
- rehabilitation
- Geriatric Evaluation and Management (GEM)
- psychogeriatric
- palliative
- maintenance
- organ procurement
- hospital boarder.

Residential aged care or flexible care may be recorded for Health Service Provider purposes, but not reported as inpatient care to the Hospital Morbidity Data Collection (HMDC). If the aged care or flexible care resident requires hospitalisation for admitted care, within the same hospital, it must be treated as a formal acute care type admission using home as the transferring medical facility.

Although there are ten different care types, not all hospitals are equipped or approved to deliver the program of care indicated by the care type.

7.1 Care type classification

All admitted episodes of care are clinically coded using the following classifications:

- the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)
- the Australian Classification of Health Interventions (ACHI).

Admitted episodes of care are grouped to the following casemix classification systems:

- acute and newborn care: Australian Refined Diagnosis Related Groups derived from ICD-10-AM and ACHI codes and other data items
- subacute and maintenance care: Australian National Subacute and Non-Acute Patient (AN-SNAP) classification, which requires the use of specialised clinical assessment tools to report phase of care, assessment of functional impairments, age, and other measures
- mental health care: Australian Mental Health Care Classification, which requires the phase of care and relevant clinical measures from the National Outcomes and Casemix Collection (NOCC) to be reported.

7.2 Care type changes

A patient's care type is changed when the primary clinical purpose or treatment goal meets the admission criteria for a different type of care.

The care type of the new episode of care is determined and authorised by the medical practitioner, who will be responsible for, or informing, the management of the new type of care for the patient.

To change a patient's care type, a new episode of care is commenced by recording a statistical discharge and admission. For example, the patient is discharged and then readmitted to the same health service with a different care type. This may only occur once per day, excluding the posthumous organ procurement care type.

If a patient's condition deteriorates on the day their care type was changed and requires a change back to acute care type, the new episode must be cancelled, and the previous acute care episode reinstated.

A patient's care type cannot be changed on the day of formal admission or discharge as only one admitted care episode per day can be reported. If it is determined that the focus of clinical care requires a change of care type on the day of admission, the new care type must be applied to a single admission for the day.

A reduction in the intensity of acute care does not trigger a change to a subacute care type unless the patient is receiving care that meets the admission criteria for subacute care. It is therefore essential that any care type change reflects a clear change in the primary clinical purpose or treatment goal of care provided.

An allocated care type is not to reflect the care that is intended for the patient to receive at some time in the future. If a patient is authorised for a change in care type, the care type must not be changed until the new type of care commences. For example; where a patient is to be transferred to another ward or hospital for planned subacute care, the new care type is assigned on admission to the new ward/hospital.

Change of care type[3] by statistical discharge must not occur:

- on the day of formal admission or discharge
- for a change in location without a change in the primary clinical intent of care
- when the intensity of treatment or resource utilisation changes but the primary clinical intent or treatment goal does not change. For example, a temporary/short interruption to the current treatment plan due to a change in patient condition that:
    - is inherent to the current diagnosis/condition being treated, and/or

[3] If the patient required ICU overnight care, it would be appropriate to change the care type.

    - does not require management by a different specialist care type medical practitioner
- for a same day procedure/treatment with a planned return
- for a non-admitted care attendance (e.g. ED or outpatient setting/attendance)
- for the recovery (mobilisation) period of an acute episode prior to discharge
- for any waiting period before the intended new type of care commences, as this itself is not a new or separate episode of care
- pending transfer to another hospital for a change in type of care
- for a consultation only by another care type specialist medical practitioner, when there is no change in the primary clinical intent and purpose of care during the admission
- to correct the incorrect assignment of a care type
- based on documentation in the medical record that does not meet the requirements below
- for transfers to HITH where there is no change in the primary clinical intent of care
- from newborn to acute care type
- between subacute care types GEM and rehabilitation
- to assign Nursing Home patient type after less than or equal to 35 days continuous care (see maintenance section 7.14.5).

7.3 Documentation

The care type to which the episode is allocated must be supported and evidenced by documentation in the patient medical record. For example, if an episode is changed to the rehabilitation care type, there must be evidence in the medical record that rehabilitation care was provided, together with meeting the admission criteria.

To initiate a care type change, the following minimum documentation must be completed in the medical record:

- actual date and time the care type change is effective from
- name of the specialist medical practitioner who will be providing or informing the new type of care
- authorisation by the specialist medical practitioner who will be providing or informing the new type of care. Processing of the change may be delegated to a medical or nurse practitioner, but documentation must evidence the care type change was authorised by the specialist medical practitioner.

Authorisation can consist of a signature or statement but must be clearly stated who issued the authorisation. Delegated authorisations must also meet these requirements, including under which specialist medical practitioner the authorisation was issued.

Information related to care type changes must be documented in a manner that allows clear determination as to what care type specific treatments occurred under.

7.4 Acute care

An episode of acute care is one in which the primary clinical intent is to do one or more of the following:

- manage labour (obstetrics)
- cure illness or provide definitive treatment of injury
- perform surgery
- relieve symptoms of illness or injury
- reduce severity of illness or injury
- protect against exacerbation or complication of an illness or injury which could threaten life or normal function
- perform diagnostic or therapeutic procedures
- provide accommodation to a patient due to other circumstances.

Acute care excludes care which meets the definition of mental health care.

Inpatient virtual care is an emerging service that involves wearable devices and other technologies which monitor patients and notify clinicians of any change in conditions. Inpatient virtual care is delivered via video conference and remote monitoring technologies which forms a part of admitted care. For example, Health in a Virtual Environment (HIVE) at East Metro Health Service and Inpatient Telehealth Service at WA Country Health Service provide acute care in an innovative way using virtual health technology for patients admitted to the hospital.

Virtual care models alone do not qualify for admission, but can be utilised in the inpatient setting as a supplementary, through services such as telehealth and remote patient monitoring. These emerging models have shown to improve clinical decision-making, support patients to receive care closer to home and allow timely access to services to improve continuity of care. It also supports the clinical team by facilitating flexible service delivery models and multidisciplinary care. Virtual care can also play a role in supporting and improving the quality and sustainability of HITH models of care, although care delivered entirely by virtual models alone do not meet admission criteria (refer to section 8 - Hospital in the Home).

Patients who remain in a public hospital bed with an acute care type after 35 days must have their care type assessed by a medical practitioner and the need for continuing acute hospital level of care documented in the patient's medical record. If the assessment reveals that acute care is no longer required, then a change of appropriate care type must occur (e.g. maintenance care).

7.4.1 Endorsed privately practicing midwives

Acute admitted care to manage labour can be provided under the care and management of an endorsed privately practicing midwife[4].

If an admitted patient under the care of the private midwife requires management by a specialist medical practitioner, and as a public patient, then the patient is not to be discharged and re-admitted. The financial election and funding source must be changed to 'public' for the current admission as supported by the WA Health Fees and Charges Manual.

[4] MP0093/18 Access for Endorsed Midwives into Public Maternity Units Policy

7.5 Newborn care

Newborn care is initiated when the patient is born in hospital or is nine days old or less at the time of admission. Newborn care continues until the care type changes or the patient is separated, noting:

- the day of birth is counted as zero days of age
- newborns who turn 10 days of age and do not require clinical care are to be discharged, and if remaining in hospital with the mother, the newborn is to be recorded as a boarder via a change of care type. Second or subsequent live born infants are the exception to this and remain qualified until discharge
- newborns who turn 10 days of age and require clinical care continue in a newborn episode of care until separated
- newborns aged less than 10 days and not admitted from birth (e.g. transferred from another hospital) are admitted with a newborn care type
- newborns aged greater than 9 days not previously admitted (e.g. transferred from another hospital) are classified as either boarders or admitted with an acute care type and status of admitted patient
- within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day
- the newborn baby's qualified days are eligible for health insurance benefits purposes and the patient day count under the Australian Health Care Agreements. In this context, newborn qualified days are equivalent to acute days and may be denoted as such.

For further information with regards to the newborn care data elements, refer to the *Hospital Morbidity Data Collection Data Dictionary* and the Classification of Newborn Admitted Care Guide (Appendix A).

7.6 Qualified newborn

A qualified newborn is:

- a patient who is nine days old or less at the time of admission, and
  - is admitted to a Level 2 Special Care Nursery (SCN2) or Neonatal Intensive Care Unit (NICU) facility for intensive or special care, or
  - is the second or subsequent live born infant of a multiple birth, or
  - is admitted to, or remains in hospital without its mother, including when the mother is unwell and unable to care for the newborn.

If the baby is removed from a SCN2 or NICU with a planned return for continued care the qualified status is not retained, the status must be changed to unqualified until the baby returns to the SCN2 or NICU.

A newborn patient day is recorded as unqualified on any day where the newborn does not meet any of the above criteria.

If remaining in or admitted to hospital without the mother, the newborn may be admitted to an inpatient ward/unit instead of a SCN2 or NICU and meet qualified newborn client status.

Note: Newborn special care is care provided to a newborn suffering from illness, disability or from the birthing event, requiring specialist medical and nursing care.

Please note that the Client Status at time of discharge must reflect the Client Status of that day.

7.6.1 Qualified Newborn Days

Multiday (overnight stays)

The date of admission is counted as a qualified newborn day if the patient was qualified at the end of the day (23:59 hours).

The day on which a change in qualification status occurs is counted as a qualified newborn day if the patient was qualified at the end of the day.

If there is more than one change of qualification status in a single day, the day is counted against the final qualification status for that day.

The date of discharge or transfer is not counted, even if the patient was qualified on that day.

Same day admissions

If the newborn becomes unwell and is admitted to the SCN2 or NICU then discharged or transferred to another hospital on the same day, this is recorded and counted as a qualified newborn day in a same day admission.

If the newborn met qualified criteria (eg. Twin 2) and is discharged or transferred to another hospital on the same day, this is recorded and counted as a qualified newborn day in the same day admission.

7.6.2 Exclusions

Newborns admitted to a SCN or NICU that do not require intensive or special admitted care. For example, the newborn is in the SCN for routine observations, tests or other non-clinical care/reason.

7.7 Unqualified newborn

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 qualified newborn criteria. As care provided to an unqualified newborn is considered inherent to the care of the mother, unqualified days are not recorded separately[5].

A newborn singleton or first infant of a multiple birth who is rooming in with the mother, is an unqualified newborn and cannot be recorded as a qualified newborn (admitted patient) separate to the mother [6].

Unqualified newborns that remain in the hospital at ten days of age:

- must have episode of care type changed to boarder, or
- if requiring ongoing clinical care, must have qualification status changed to qualified newborn. In this case the newborn episode continues and every day of acute care from day 10 onwards is a qualified day.

[5] METeOR Newborn qualification status https://meteor.aihw.gov.au/content/index.phtml/itemId/327254.
[6] Definition of 'patient' http://www.austlii.edu.au/au/legis/cth/consol_act/hia1973164/s3. html.

7.8 Mental health care type

Mental health care type (MHCT) is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient's mental disorder.

7.8.1 Admission criteria

The following requirements must be met for the admission to be recorded with a MHCT. Mental health care:

- is delivered under the management of, or regularly informed by, a medical practitioner with specialised expertise in mental health
- is evidenced by an individualised formal mental health assessment and implementation of a documented mental health plan
- may include significant psychosocial components, including family and carer support
- includes services provided as assessment only activities
- requires the mental health phase of care and relevant clinical measures to be recorded:
    - Clinical measures refer to the clinician rated measures from the NOCC.

Mental health care is usually initiated with a referral to a mental health specialist medical practitioner which may result in a consultation only, or authorisation to change the care type to mental health. If so, the specialist medical practitioner will either assume management of the patient, or the clinical governance will not change, and the specialist medical practitioner will inform the management of care by providing direct mental health care or overseeing the provision of that care.

A mental health plan comprises a series of documented and agreed initiatives or treatments (specifying program goals, actions and timeframes) which have been established through consultation with the specialist medical practitioner and the client and/or carer. A copy of the mental health plan must be kept in the patient's medical record.

A patient receiving same day ECT should have a MHCT and mental health phase of care and clinical measures recorded. A patient discharged or temporarily transferred from one facility and admitted to another facility for same day ECT will require the phase of care and clinical measures for that ECT episode to be recorded by the facility administering the ECT.

7.8.2 Scope

Activity recorded under MHCT is provided via a specialised mental health inpatient service (e.g. in psychiatric hospitals or designated mental health observation or care units) where clinical staff are equipped to provide the specialised care necessary to deliver optimal mental health care, and complete the necessary mental health assessments, plans and data collection.

The MHCT:

- may include admission for psychiatric assessment only. For example, those patients pending psychiatric assessment under the *Mental Health*

Act 2014

- includes admitted patients meeting the MHCT admission criteria and receiving treatment in wards other than specialised mental health services.

A patient transferred to another facility for same day ECT, must be admitted with a MHCT.

An acute admitted patient may have a mental health principal diagnosis without assignment of a MHCT.

7.8.3 Mental health legal status

Patients with a MHCT must have a Mental Health Legal Status (MHLS) recorded. Patients admitted under an involuntary treatment order (Form 6A, 6B or CLMIAA order) under the *Mental Health Act 2014* must have an 'Involuntary' MHLS recorded irrespective of care type or location of care.

The MHLS is required to monitor trends in the use of compulsory treatment by Western Australian hospitals and community healthcare facilities. If a patient is admitted for psychiatric examination and thereafter deemed as not requiring admission, the *Mental Health Act 2014* considers the MHLS of this patient as 'Detained.'

Until there is a means to collect a legal status of 'Detained' in all patient management systems, the only reportable MHLS options are 'Voluntary' or 'Involuntary.'

A MHLS must be reported if a patient:

- is being treated in a designated mental health ward/bed during an episode of care (psychiatric days are being reported), or
- has a care type of mental health (and meets the relevant criteria).

The MHLS of admitted patients treated within approved hospitals may change throughout an episode of care. Patients may be:

- admitted to hospital as 'Involuntary' and subsequently changed to 'Voluntary,' or
- admitted as 'Voluntary' but transferred to 'Involuntary' during the hospital stay.

In these instances, the 'Involuntary' status over-rules any other status and the activity must be reported as involuntary.

At the time of admittance for psychiatric assessment, the MHLS is 'Voluntary' until, if required, a clinical decision is made to admit the patient as an involuntary patient under the *Mental Health Act 2014.*

7.8.4 Mental Health Observation Area

Mental Health Observation Area (MHOA) is also known as Mental Health Observation Unit or Mental Health Emergency Centre co-located with the Emergency Department (ED) to provide mental health treatment in acute situations. The unit provides 24 to 72 hours mental health observation and treatment for patients that require admission for extended monitoring and assessment.

Patients admitted to MHOA require further treatment due to mental health crisis or exacerbation of their mental illness or disorder. MHOA is not an authorised unit, generally only voluntary patients would be suitable for admission to MHOA. Patients are referred from the Emergency Department (ED), community mental health services or transfer from other wards.

Admission to the MHOA must:

- be dedicated for treating patient presenting with signs or symptoms indicating a mental illness or reporting self-harm/ suicide ideation and requiring observation in a safe low-stimulus environment. See ED short stay for treatment of other conditions in acute situations.
- meet the definition of admitted activity
- qualify for admission
- meet the admission criteria for Mental Health Care Type
- be Admitted under a MHOA Consultant Psychiatrist with admitting rights to the hospital
- have documentation and recording of a Mental Health Legal Status (MHLS)
- have a discharge plan with a clear pathway for discharge or transfer from MHOA within 72 hours
- apply exclusion criteria in Section 6.3.1 Exclusions
- must not have multiple care type changes recorded on the same day.

7.8.5 Mental Health HITH

HITH rules apply to approved mental health HITH programs, including acceptable use of virtual wards and beds.

Mental Health HITH must record both HITH days and days of psychiatric care.

7.8.6 Mental Health funding

Admitted Mental Health activity is priced and funded using the Australian Mental Health Care Classification (AMHCC). This classification improves the clinical meaningfulness of the way that mental health care services can be classified. WA health system entities must ensure that all Mental Health Admitted activity is recorded correctly to ensure appropriate allocation of funding.

Further information on the AMHCC is available from the IHACPA website: Australian Mental Health Care Classification.

7.8.7 Mental Health Rehabilitation

Mental health rehabilitation care type is only applicable at certain hospitals. It is used for Hospital Extended Care Service wards only, where long term non-acute mental health care is provided. This care type is used to capture long stay per diem funded episodes accurately.

7.9 Subacute care

Subacute care is specialised multidisciplinary care in which the primary need for care is the optimisation of the patient's functioning and quality of life. A person's functioning may relate to their whole body or a body part, the whole person in a social context, and to impairment of a body function or structure, activity limitation and/or participation restriction. Paediatric patients aged more than 10 days may, where applicable, qualify for subacute care.

Subacute care is healthcare for people who are not severely ill but need:

- support to regain their ability to carry out activities of daily life after an episode of illness
- help to manage new or changing health conditions
- assistance to live as independently as possible.

Subacute care comprises the following care types:

- palliative
- rehabilitation
- GEM
- psychogeriatric.

7.9.1 Subacute generic admission criteria

Subacute care is always delivered under the management of, or informed by, a medical practitioner with specialised expertise in the relevant subacute care type.

The specialist medical practitioner responsible for informing the management of the subacute care may not necessarily be located in the same facility as the patient. In these circumstances, a clinician at the patient's location will continue to provide care to the patient, however the expertise of this clinician does not affect the assignment of care type. Where the care plan is being informed by a medical practitioner with specialised expertise, the requirement for necessary documentation within the patient's medical record still exists.

If a patient is authorised for a change in care type to subacute care, the care type must not be changed until the new type of care commences. Where the patient is transferred to another hospital for planned subacute care, a subacute care type is to be assigned on the day of admission to that hospital.

Each subacute care type has specific data collection requirements to enable the activity to be classified using the AN-SNAP classification. Staff require training, and in some cases accreditation, to be able to administer the associated assessment tools. The additional data items needed for the allocation of an AN-SNAP code are dependent on the age of the patient and the care type. Staff are not required to allocate AN-SNAP codes but are responsible for collecting the clinical assessment data items which are used during the ABF reporting process to calculate the AN-SNAP code.

For further information related to the collection of clinical and administrative data for all subacute care types refer to the *Subacute and Non-acute Data Collection Data Specifications* and *Subacute and Non-acute Data Collection Data Dictionary*.

7.10 Palliative care

The palliative care type includes specialist palliative care in which the primary clinical intent or treatment goal is the optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs.

The palliative care type excludes admitted patients receiving end of life palliation that is not managed or informed by a Specialist Palliative Care (SPC) medical practitioner.

If the hospital does not have access to a SPC medical practitioner and the primary clinical intent of patient care is or becomes palliation, the care type cannot be changed to palliative. The care is to be managed within the existing admitted care episode.

Where palliative care is a component of the admitted care but a change to the palliative care type is not eligible, this activity will continue to be identified through the clinical coding process with the allocation of appropriate ICD-10-AM palliative care codes.

Patients who are placed on a care plan for the dying person do not automatically qualify for the palliative care type. Patients must be assessed by a specialist palliative care team and meet specific admission criteria.

7.10.1 Palliative care admission criteria

In addition to the subacute generic admission criteria, palliative care is always delivered under the management of, or informed by a SPC, and is evidenced by:

- a multidisciplinary assessment and management plan for the patient, documented in the medical record that covers the physical, psychological, emotional, social and spiritual needs of the patient and negotiated goals
- Resource Utilisation Groups – Activities of Daily Living (RUG-ADL) clinical assessments recorded at the commencement of each palliative phase.

For supplementary information on the Palliative Care Care Type, refer to the *Palliative Care Care Type Supplementary Information*.

7.11 GEM care

The GEM care type includes care in which the primary clinical intent or treatment goal is improvement in the functioning of a patient with multi-dimensional needs associated with medical conditions related to ageing, such as tendency to fall, incontinence, reduced mobility and cognitive impairment. The patient may also have complex psychosocial problems.

Patients must be classified as GEM where:

- admission is for reconditioning of an older patient with significant co-morbidities
- they have geriatric syndromes which require specialist geriatric medical input such as:
  - poor cognitive status
  - falls without significant injury
  - frailty.

GEM includes care provided:

- in a GEM unit
- in a designated GEM program
- under the principal clinical management of a GEM physician.

The GEM care type is generally applicable to older patients, however, younger adults with clinical conditions generally associated with old age may be classified under this care type.

7.11.1 Admission Criteria

In addition to the subacute generic admission criteria, GEM care is always delivered under the management of, or informed by a clinician with specialised expertise in GEM, and is evidenced by:

- an individualised multidisciplinary management plan which is documented in the patient's medical record, that covers the physical, psychological, emotional and social needs of the patient, and includes negotiated goals within indicative time frames
- a Functional Independence Measure (FIM™) clinical assessment recorded at the commencement of the GEM episode.

7.12 Rehabilitation care

The rehabilitation care type includes care in which the primary clinical intent or treatment goal is the improvement in the functioning of a patient with impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating.

Rehabilitation is typically more goal oriented than GEM and is provided for a patient with an impairment, disability or handicap for whom the primary treatment goal is improvement in functional status. Rehabilitation usually occurs after a readily defined event such as:

- stroke
- orthopaedic surgery
- traumatic injury
- defined disability.

Rehabilitation care type excludes care which meets the definition of mental health care.

7.12.1 Admission Criteria

In addition to the subacute generic admission criteria, rehabilitation care is always delivered under the management of, or informed by, a medical practitioner with specialised expertise in rehabilitation, and is evidenced by:

- an individualised multidisciplinary management plan, which is documented in the patient's medical record that includes negotiated goals within specified time frames
- a FIM™ clinical assessment recorded at the commencement of the rehabilitation episode.

7.13 Psychogeriatric care

The psychogeriatric care type includes care in which the primary clinical intent or treatment goal is improvement in the functional status, behaviour and/or quality of life for an older patient with significant psychiatric or behavioural disturbance, caused by mental illness, age-related organic brain impairment or a physical condition.

While psychogeriatric care is a subspecialty of mental health, it is an established component of subacute care. Therefore, if a patient meets the definition of psychogeriatric care, then the psychogeriatric care type should be allocated.

The psychogeriatric care type is not applicable if the primary focus of care is acute symptom control.

7.13.1 Admission criteria

Psychogeriatric care is always delivered under the management of or informed by a medical practitioner with specialised expertise in psychogeriatric care, and is evidenced by:

- an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames
- a Health of the Nation Outcome Scale 65+ clinical assessment recorded at the commencement of the psychogeriatric episode.

7.14 Maintenance care

The maintenance (or non-acute) care type includes care in which the primary clinical intent or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition. Following assessment or treatment the patient does not require any further complex assessment or stabilisation. Patients with a care type of maintenance care may require care over an indefinite period.

Paediatric patients aged 10 days and over may qualify for maintenance care type.

The maintenance care type requires completion of a RUG-ADL clinical assessment when the maintenance episode commences to enable the activity to be assigned to the AN-SNAP classification.

Maintenance care type excludes care which meets the definition of mental health care.

7.14.1 Admission criteria

A patient may be admitted with a care type of maintenance for a few purposes. These are listed below.

7.14.2 Convalescence

Convalescence is provided when, following assessment and/or treatment, the patient does not require further complex assessment or stabilisation but continues to require care over an indefinite period. Under normal circumstances the patient would be discharged but due to factors in the home environment, such as access issues or lack of available community services, the patient is unable to be discharged. Examples may include patients waiting for:

- completion of home modifications essential for discharge
- provision of specialised equipment essential for discharge
- rehousing
- supported accommodation such as hostel or group home bed
- whom community services are essential for discharge but are not yet available.

7.14.3 Respite

An episode of respite occurs where the primary reason for admission is the short-term unavailability of the patient's usual carer. Examples include:

- admission due to carer illness or fatigue
- planned respite due to carer unavailability
- short term closure of a care facility
- short term unavailability of community services.

7.14.4 Other maintenance

This refers to patients other than those already stated. This includes patients that have been assessed as requiring more intensive day-to-day care than can be provided in the home environment and who are awaiting aged care services, including placement in a residential care facility, for example:

- Commonwealth-subsidised permanent Residential Aged Care
- Commonwealth-subsidised Home Care Packages.

This also includes children who are well but awaiting foster placement or adoption.

7.14.5 Nursing home type patient

Maintenance care must be selected for all patients with a client status of nursing home type.

A nursing home type patient is a patient who has been in one or more hospitals (public or private) for a period of more than 35 days of continuous care, and who is now remaining in hospital for nursing care and accommodation as an end in itself.

7.14.6 Discharge Delay and Long Stay

New data items have been introduced for the collection of discharge delay including Medically Cleared for Discharge. Refer to Discharge Delay and Long Stay Patients.

7.15 Posthumous organ procurement

Posthumous organ procurement is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead.

At the time of death, the patient must be discharged as deceased; this is the official time of death. A separate admission for posthumous organ procurement is to be recorded.

7.16 Hospital Boarder

A hospital boarder is a person who is receiving food and/or accommodation at a hospital but for whom the hospital does not accept responsibility for treatment and/or care[7]. Boarders do not receive formal care or treatment and are therefore not considered admitted patients. However, boarders are within the scope of this collection and hospitals are required to register boarders.

Boarders are accommodated in hospitals to:

- assist the transition between the community and acute sectors by providing accommodation and hotel services
- provide accommodation, minimal patient supervision, support and facilities for patients, a family member, or carer.

There are three types of boarders:

1. Self-caring patients who require overnight or short-stay accommodation due to:
    - arriving prior to or remaining post formal admission to facilitate transport arrangements
    - delayed discharge for a non-clinical reason (no longer requiring inpatient care).
2. A self-caring parent, family member or carer accompanying a patient(excludes same day admissions)
3. Unqualified Newborns who turn 10 days of age and remain in hospital with the mother.

Boarders are 'admitted' or registered in PAS following specific boarder processes for the purposes of:

- recording all persons in the hospital in case of an emergency
- mitigate clinical risk
- non-admitted and non-clinical service provision pre/post formal admission.

Billing and invoicing for boarder services (refer to WA Health Fees and Charges Manual). Boarders must be registered to the unit providing accommodation. Leave days should be recorded for Boarders to correctly inform charging of accommodation fees. Newborns in hospital at age 9 days or less cannot be boarders; they are admitted patients with each day of stay deemed to be either qualified or unqualified.

7.16.1 Boarder who is subsequently admitted

If a boarder has been accommodated in a hospital and a change in their condition requires admission to hospital, this cannot be recorded as a change in status via statistical discharge. Even though the hospital has previously "registered" the person as a boarder, the patient must be admitted and treated as a first-time admission.

If a Boarder requires minor treatment or investigation, which would normally be performed as a non-admitted patient service, this treatment should be recorded according to provision as either non-admitted service event or Emergency Department attendances and does not alter the patient's status as a boarder.

[7] Hospital boarder (aihw.gov.au)

7.17 Medi-hotel

The role of a medi-hotel is to provide accommodation and hotel services for self-caring patients accessing acute health services. This term is used for beds in a non-ward residential service maintained by the hospital, as a substitute for traditional hospital ward accommodation. Patients may be accommodated in a Medi-hotel overnight after receiving admitted care as a same-day patient or receive non-admitted patient services during the day. Patients may be accommodated in the Medi-hotel before, during or after a multi-day admitted episode.

The development of medi-hotels in WA is evolving, all HSPs must contact DoH.AdmittedDataCollection@health.wa.gov.au for direction on reporting medi-hotel activities.

8. Hospital in the Home

Hospital in the Home (HITH) is the provision of acute or mental health overnight/multiday 'admitted care' provided in the patient's home, usual place of residence or temporary residence as a substitute for hospital accommodation.

Models of care that are an alternative to inpatient care do not automatically qualify for HITH. Health services establishing or planning new HITH services, must contact the Department of Health for directions on recording of activity via DoH.AdmittedDataCollection@health.wa.gov.au

If the care being provided to the patient would not otherwise require in-hospital admission, then provision of that care in the patient's home does not qualify for HITH and cannot be recorded as admitted care activity. For example, care provided entirely via telehealth/virtual non-admitted care, post-acute and community outreach care.

HITH care may sometimes initiate from a direct referral as a substitute for an inpatient hospital admission or to facilitate early discharge with continuation of admitted care in the patient's residence.

Private patients must not be discharged and then readmitted as public HITH patients[8]. A HITH day is deemed to have occurred when the patient has stayed in hospital past midnight. If a patient is discharged from a HITH before midnight, then that day will be not be counted towards the overall HITH length of stay.

Home births may be recorded as eligible HITH admissions when provided under an approved home birth program and in accordance with *MP 0141/20 Public Home Birth Policy.*

8.1 Admission criteria

A HITH admission is governed by the same rules that apply to in-hospital admitted activity and must:

- meet the definition of admitted activity
- qualify for admission and
- meet the admission criteria for the applicable admission category and care type.

HITH care is the equivalent of admitted care services provided by hospital based medical practitioners, nursing or allied health staff in the patient's usual place of residence, or at an alternative suitable location nominated by the patient.

As HITH is a substitute for in hospital admitted care, it is expected that patients receive direct clinical admitted care in the home daily. A complete set of observations as part of the daily clinical assessment should be undertaken and documented within the medical record. The admitting medical practitioner must also frequently review the patient to ensure they only remain in HITH for as long as admitted care is required.

While a multidisciplinary team, including medical, nursing and allied health, can be provided as part of HITH care, the patient must still meet admission criteria and receive daily clinical admitted care in the home. Similarly, while virtual models of care can play a role in HITH, care solely provided virtually would not be considered a substitute for in hospital admitted care.

[8] See Section 4.3 of the WA Health Fees and Charges Manual.

8.1.1 Exclusions

A HITH admission must not be recorded for:

- same day care (with the exception of home births)
- care that is not frequently reviewed by a medical practitioner
- telehealth/virtual only (non-admitted) care
- the purpose of referral and assessment only, without provision of ongoing HITH care
- care provided entirely by non-hospital based clinicians or external providers
- voluntary assisted dying.

8.1.2 HITH days of care reporting criteria

Where the patient is transferred to a HITH service provided by the same hospital, the movement must be recorded as an internal ward transfer within a single episode of care. The patient is not to be discharged home and readmitted to HITH Virtual Ward within the same hospital.

In the case where the patient requires HITH at another hospital, the patient is to be transferred to the other hospital (or discharged to the other hospital where transferring is not possible due to limitation of webPAS) and the receiving hospital identified. The patient must be then directly admitted to the HITH virtual ward at the receiving hospital.

8.1.2.1 HITH days of leave

Any days between leaving hospital and commencement of HITH within the same hospital are to be recorded as leave days (refer to Hospital Leave). Patients transferred to another hospital HITH must be firstly admitted to the other hospital HITH and be placed on HITH leave at the receiving hospital.

HITH leave must not exceed two consecutive days in duration. If leave exceeds two consecutive days, the patient must be followed up and either returned from leave to continue HITH treatment or discharged.

A HITH patient must be put on leave for each day that they are not receiving admitted care in the home. If scheduled care is cancelled, or the patient is not home when HITH staff visit, a leave day is to be recorded. HITH clinicians must document leave days and the clinical care provided for a recorded HITH day in the hospital medical record to evidence provision of admitted care.

8.1.2.2 HITH day of care

A HITH day of care can only be recorded when the patient has been visited in their place of residence by HITH staff who provide admitted services to the patient. As HITH is a substitute for inpatient care, it is expected that patients receive direct clinical admitted care in the home daily. Telephone consultations, telehealth services, or attendance at community health clinics are all non-admitted care which alone would not qualify for HITH days of care. Care provided that would not qualify for admission and would be classified as non-admitted care is excluded from HITH day of care.

If the patient returns to the hospital, at which they are a current HITH inpatient, for care that cannot be provided in the patient’s residence, e.g. specialist

medical review, or an ED attendance, then HITH days may be recorded for this contact. This care is included as part of the single admitted care episode with the same hospital. This does not apply where the attendance is at another hospital.

Designated psychiatric facilities recording HITH activity, must record both HITH days and Psychiatric Care days.

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

9. Contracted care

Hospitals may purchase contracted care services from other hospitals or external entities for all or part of the care provided during an admitted care episode. To inform the correct counting, classification and funding for contracted care activity, the following requirements must be met.

Health services establishing or planning new contracted care services, must contact the Department of Health for directions on recording of activity. Please contact the Data Custodian of HMDC via email to: DoH.AdmittedDataCollection@health.wa.gov.au

For supplementary information on the recording of contracted care activity refer to the *Patient Activity Data Policy Information Compendium*.

9.1 Contracted care definition

Contracted care is an episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a health service purchaser of care (contracting hospital), and a provider of an admitted service (contracted hospital). The provider of the contracted healthcare service must be a private hospital or a private day facility.

Contracted care can be categorised into two groups:

i. the patient is admitted directly to the contracted hospital, which provides the whole episode of admitted care. For example:
   - same-day dialysis that is provided by a contracted service provider
   - an acute patient is discharged to another hospital to commence contracted subacute care.

ii. the patient is admitted and transferred between both the contracting and contracted hospital with each providing components of the admitted episode of care (part of the care is contracted to another service). For example:
   - where the patient is admitted to the public hospital then transferred to the contracted hospital for a procedure and returns for continued care.

9.2 Out of scope of contract care

These business rules are not applicable to the following arrangements:

- agreements with Contracted Health Entities to provide public health services which are deemed to be an extension of the public health service and therefore out-of-scope. For example, Health Service Provider service agreements with St John of God Midland and Joondalup Health Campuses
- care provided entirely by the contracted health service/hospital to non-public funded patients where the contract type is (A)B
- arrangements between a public hospital to other public hospitals
- other special services where designated institutions are funded to provide entire services for the State
- hospital services that are provided to the patient in a separate facility during the contracted care episode, for which the patient is directly responsible for paying
- where patient care is provided cross-border with other states or territories, the

interstate activity must not be recorded in Western Australia

- investigations performed at another location such as diagnostics, using specimen collected at the contracting hospital
- the leasing of another organisation's facilities or services, such as theatre room, equipment, or beds, with the contracting hospital providing staff. See section 9.8 Contracted Services for activity recording requirements.

Any arrangements that do not fall under the Contracted Care definition must be reviewed by the Department of Health. Please contact the Custodian of HMDC via email DoH.AdmittedDataCollection@health.wa.gov.au.

9.3 Contract Role

Under contracted care, it is important to establish the role each Hospital plays to select the correct data items in the Patient Administration Systems and Hospital Morbidity Data Collection (HMDC).

- Hospital A is the contracting hospital (funding/purchaser)
- Hospital B is the contracted health service/hospital (provider).

9.4 Contract Type

Contract Type is a term to describe the contracted care relationship between Hospital A and Hospital B and demonstrates the patient's care journey. To define the contracted care arrangements between the contracting and contracted health services, five different contract types have been identified as shown in Table 1.

Table 1 - Contract Types for Contracted Care

Contract Type	Definition and Description
(A)B Public patients only	Hospital A contracts with Hospital B to provide a whole episode of care. • The patient does not attend Hospital A for any part of the episode of care. • Hospital A is not to record an admitted care episode for the contracted care provided at Hospital B. • Hospital B will report the admission to the Department of Health where it will be allocated to Hospital A's activity. For example: A patient attends Fresenius Dialysis Service for haemodialysis under contract to Fiona Stanley Hospital. A patient receiving care at Bunbury Hospital is transferred to St John of God Bunbury Hospital to commence subacute care. The patient is to be discharged from Bunbury Hospital and commence a new admission as an (A)B contract type. Patient attended Emergency Department (ED) at Bunbury Hospital and is then transferred to St John of God Bunbury for admitted care as an (A)B contract type.

Contract Type	Definition and Description
	Note: This Contract Type is only applicable to 'Public Funding Source' admissions.
AB	Hospital A contracts with Hospital B to provide an admitted service. • The patient first attends and is admitted to Hospital A prior to transfer to Hospital B for ongoing contracted care. • The patient does not return to Hospital A. • Hospital A records an admitted episode covering the care and duration of time at both hospitals A and B, with a patient type of Funding Hospital. • Hospital A places the patient on contract leave while receiving care at Hospital B. • Patient is discharged from Hospital B upon completion of care. • Hospital A then returns patient from contract leave and discharges the patient recording the same separation data as Hospital B. • Discharge date/time in Hospital A is the actual date/time the patient is separated from Hospital B. For example, a patient is admitted to Geraldton Hospital and then is transferred to St John of God Geraldton Hospital for a procedure and/or ongoing care and does not return to Geraldton Hospital. Note: This contract type excludes patients transferred to commence a new care type of subacute/non-acute/mental health. See (A)B.
BA	Hospital A contracts with Hospital B to provide an admitted patient service • The patient is initially admitted to Hospital B then transferred to Hospital A for ongoing care. • Hospital A records an admitted episode covering the care and duration of time at both hospitals A and B, with a patient type of Funding Hospital. • Hospital A places the patient on contract leave while receiving care at Hospital B. • Hospital A returns patient from contract leave when patient transfers to Hospital A. Admission date, time, source etc. recorded by Hospital A is to match the data recorded on admission at Hospital B For example, a patient is admitted at St John of God Geraldton for a procedure and then is transferred to Geraldton Hospital for after care.
ABA	Hospital A contracts with Hospital B to provide an admitted service.

Contract Type	Definition and Description
	• The patient first attends and is admitted to Hospital A prior to transfer to Hospital B for ongoing contracted care. • Hospital A places the patient on contract leave while receiving care at Hospital B and changes the patient type to Funding Hospital. • The patient then returns to Hospital A for ongoing care. • Hospital A records an admitted episode covering the care and duration of time at both hospitals A and B, with a patient type of Funding Hospital. • The discharge date/time at Hospital A is the date/time the patient is discharged from Hospital A after returning from Hospital B. For example, a patient is admitted to Bunbury Hospital for elective lower segment Caesarean section. The patient is then transferred to St John of God Bunbury for the Caesarean procedure and returns to Bunbury Hospital for aftercare. A current multi-day inpatient at Kununurra Hospital receives Dialysis under contract at the Kununurra Dialysis Unit during their admission.
BAB	Hospital A contracts with Hospital B to provide an admitted patient service • The patient is initially admitted to Hospital B then transferred to Hospital A for ongoing care. • The patient then transfers back to Hospital B for further contracted care. • Hospital A records an admitted episode covering the care and duration of time at both hospitals A and B, with a patient type of Funding Hospital. • At Hospital A, the patient is placed on contract leave while receiving treatment at Hospital B. • Admission and Separation Data; date, time, source, separation, destination etc recorded by Hospital A is to match the data recorded at the initial admission and final discharge by Hospital B. For example, a patient is admitted to St John of God Hospital Bunbury for a cardiology procedure. After the procedure, the patient is transferred to Bunbury Hospital for ongoing care. The following day the patient is transferred to St John of God Hospital again for further care and is discharged from there.

Note: Brackets indicate the patient was not admitted to the hospital.

9.5 Data elements to be recorded for contracted care

The following data elements are essential to inform the contract type and associated criteria for the counting, allocation and funding of contracted care activity.

9.5.1 Admitted from

It is essential to only record the contracting/contracted hospital as the 'Admitted from' establishment if the patient was a current inpatient there prior to being admitted.

9.5.2 Admission status

Admissions directly from ED must have an admission status of 'Emergency-Emergency Department Admission'.

9.5.3 Client Status/Patient Type

The Client Status defines the type of hospital service being provided for the patient. This defines the role of the hospital as the contracting or contracted hospital. These are:

- funding hospital (contracting service)
- contracted service
- funding qualified newborn (new code)
- funding unqualified newborn (new code).

9.5.4 Contracted/Funding Establishment

The contracted/funding establishment code is recorded to link the activity of Hospital A and Hospital B.

- Hospital A record the establishment code for Hospital B.
- Hospital B record the establishment code for Hospital A.

9.5.5 Discharged to

It is essential to only record the contracting/contracted hospital as the 'Discharge to' establishment if the patient is being transferred there for admission.

9.5.6 Source of referral - Professional

If the patient is admitted directly from an ED attendance (not admitted at the preceding hospital) record 'Emergency Department Clinician'.

9.5.7 Leave

Leave is recorded where both Hospital A and B are providing components of the admitted episode of care.

9.5.7.1 Contract Leave

Contract leave refers to a type of leave recorded by a contracting hospital (Hospital A), when an admitted patient is sent for/receiving care at a contracted hospital (Hospital B) as part of contracted care.

Contract leave only applies where both the contracted and contracting hospital are providing components of the admitted episode of care. A patient cannot be recorded as admitted to both hospitals at the same time, unless the patient is on contract leave at Hospital A.

A patient receiving a contracted care service at another establishment can be placed on contract leave for more than 7 days, however the patient's status is to be reviewed after 35 days on leave

Contract leave is recorded through the 'Leave Type' data element. It is only recorded by Hospital A for the duration of the contracted care at Hospital B as shown in Table 2.

Table 2: Recording contract leave

Contract type	Contract Leave
AB	Contract leave is recorded for the duration of time between the transfer to Hospital B and discharge.
BA	Contract leave is recorded for the duration of time between the admission to Hospital B and transfer to Hospital A.
ABA	Contract leave is recorded for the duration of time between transfer to Hospital B and return transfer to Hospital A.
BAB	Contract leave is recorded for the duration of time between admission to Hospital B and transfer to Hospital A, and also between the transfer back to Hospital B and discharge.

9.5.8 Hospital Leave

Hospital B must not discharge but must place contracted care patients on leave (hospital leave) if a patient attends Hospital A (or other health service) for planned or unplanned care, and it is expected to return to Hospital B to continue their care. For example: A multi-day contracted palliative care patient in Hospital B would be placed on hospital leave during a same-day admission to Hospital A for chemotherapy.

9.6 Length of Stay

For a multi-day patient, length of stay is calculated by subtracting the admission date from the discharge date minus leave days. Contract leave days are treated as patient days and excluded from leave days for the length of stay calculation.

9.7 Clinical Coding

- ICD-10-AM codes, ACHI codes and Condition Onset Flags (COFs) must be assigned to admitted episodes of care according to Section 16 Clinical Coding.

Refer to Clinical Coding Guidelines: Contracted Care for further information.

A Contracted Care Flag is recorded in WebPAS to identify procedures and diagnoses

that are associated with the contracted care provided by Hospital B.

There are two types of Contracted Care Flags:

- Contracted Care Flag B
- Contracted Care Flag AB.

The following apply to the assignment of the contracted care flag by the contracting hospital:

- where a procedure is performed at the contracting hospital (Hospital A) only, the procedure should not be assigned a contracted care flag
- where a procedure is performed at the contracted hospital (Hospital B), the procedure must be recorded by Hospital A with a contracted care flag B
- where a procedure that is only coded once is performed at both the contracting hospital (Hospital A) and also at the contracted hospital (Hospital B), the procedure must be recorded by Hospital A with a contracted care flag 'AB'
- where a procedure that is only coded once is partially performed at both the contracting hospital (Hospital A) and the contracted hospital (Hospital B), the procedure must be recorded by Hospital A with a contracted care flag 'AB'
- where a diagnosis is treated at only Hospital B, the diagnosis code must be flagged with a contracted care flag 'B'
- where a diagnosis is treated at both Hospital A and B (Type AB BA ABA BAB), the diagnosis code must be flagged with a contracted care flag 'AB'.

Refer to Table 3, Contracted Care Clinical Coding Guide below for summary of the clinical coding requirements for each contract type.

Table 3 - Contracted Care Clinical Coding Guide

Contract type	Hospital A assigns	Hospital B assigns
ABA AB BA BAB	• All diagnosis, procedure codes and COFs applicable to the care provided for the entire admitted care episode in both hospitals A and B • Contracted care flag for all procedure codes that were provided by Hospital B • Contracted care flag for Diagnoses that are treated during care at Hospital B (See also, section 9.9 Responsibilities)	Only diagnoses, procedure codes and COFs related to the care provided at Hospital B.
(A)B	Nil - Activity is not recorded by Hospital A	

Note: There are some procedures for which ACHI codes are not generally assigned, e.g. Imaging services (i.e. X-rays, CT scans etc.). These procedures should not be coded solely because they were performed at another hospital under contract.

9.8 Contracted Services

Contracted Services are where the Contracting Hospital A is providing the clinical care under an arrangement with the contracted hospital to provide non-clinical services. For example, Accommodation only, use of operating theatres or equipment, or other goods and services. This service would not be considered 'Contracted Care' for activity data recording purposes.

9.8.1 Recording Requirements

Hospital A

- The Contracting (public) Hospital A is to record the patient activity as an admission to their hospital as an 'admitted client' patient type/client status.
- The recording of admission and discharge dates, and clinical coding would cover the duration and all care provided at either hospital during the admitted care episode.
- The patient would not be placed on leave or discharged when transferred to the private hospital but would be transferred to a virtual ward established for this purpose.
- The admission at the public hospital would not record the private hospital as the 'contracted/funding establishment'. This is only a requirement for Contracted Care.

Hospital B

- Record the admission as a client/patient type 'boarder'.

9.9 Responsibilities

Health services establishing or planning new contracted services, must contact the Department of Health for directions on recording of activity. Please contact the Data Custodian of HMDC via email to: DoH.AdmittedDataCollection@health.wa.gov.au.

Where the patient is admitted at both the contracted and contracting hospitals, the contracting hospital (Hospital A) is responsible for ensuring that the contracted hospital (Hospital B) provides them with required clinical documentation and information necessary to enable ongoing patient care at Hospital A (where applicable).

To the extent that the requirements contained within these Business Rules are applicable to the services purchased from Contracted Health Entities, WA health entities are responsible for ensuring these requirements are accurately reflected in the relevant contract and managed accordingly. It is recommended that the contractual agreements include the following:

- compliance with the mandatory policy requirements of the WA health department's Policy Frameworks with specific reference to MP 0164/21 *Patient Activity Data Policy* within the Information Management Policy Framework
- provision of administrative information/clinical documentation to:
  - inform of changes to qualified newborn status change at time of the change (to inform the correct calculation of qualified newborn bed days)
  - inform accurate clinical coding of diagnoses and procedures

    - inform recording of mandatory data elements
- ensure clinical assessment scores for sub-acute care are recorded accurately
- expected time frame for provision of information/data between hospitals and to the Department of Health
- manage data quality issues and facilitate audits carried out by the Department of Health - Information and Performance Governance Unit by providing information and resources to the Health Information Audit team
- ensure a secure method of information exchange between the contracted and contracting Hospitals.

10. Ward and Bed Maintenance

10.1 Ward and bed availability maintenance

Timely and accurate data on bed availability and occupancy is necessary for a number of statutory reporting requirements and key demand and capacity metrics being monitored by the State Health Operations Centre and other system flow initiatives.

The active and open status of all public beds (including accurate room and ward details) must be maintained in the PAS in a timely manner.

Beds that are operationally unavailable for prolonged periods of time (such as for the maintenance or refurbishment of an area) must be marked as inactive in the PAS and promptly reactivated when brought back into operational use.

Due to centralised reporting requirements, significant changes to public ward and bed capacity or the classification of existing beds must be notified to the Department of Health to ensure capacity monitoring can be updated accordingly. Notifications can be submitted to DoH.AdmittedDataCollection@health.wa.gov.au.

10.2 Virtual beds/wards

A virtual bed is a term used to denote a nominal location which the patient is held against in the hospital's PAS. Admission to a virtual bed, with very few exceptions, does not form part of a valid admitted care episode.

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

It is only acceptable to admit a patient to, or discharge a patient from a virtual ward in the following scenarios:

- to admit patients who are transferred directly to theatre when a ward has not yet been allocated
- admissions to HITH - ward code/name to include the acronym 'HITH'
- discharge from a discharge/transit lounge
- discharge from a theatre virtual ward
- current admitted patients who deteriorate and/or require transfer for care within the location of an ED, can be transferred to an ED virtual ward for bed movement tracking purposes
- current admitted HITH patients who present to ED
- at the discretion of the Health Service Provider virtual wards and beds can be used for the purpose of recording a patient on contract care leave.

All other admitted care must occur within a physical inpatient ward or unit as per the definition of admitted activity.

Patients still being cared for in the ED and waiting to be allocated/transferred to an inpatient bed must not be admitted to a virtual ward.

Patients receiving the entirety of care within a non-admitted clinical area e.g. an outpatient clinic or allied health department are not to be admitted to a virtual ward and must be recorded as non-admitted patient activity.

11. Cancelled or abandoned booked procedures

When a patient is admitted for a booked procedure and the procedure is subsequently cancelled, the admission must not be recorded unless:

- the procedure is for dialysis, infusion, transfusion, apheresis or induction of labour and the procedure has already commenced
- the patient is already in the operating theatre or procedural unit. A procedural unit includes endoscopy procedure room, cardiac catheter laboratory, radiology
- the patient has received pre-medication such as Emla gel/cream, eye drops, iodine lotion, IV saline, anxiolytics and anti-emetics
- anaesthesia has already been administered
- despite the procedure being cancelled, the admission is continued for some other treatment or circumstance, under the medical practitioner's orders and meeting admission criteria.

If for non-clinical reasons, a patient is admitted on the day prior to their scheduled procedure and the procedure is subsequently cancelled, the admission is recorded if meeting admission criteria and other admission circumstances.

Establishment of intravenous access only prior to commencement of a procedure, without administration of anaesthesia, is to be considered cancelled, not abandoned.

For recording of cancelled/abandoned procedure activity as a non-admitted service event refer to the *Non-Admitted Activity Data Business Rules*.

Refer to the Appendix B – Flowchart – Cancelled or abandoned booked procedures for further information.

Refer to Clinical coding guidelines: ACS 0011 and ACS 0019 for further information.

12. Unplanned Return to Theatre

An unplanned return to theatre (URTT) occurs when a patient has a surgical procedure/operation which requires an unexpected return to the operating theatre for a further procedure during the same admitted episode.

URTT is a measured performance indicator under the Performance Management Policy and also impacts the calculation of Hospital Acquired Complication (HAC) adjustments for activity based funding.

All URTT must be documented as such in the patient medical record and the URTT status must be recorded against that admitted procedure in the Patient Administration System or theatre management system (TMS).

For WA public hospitals the unplanned return to theatre status is collected from the TMS application.

In circumstances where the TMS application is not routinely used for the scheduling/management of certain procedures, the unplanned return to theatre status must be accurately recorded in the patient administration system (i.e. webPAS).

13. Readmission

A hospital readmission occurs when a patient has been discharged from hospital and is admitted again within a certain time interval.

Generally, hospital readmissions can be considered in two broad categories:

- readmissions that relate to routine care, for example those that relate to necessary treatments such as chemotherapy or dialysis, and are required to ensure safe clinical care
- readmissions that are potentially avoidable.[9]

Where there is an intention to readmit a patient, this must be clearly documented in the medical record by the treating medical officer at the time of discharge.

Readmissions are further classified as either planned or unplanned based on the clinical intention to readmit or the time interval between discharge and readmission. Refer to the Readmission Flowchart (Appendix C) for further information.

13.1 Planned readmission

A planned readmission is when the patient is readmitted at a time following discharge, on the advice of the treating medical practitioner. This may include further treatment related to the same condition for which the patient was previously hospitalised.

Patients discharged with a plan for readmission within seven days, (e.g. returning for a scheduled procedure or to continue the same admitted care) must not be discharged and instead be placed on leave.

This excludes staged day case admissions for procedures or ongoing treatment such as recurring cases of chemotherapy and dialysis.

See also Section 12.3 for readmissions within the same day.

13.2 Unplanned readmission

Unplanned readmission is an unexpected admission of a patient within 28 days of discharge to the same establishment. This is where there was no intention by the treating medical practitioner to readmit for treatment of the same or related condition as the previous admission.

A patient who is admitted within 28 days of discharge is considered an unplanned readmission if it is:

- for treatment of a condition related to the one for which the patient was previously hospitalised and was potentially preventable[10]
- a complication of the condition for which the patient was previously hospitalised (this may include mechanical complications).

Unplanned and unexpected hospital readmission rates for some specified surgical procedures and mental health care form part of the Health Service Performance Report in MP 0111/19 Performance Management Policy and/or Patient Safety and Quality management processes.

[9] Source: Avoidable hospital readmissions | Australian Commission on Safety and Quality in Health Care
[10] Source: Avoidable hospital readmissions | Australian Commission on Safety and Quality in Health Care

Unplanned readmissions must follow the applicable admission criteria.

Refer also to the section on Discharge against medical advice or left at own risk.

13.3 Readmissions within the same day

A patient may be scheduled to attend the same hospital on one day for more than one planned admission (for example, a day procedure on the same day as scheduled dialysis) however only one admitted episode must be recorded per day.

Patients that are readmitted on the same day of discharge where the second admission is an unplanned and unrelated emergency admission may have a second admission recorded.

Patients that are readmitted to resume care on the same day of discharge where the second admission is planned and related must not have a second admission recorded. Patient to be placed on leave for the period away from the Health Service, refer to planned leave.

Patients that are readmitted to resume care on the same day of discharge where the second admission is unplanned and related can have a second admission recorded constitutes unplanned readmission. A second admission must not be recorded when the patient is advised to return if required or recalled by the medical practitioner to continue the same inpatient treatment on the same day as discharge.

A patient must not be readmitted on the same day for the purpose of changing the financial election or transfer to HITH.

13.4 Mental health readmissions

Mental health readmissions are overnight separations from the mental health service organisation's acute psychiatric inpatient unit that are followed by readmission to the same or another public sector acute psychiatric inpatient unit within 28 days of discharge[11]. Mental health readmission may indicate that inpatient treatment was incomplete or ineffective, or that follow-up care was inadequate to maintain the person's treatment out of hospital. Refer to the Readmission Flowchart (Appendix C) for further information.

13.5 Readmission following Discharge Against Medical Advice (DAMA)

See section on Discharge against medical advice or left at own risk.

[11] Key Performance Indicators for Australian Public Mental Health Services, 2013

14. Discharge

Discharge (also referred to as ‘separation’) is the process by which an admitted patient completes an episode of care. The documentation on discharge destination, the date and time of discharge must be evident in the medical record.

14.1 Formal discharge

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

- is discharged to private accommodation or other residence
- is transferred to another hospital, health service or other external healthcare accommodation
- leaves against medical advice
- fails to return from leave
- is deceased.

Refer to Section 3.4 In-patient Discharge Planning of *MP 0095/18 Clinical Handover Policy*, for mandatory discharge summary requirements.

14.2 Statistical discharge

Statistical discharge is an administrative process that completes an admitted patient episode of care when there is a documented change in the clinical intent of treatment (for example, change in care type from acute care to palliative care). For each statistical discharge, there must be a corresponding statistical admission. Also refer to Section 7.2 Care type changes.

14.3 Self-discharge

14.3.1 Discharge against medical advice

Discharge Against Medical Advice (DAMA) occurs when a patient chooses to leave the hospital before the completion of treatment and against the advice of the treating medical practitioner. The patient is aware and understands the consequences of leaving the hospital and has the ability to make the decision to leave the hospital against medical advice. The patient is required to sign a DAMA form and clinical documentation must be evident in the patient’s medical record. This is recorded on PAS as discharge against advice.

14.3.2 Left at own risk

Left at own risk occurs when patient has left the hospital without informing staff and treatment is incomplete, against the advise of the treating team. When patients leave hospital and it is unclear whether they intend to return, it is a clinical decision whether to place the patient on leave or to discharge the patient. Medical practitioners may allow patients to remain on leave up to a maximum of seven days and if the patient returns during this time, the admission can resume, as long as leave requirements are met when sending and returning patients on leave.

The medical practitioner may decide to discharge the patient after patient had left the hospital without informing staff. The mode of separation must be

recorded on PAS a ‘Left without notice’.

The medical practitioner may decide to discharge the patient during the patient’s unauthorised absence from hospital. The mode of separation must be recorded on PAS as ‘Leave Against Advice.’

The decision to place the patient on leave or DAMA is to be documented in the patient’s medical record by the medical practitioner. If the patient represents after being discharged as against medical advice and they require admission, they may be readmitted (new admission).

If a patient discharges themselves and as a result does not meet the criteria for admission the episode of care must be cancelled.

14.3.3 Patient initiated early discharge

If a patient expresses a desire to discharge earlier than planned and the clinical team has assessed the patient and determined it is safe to discharge and a change in discharge plan can facilitate early discharge, then this should be recorded as a normal discharge to the appropriate destination such as home. The patient is not required to sign a DAMA form or a declaration for early discharge. This clinical decision on completion of treatment must be supported by clinical documentation to evidence safe discharge.

14.4 Discharge Delay and Long Stay patients

Monitoring and measuring the impact of discharge delays on system flow is a key strategic priority for the WA health system. While nationally consistent data definitions are yet to be developed, to support this strategy the Department of Health is introducing new data recording concepts and requirements for implementation in WA public hospitals.

Commencing in 2024 public hospitals utilising the webPAS Patient Administration System will be able to record:

- medically Cleared for Discharge, date and time
- no longer Cleared for Discharge (if appropriate)
- primary and Secondary Reasons for Discharge Delay.

For the purpose of reporting, a discharge delay is deemed to have occurred if a patient has been medically cleared for discharge, however continues to occupy an inpatient hospital bed past the medically cleared for discharge date and time. Following an identified discharge delay, it is neccessary to record the Primary and Secondary reason for discharge delay.

14.4.1 Medically Cleared for Discharge (MCFD)

The decision as to whether an inpatient is MCFD is made by the treating clinician responsible for the care of the patient. The MCFD decision must focus on the needs of the individual and must consider any multidisciplinary assessments carried out in consultation with all internal professionals involved in planning that patient’s discharge. For example, a patient should not be considered Medically Cleared for Discharge if internal hospital coordination reasons, such as waiting on pathology, are delaying the patient’s discharge.

The MCFD date and time is only mandatory for collection when it is realised that a patient has become MCFD and they are continuing to occupy an

inpatient bed exceeding day 7 of the current admission. However, MCFD can be captured for patients with any length of stay.

14.4.2 Discharge Delay and Maintenance Care Type

If, at the time a patient is determined to be MCFD, they are also eligible for a care type change to Maintenance Care, this should be undertaken as per the standard care type change process (statistical discharge and readmission). In this scenario the MCFD date/time and Reasons for Discharge Delay should be recorded against the new Maintenance Care episode immediately.

It is acknowledged that not all MCFD patients may be eligible for reclassification to Maintenance Care, or that all Maintenance Care type patients are MCFD.

15. Leave

It is essential to record leave to ensure the reporting of an accurate length of stay. Leave is defined as temporary absence from hospital with the expectation that the patient will return to resume care.

A patient may be placed on leave for up to seven days in accordance with applicable conditions outlined in this section. If a patient fails to return from leave within seven leave days without explanation, the patient must be discharged and recorded as 'discharged against medical advice.' If the reason for not returning is known to be the death of the patient, the discharge destination would be recorded as 'deceased.'

If the patient is an involuntary patient in an authorised, specialised mental health service, then in accordance with the *Mental Health Act 2014* they may be placed on leave for up to 21 days. At 21 days the appropriateness of the patient's leave arrangements must be considered and reviewed by the treating psychiatrist, in accordance with s.108(2) of the *Mental Health Act 2014.*

A HITH patient may be placed on leave for no more than two consecutive days, that they are not receiving admitted care in the home. Refer to the section on HITH for further information on HITH leave days.

The reason for leave, the date and time leave commenced, and if known, the expected return date, are to be documented in the patient's medical record.

A patient may be placed on leave for a variety of reasons. For example:

- during treatment at another hospital
- during a gap in treatment
- pending a scheduled procedure
- day, overnight or weekend leave
- trial leave at home or other place of residence
- left against medical advice.

15.1 Hospital leave

Patients may be placed on leave when transferred to another hospital, for planned or emergency care, and it is expected they may return to continue their care. However, patients who are transferred to another hospital with no expectation of returning must be discharged.

If a patient is on leave to receive care at another hospital, and it is determined that the patient will not be returning, then the discharge must be recorded as a 'transfer to another hospital' on the date the patient was transferred to the other hospital.

Hospital leave excludes leave recorded during contracted care.

15.2 Contract Leave

Refer to Contracted Care.

15.3 Planned leave

Planned leave applies where there is an expectation that the patient will return to resume the current care. For example, returning for a scheduled procedure or continuation of current care.

Patients discharged with a plan for readmission within seven days for continuation of current care (e.g. returning for surgery), must not be discharged and must be placed on leave. Overnight leave is not applicable to planned (elective/booked) same day admissions.

A patient cannot be admitted (administrative only) and sent on leave for a planned same day admission scheduled for the following day or future date as this will inappropriately classify this as an overnight admission.

Patients receiving a series of same day treatments (>2 admissions) which meet the definition of same day care, are not to be recorded as one multiday admission with periods of leave in between.

If during planned leave it is determined that the patient will not be returning to continue their care, and a decision is made to discharge the patient, this must be recorded as 'discharged from leave' on the date the decision is made. The discharge date is not backdated to when the patient left the hospital.

If the patient is admitted to another hospital while on leave, communication must occur between the two hospitals to ensure that admission dates and times do not overlap.

15.4 Unplanned leave

Patients who leave the hospital against the advice of the treating medical practitioner and it remains unclear whether the patient intends to return may be placed on leave. See DAMA for further guidance.

15.5 Patients on leave who present to an ED

A patient on leave who presents to the ED of the hospital to which they are currently admitted must not be discharged and then readmitted. The patient must have an ED type of visit recorded that identifies the patient as a 'current admitted patient presentation' in the ED information system.

Patients on leave who present to the ED of another hospital and are admitted to that hospital may remain on leave and return to the first hospital to continue their care. The second hospital must inform the first hospital that they have admitted the patient.

15.6 Sending patients on or returning patients from leave

For involuntary mental health inpatients, the maximum consecutive leave days are 21. Involuntary mental health patients not returning after 21 days must be discharged and readmitted if they return from leave.

For HITH patients, the days that the patient was not receiving admitted care must be reported as leave days. If scheduled care is cancelled or the patient is not at home when HITH staff visit, a leave day must be reported for the patient.

If two inpatient events occur on the same day only one admission must be recorded, with the patient recorded as being on leave in between admissions. For example, patients discharged with a plan for readmission later in the day for a scheduled procedure or other intended care, must not be discharged and instead be placed 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 unless they are admitted and go on leave on the same day, this day is counted as a patient

day, not a leave day

- the day the patient is on leave is counted as a leave day unless they are admitted and go on leave on the same day, this day is counted as a patient day, not a leave day
- the day the patient returns from leave is counted as a patient day unless 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 is not to be counted as either a patient day or a leave day.

15.7 Patients not returning from leave

The following rules apply to patients who do not return from leave:

- the day the patient goes on leave is counted as a leave day (if patient is admitted overnight or returns from leave) unless the patient is admitted and is sent on leave on the same day. In this scenario, this is counted as a patient day, not a leave day
- if a patient does not return from leave after the eighth day (or after the seventh day if the patient went on leave on the same day they were admitted), then the patient must be discharged
- the patient may be discharged against medical advice or discharged on leave
- if a patient returns to hospital after being discharged, the patient must be medically re-assessed and re-admitted as a new admission if required.

16. High-cost, highly specialised therapies

Access to new, high cost, highly specialised and potentially curative therapy treatments are an emerging option for patients in WA. A small number of patients are expected to benefit from access to highly specialised therapies (HST) each year. This includes, but is not limited to, the provision of Chimeric Antigen Receptor Therapies (CAR-T) such as Yescarta ®, Kymriah, and Tecartus, and other specialised therapies including Qarziba ® and Luxturna ™.

IHACPA has developed guidelines for the costing, counting and reconciliation of funding. In order to comply, all HSP's must provide patient level activity recording of HST to the DoH on a quarterly basis through DoH.AdmittedDataCollection@health.wa.gov.au.

The specifications are available on the IHACPA website, under Alternative funding source, however the Department of Health requires HSPs and CHEs to provide the patient UMRN, activity type, type of treatment, and date of event to identify activity within central records. This will enable the required reporting to IHACPA and will ensure that HST can be identified and reported for a range of purposes, including patient safety, research and funding.

17. Clinical coding

17.1 Coding admitted episodes of care

Admitted episodes of care must be coded in accordance with the current editions of:

- the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)
- the Australian Classification of Health Interventions (ACHI)
- the Australian Coding Standards (ACS).

Admitted episodes of care must also be coded in accordance with the current:

- IHACPA Coding Rules located on the Australian Classification Exchange
- Western Australian Coding Rules and Clinical Coding Guidelines located on the Western Australian Clinical Coding Authority website.

17.2 Technical coding queries

Technical coding queries, not able to be resolved within a health system entity's coding team, are to be e-mailed to the Western Australian Clinical Coding Authority at coding.query@health.wa.gov.au, following the Coding Query Process.

18. Compliance and Audits

18.1 Audit of Business Rules

The System Manager, through the Purchasing and System Performance Division, will carry out audits to ascertain the level of compliance with the business rules contained in this document. The purpose of the audit program is to add value, improve performance and support the business objectives of the Department of Health. Audit findings will be communicated to the HSPs, CHEs, Information Stewards, HSP Chief Executives, the Director General and other relevant persons.

WA health entities are required to facilitate these audits by providing the required information and resources to the audit team.

Further information regarding audits conducted by the Health Information Audit Team is contained in the Health Information Audit Practice Statement.

18.2 Data quality and validation correction process

Data quality and validation processes are essential tools used to ensure the accuracy and appropriateness of data submitted to the HMDC. Validations are applied to individual data elements and reflect national reporting obligations, best practice and compliance with policy requirements, as well as the five data quality principles of relevance, accuracy, timeliness, coherence and interpretability.

Validations are used to support:

- Key Performance Indicators
- Activity Based Funding
- Clinical Indicators developed by the Office of Patient Safety and Clinical Quality
- health service monitoring, evaluation and planning
- reporting to the Federal Government
- research
- respond to Parliamentary requests/questions.

Further information on data quality and validation processes and timeframes, refer to the *Patient Activity Data Policy Information Compendium*.

19. Glossary

The following definition(s) are relevant to this document:

Term	Definition
Data collection	Refer to Information Asset.
Health Service Provider	As per section 6 of the *Health Services Act 2016*, a Health Service Provider established by an order made under section 32(1)(b).
Information asset	A collection of information that is recognised as having value for the purpose of enabling the WA health system to perform its clinical and business functions, which include supporting processes, information flows, reporting and analytics.
Information Management Policy Framework	The Information Management Policy Framework specifies the information management requirements that all Health Service Providers must comply with in order to ensure effective and consistent management of health, personal and business information across the WA health system.
Patient Activity Data Business Rules	Patient Activity Data Business Rules mandate the rules, scope and criteria to be used when recording health service patient activity data and reporting to the Department of Health.
WA health system	The WA health system is comprised of: (i) the Department; (ii) Health Service Providers (North Metropolitan Health Service, South Metropolitan Health Service, Child and Adolescent Health Service, WA Country Health Service, East Metropolitan Health Service, PathWest Laboratory Medicine WA, Quadriplegic Centre and Health Support Services); and (iii) contracted health entities, to the extent they provide health services to the State.

Appendix A – Classification of Newborn Admitted Care Guide

BIRTH EPISODE

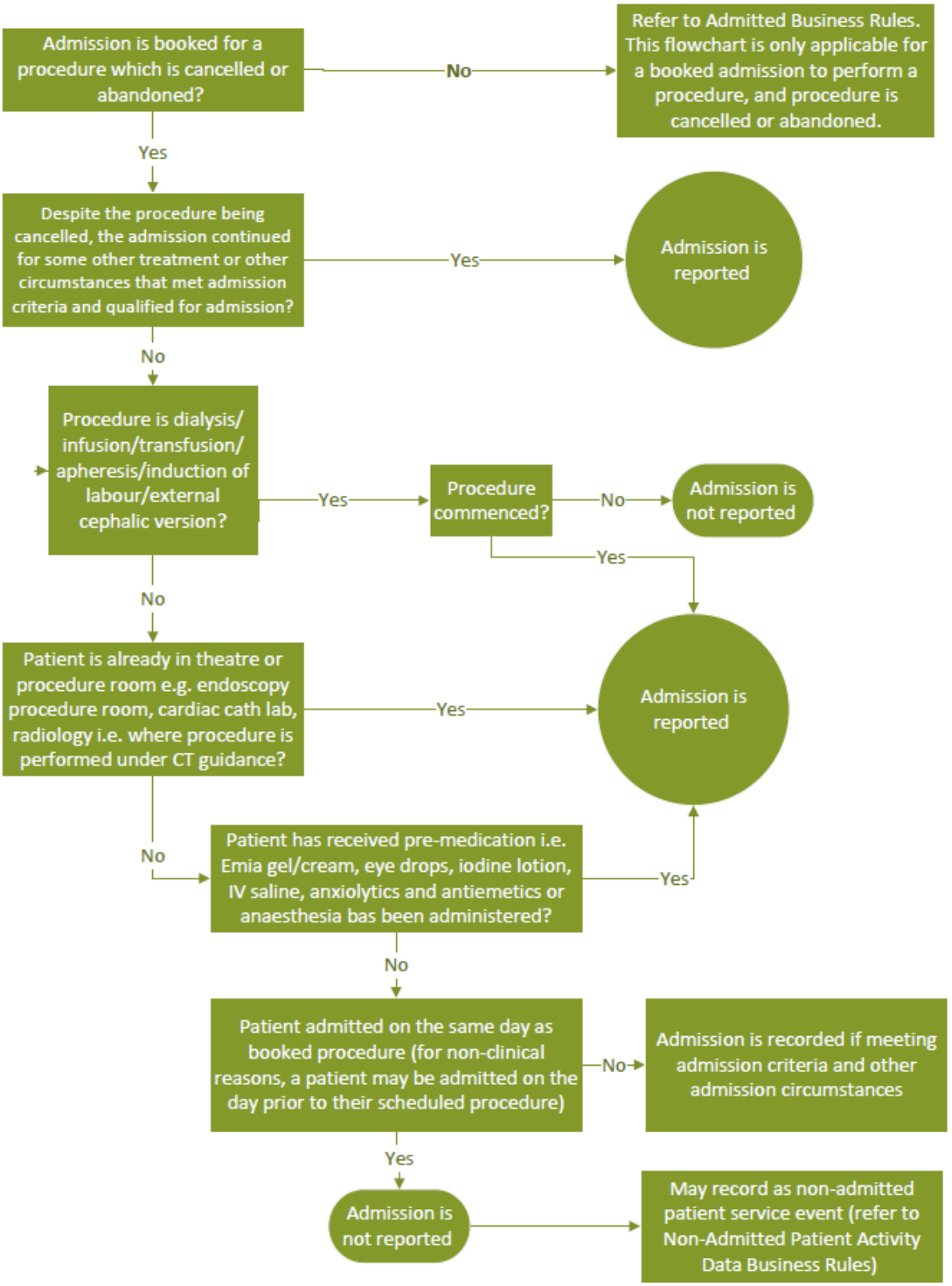
1 2 3 4 5 6 7 8 9 — 10 days onwards until discharge

Day →

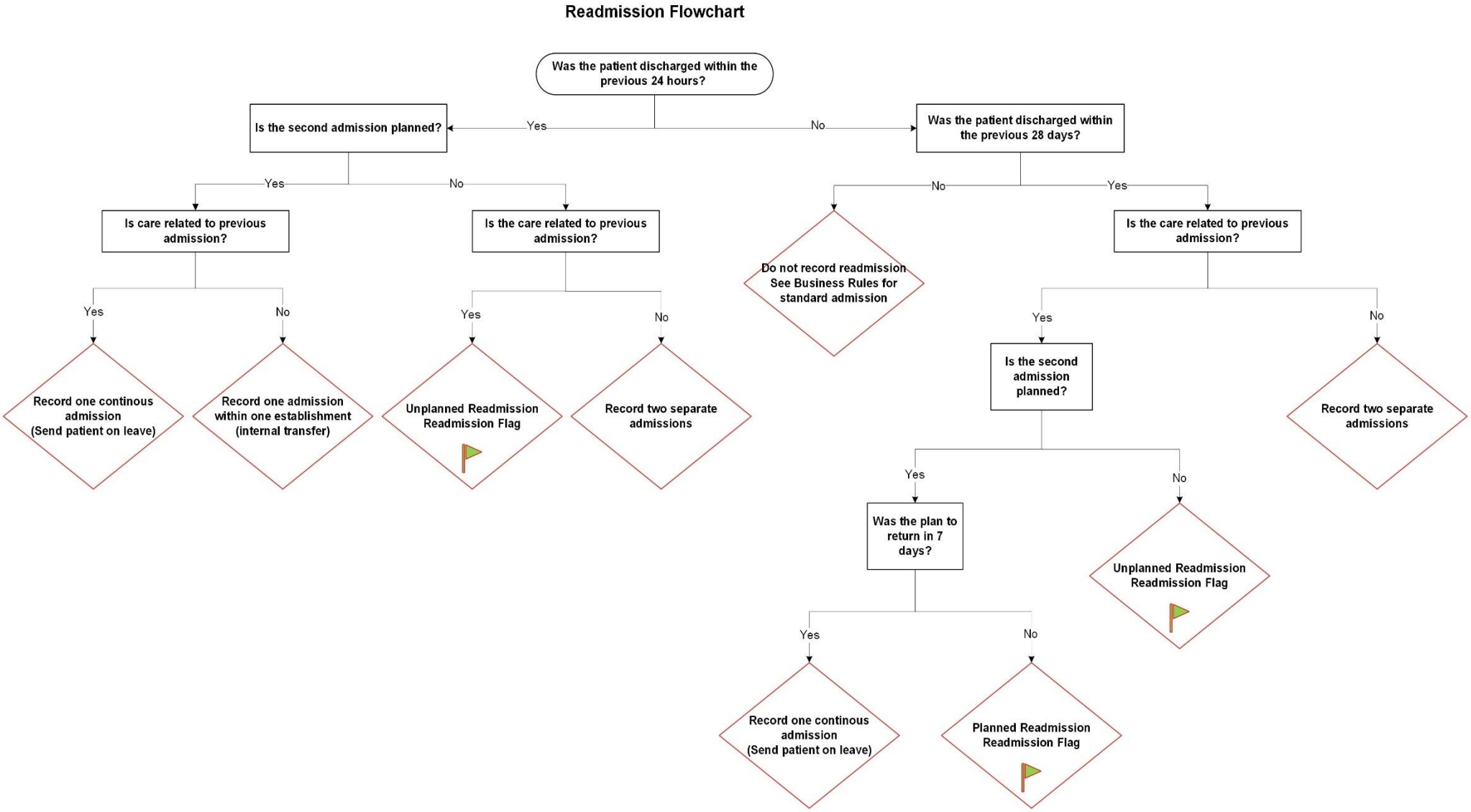
SCENARIO	CLIENT STATUS	CARE / PATIENT TYPE
Baby born and not requiring any acute care	**Unqualified**	**Newborn**
Baby born requiring SCN2 NICU acute medical care	**Qualified**	**Newborn**
Baby born goes to SCN2 on day 2 until day 8, when is well enough to go back to ward. Mother still a patient.	**Qualified** Day 8 changed to **Unqualified**	**Newborn** Day 8 remains **Newborn**
A Twin 2 (or second onwards of multiple birth) born in hospital Past first-born multiple paras	**Qualified**	**Newborn**
Newborn requiring SCN2 NICU and on the same day is transferred to another hospital	**Qualified**	**Newborn**
Newborn, not requiring acute care. Mother unwell and transferred to another hospital or requires intensive acute care at day 3 until day 6 returning.	Days 1 – 2 **Unqualified** Day 3 – change to **Qualified** Day 6 – change to **Unqualified**	**Newborn**
Baby readmitted requiring acute care and < 10 days old.	**Qualified**	**Newborn**
Birth episode different hospital requiring acute care		
Birth episode different hospital not requiring acute care		

SCENARIO	CLIENT STATUS	CARE / PATIENT TYPE
Baby remains in hospital rooming with the mother who is patient	Change from Unqualified to **Boarder**	Change from Newborn to **Boarder**
Requires ongoing acute medical care until discharge >10 days	Remains **Qualified**	Remains **Newborn**
Baby remains in hospital accompanying mother who is patient >10 days	Statistically discharged from Unqualified. Admit as **Boarder**	Statistically discharged from Newborn Admit as **Boarder**
Twin 2 remains in hospital with mother	Remains **Qualified** until discharge	Remains **Newborn** until discharge
Remained in hospital with mother who is patient until >10 days.	Statistically discharged. Readmit as **Boarder**	Statistically discharged. Readmit as **Boarder**
Continues to require acute medical care until discharge	Remains **Qualified** until discharge	Remains **Newborn** until discharge
Baby admitted from day 10 from another hospital SCN2/NICU	**Acute**	**Admitted patient**
Baby admitted with mother who is patient Day 11	**Boarder**	**Boarder**

Appendix B – Flowchart – Cancelled or abandoned booked procedures



Appendix C – Readmission Flowchart



Appendix D – Summary of revisions

Date Released	Author	Approval	Amendment
1 July 2021	Arek Szejna & Catherine Ayling	Rob Anderson, Assistant Director General, Purchasing and System Performance	Document created, adapted from the Admission Policy Reference Manual 2020-2021. Contracted Care: New definitions, data recording and reporting rules for contracted care introduced
1 July 2022	Catherine Ayling & Bernard Sharpe	Rob Anderson, Assistant Director General, Purchasing and System Performance	Document reviewed. Dates updated. **New sections:** -Hospital Boarder. -Medihotels. **Content updated for:** -COVID-19: reference to COVID-19 Activity Data Recording document included. -ED Short stay admissions -High Cost Therapy: New definition and reporting rules for High Cost Therapy introduced. - Qualified newborn status Out-of-scope of contract care
1 July 2023	Selina Li & Bernard Sharpe	Rob Anderson, Assistant Director General, Purchasing and System Performance	Document reviewed. Dates updated. **New sections:** -Mental Health Observation Area (MHOA) **Content updated for:** -Acute care -Hospital in the Home -Readmissions -Qualified newborn -Contracted care -Hospital Boarder -Medi-hotel -Discharge Improvements and additional content throughout document to improve clarity and flow
1 July 2024	Bernard Sharpe & Xiaoyu Zhao	Rob Anderson, Assistant Director General, Purchasing and System Performance	Document reviewed. Dates updated. **New sections:**

			-Voluntary Assisted Dying -Discharge delay and long stay --Unplanned Return to Theatre **Content updated for:** -Scope -Requirements for Admitted activity -Care Type documentation -Qualified newborn Care Type -Mental Health Care Type -Hospital Boarder -Hospital in the Home -Cancelled or abandoned booked procedures

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