Admissions and Discharge *Guidelines*

Health Strategy Implementation Project 2003

The Health Boards Executive
Working Together for Health

Admissions and Discharge

Guidelines

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Foreword

These guidelines have been produced in response to specific commitments in the National Health Strategy: Quality and Fairness – A Health System for You; they aim to develop a health service approach to Admissions and Discharge. The guidelines have been developed using international best practice which focuses on a "whole systems approach".

The specific commitments: "the discharge planning function in each acute hospital will be enhanced to ensure that patients do not have to remain in hospital for any longer than necessary" (Action 84); and "admission protocols will ensure that emergency patients will be the only group of patients admitted to the hospital through the A & E Department" (Action 86) are at the heart of the principle of *"people-centredness"* approach set out in the National Health Strategy.

These guidelines follow on from the series produced in 2002 which cover a range of actions set out in the Strategy. They were produced by a team of people drawn from across the health service and have been adopted by the Chief Executive Officers of health boards.

The guidelines are not intended to be prescriptive rather they should act as a reference or guide to people working within the system, supporting the overall commitment to delivering better quality health services.

Finally, I would like to thank the project team who, in consultation with a wide range of people, produced these guidelines.

Executive Summary

Introduction

Admission to an acute hospital may be planned (*elective*) or may be required as a matter of urgency (*emergency*). Elective admissions are those which occur as a consequence of referral to hospital by a general practitioner, medical consultant, a visit to the hospital outpatient department or a planned transfer from another hospital. Some patients may confound these definitions e.g. patients requiring chemotherapy who may be both urgent and planned.

These guidelines have been developed in response to the National Health Strategy, Quality and Fairness (DOHC 2001) which states, among other things, that

"The discharge planning function in each acute hospital will be enhanced to ensure that patients do not have to remain in hospital for any longer than necessary" (Action 84) [1]
"Admission protocols will ensure that emergency patients will be the only group of patients admitted to the hospital through the A & E Department" (Action 86)[1]

This document is based on international best practice, focusing on a "whole systems approach" to effectively address elective and emergency admissions and discharges. Grounded in the principle of "people-centredness" which, increasingly, influences the planning and delivery of services, the guidelines aim to support health care professionals in the development of local policies and protocols.

The purpose of the guidelines is to direct the provision of an effective and efficient level of appropriate patient centred care, through the development of appropriate links between Primary (e.g. General Practitioner, Practice Nurse), Secondary (e.g. Acute Hospital), Community and Continuing Care Services (e.g Cottage Hospital and Hospice).

A system wide approach will require the enhancement of relationships between hospitals and primary care, pre-hospital care, emergency transport and community care.

What is required for a system wide approach?

The National Health Strategy and the proposed reforms of health care organisation provide the context for the provision of a system wide approach in addressing and managing patient's needs based on the principles set out below.

The key elements to such an approach include:

- Strategic and timely service planning (e.g. regular annual review).
- Uniformity of structures and processes (i.e. following national guidelines where they exist).
- Linked protocols and pathways (e.g. shared between primary and secondary care and based on international best practice, so that objective measures of performance are readily available).

Strategic planning for all service areas should provide demonstrable evidence of coherent assessment, evaluation and planning, taking account of the health care needs of the population.

The proposed structural reforms should be developed in the context of the links required between service areas to ensure smooth and timely movement of patients from one care setting to the next. This will require connectivity at national, regional, and local levels; and between all stakeholders.

It is recognised that regardless of policies and procedures adopted, there are constraints that apply, including capacity and funding issues, both current and future. The guidelines seek to recommend best practice within these constraints. Service evaluation and measurement of outcomes that are comparable with other similar services nationally and internationally should form part of routine performance review and ongoing quality improvement.

The proposed National Hospitals Office and the Health Information and Quality Authority may oversee the adoption of standardised practices, procedures, and protocols in each care setting in line with international best practice.

Strategic objectives

The key strategic objectives underpinning an effective and coherent admissions and discharge policy for emergency and elective patients are:

- The provision of an integrated personal health and social services system resulting in seamless patient centred care at all times.
- The utilisation of resources to maximise clinical and organisational effectiveness and outcomes.
- The establishment of fully integrated networks of acute care which are accessible to each person.
- The provision of levels of local access to acute care whilst at the same time ensuring high quality clinical care.
- The acquisition of clinical admissions data to assist service planning and monitoring.

What are the Principles Underpinning Best Practice in Hospital Admissions?

A number of principles should underpin the development of an effective emergency and elective admissions and discharge planning function. These include:

- The provision of patient centred services, which are accessible to the population without compromising safety, quality and clinical standards, to the right people in the right location and at the right time.[1]
- Patients should be consulted and included in all decisions about their care.
- Clinical practice and care should be based on the most up to date evidence.
- Co-operation and clinical networking between hospitals and between care groups are essential to optimise outcomes, particularly where complex care issues are involved.
- A service based on good clinical governance (i.e. founded on continuous quality improvement, staff development, risk management and audit).
- Acute hospital services should be organised into three parallel streams of care interdependent of each other. This involves a division of acute hospital services into emergency, elective and out patients department/day care.[2,14]
- The pivotal role of the Primary Care Teams should be emphasised.
- Early induction training of healthcare professionals in relation to the principles set out above.

Effective management of hospital beds and associated resources

The effective management of hospital beds and associated resources is vital if the growing demand placed on hospital resources is to be met.[3] Recognised impediments to patient "flow" in hospitals include:

- Difficulties in gaining access to inpatient beds (i.e. insufficient bed capacity).
- The resulting congestion within Emergency Departments (EDs)[2].
- Inappropriate retention of patients in hospital beds.

The active management of admissions and discharges should ensure that:

- Beds are available for emergency admissions.
- Beds are available for elective patients; this assists in keeping waiting lists down.
- The quality and appropriateness of patient care is high.
- Patients get the care they require when they are discharged from hospital.
- Scarce financial resources are not wasted and value for money is achieved.[4]

Quality and safety

To ensure that all patients admitted to hospital receive the high quality and safe service to which they are entitled, resources must be efficiently and effectively utilised. Services are organised so that patients, depending on their needs, can move smoothly between emergency care and the best and most appropriate inpatient care, primary care and continuing care.[2]

Effective quality assurance and safe care are essential rights of all users of the health services. Achieving the standards set by the Irish Health Services Accreditation Board will ensure that all hospitals are providing such care.

Emergency admissions

An emergency hospital admission is defined as one that is not planned and which results from trauma (injury) or acute illness which cannot be treated on an outpatient basis.[5]

In order to manage the balance between elective and emergency admissions, the factors below have been identified as effective in improving the management of admissions and general patient flow in the Emergency Department (ED):

- Where there is a mix of elective and emergency admission in hospitals, occupancy levels should allow for flexibility in dealing with the natural ebb and flow of illness and injury in the community. Thus, a level of about 85% hospital bed occupancy is desirable.
- Having a senior medical presence in the emergency department at all times. Only appropriately assessed patients should be placed in a hospital bed options for outpatient, day care and primary care (including home care and ambulatory practice) should be maximised.
- Investment to support adequate provision of primary and community care so as to:
    - reduce avoidable attendances at the ED; and
    - support early discharge from hospitals where appropriate.[6,7]

Elective admissions

Achieving the correct balance between the competing demands for hospital beds by elective and emergency cases of varying complexity is likely to remain a considerable challenge for the future.

In order to improve the experience of patients waiting for elective admission, the following priorities have been identified:

- Local clinical consensus on the ratio of emergency admissions to planned elective procedures.
- Measures to review and monitor criteria for hospital admission and for lengths of stay.
- Greater emphasis on ensuring that in admitting elective patients, consideration is given to the length of time they have been waiting since the decision to admit was taken - taking account of their clinical needs.
- Greater standardisation of waiting list administration with consistent monitoring of cancellations, suspensions and removal from lists without treatment.
- Emphasis on planning discharge from day of admission.
- The adoption of a whole systems approach to bed management.
- The appointment of a manager or clinician with sufficient authority and support to balance and monitor the competing demands of emergency and elective pressures ensuring all bed and theatre resources are fully utilised.[8]

Discharge planning

Discharge from hospital is a process, not an isolated event. It involves the development and implementation of a plan to facilitate the transfer of an individual from hospital to an alternative setting where appropriate. Components of the system (family, carers, hospitals, primary care providers, community services and social services) must work together. Activity and performance standards should be frequently monitored and there should be openness to innovative solutions. This will ensure that the whole systems approach to admissions and discharges is positively reflected in the patient's experience. All hospitals should have their own operational policies for discharge planning. Staff should to be involved in the development and regular review of these policies.[9] As with admissions, the standard of discharge management impacts on hospital efficiency, quality and safety of patient care.

Good discharge management is vital to ensure:

- patient satisfaction;
- bed availability for emergency and elective admissions; and
- quality of patient care remains high.[4]

Several key priorities in effective discharge and transfer of care have been identified. These include:

- The engagement and active participation of the individual and their carer as partners with clinical staff.
- Staff co-operating within a framework of integrated multidisciplinary and multiagency teamwork to manage all aspects of the discharge process. The process of discharge planning may be co-ordinated by a named person who has responsibility for co-ordinating all stages of the "patient journey".
- Effective use is made of transitional and intermediate care services, so that existing acute hospital capacity is used appropriately and individuals achieve their optimal health outcome.[1]
- Specialised expertise and/or support services for special needs cases e.g. the homeless and ethnic minorities.

Best Practice Links between Acute Hospitals and Primary, Community and Continuing Care Services.

What are the principles underlying good working relationships?

The foundation of best practice in the development of effective links between acute hospitals and primary, community and continuing care services is a multidisciplinary approach to assessment, care planning, discharge planning, case management, and integrated care pathways.

This multidisciplinary input is best provided through a team approach to service delivery in line with existing strategies such as the National Health Strategy, Primary Care Strategy and the recent (Hanly) Report of the National Task Force on Medical Staffing.

These features may be organisationally supported through strategic and multi-annual planning, linked processes and protocols, and appropriately designed organisational structures. All health and social care service elements should be delivered on a collaborative basis to ensure a continuum of care for patients and their carers. Services should be developed in line with the implementation of the Primary Care Strategy model of Primary Care Teams and Networks. There is a need to strengthen the community and continuing care settings to provide rehabilitation, respite and ongoing care, reflective of special population needs.[11]

The process of hospital admission

A range of service processes have been identified as effective in managing the flow of patients through acute hospital services which will be outlined later. In addition, regular communication, good relations and *ad hoc* liaison, between all those involved are essential to effective bed management.

Opportunities to provide an integrated service delivery system arise at two important service points, before hospital admission and after hospital admission.

Before the patient is admitted to hospital

- There should be a clearly defined pre-admission process, which applies to both emergency and elective admissions.
- The decision to access a hospital service should be shared between the patient and a member of the primary care team (PCT) where possible.
- Pre-admission services are integrated into secondary care service delivery.
- Pre-admission assessment is conducted on an outpatient basis wherever possible; some aspects of pre-admission assessment may be undertaken by the Primary Care Team if appropriate.
- Pre-admission assessment aims to optimise a patient's health status before planned admission to hospital.
- At the pre-admission visit, the patient and his/her carers are properly informed about their medical condition, proposed treatment and likely hospital procedures.
- The patient's General Practitioner and/or the Primary Care Team with which the patient is enrolled should be involved in the pre-admission process, as appropriate.
- The planning for the patient's discharge from hospital should begin at the pre-admission visit and co-ordination of the patient's care for both admission and discharge is commenced at the pre-admission visit.
- Patient information is co-ordinated and made available to all relevant providers in an efficient and timely manner.
- Pre-admission planning to facilitate 'day of surgery admission' where appropriate.
- Pre-admission services may require a dedicated individual e.g. Admissions Manager.
- Referral pathways for primary care should enhance service delivery and complement the streaming of patients into appropriate diagnostic and therapeutic services within the acute setting.
- Integrated service delivery using a range of tools to support the process, for example:[12]
    - shared care protocols for chronic disease and other healthcare management;
    - integrated care pathways with or without care/case management; and
    - key worker concept for co-ordinating patient care.

After the patient has been admitted to hospital

The Acute Hospital Service should co-operate with other service providers in primary, community and continuing care. To achieve this, the following factors have been identified as important in the effective integration of patient care:

- A description of the range and detail of the services provided in each care setting should be available to all users and providers.
- The route of access to each service is made explicit in appropriate formats to providers and users.
- A range of tools to support effective service delivery, including:
  - Referral guidelines and protocols for consultant care and diagnostic services.
  - Discharge plans agreed between the hospital and a key worker in primary care.
  - Discharge planning that commences on day of admission.
  - Efficient communication from acute care service providers e.g. discharge letter accompany patient or/and e-mailed to GPs and key worker on or before the day of discharge.
  - Integrated care pathways facilitated by key workers.
  - Individual care plans appropriate to the needs of the patient and their carers are developed by the multidisciplinary team and in collaboration with them e.g. chronic disease management.
  - Shared care arrangements between patient/GP/consultant for specific health conditions.
  - The development of care/case management in the health services should be further developed.
- Effective communication systems to be developed between service providers to support efficient continuity of care. This to be supported by an appropriate Information Technology interface.
- The provision of medical prescriptions, aids and appliances along with transport issues to be identified and addressed to meet the needs of patients/clients, families and communities.
- Formalised arrangements for liaison between hospitals and GP and /or primary carers is initiated, supported and enhanced, on issues of policy development as well as individual care plans.

Best Practice, Protocols and Policies for Improving Emergency, and Elective Admissions and Discharges

Introduction

Bed management within the hospital setting is often the driver for the development of policy in relation to patient admission and discharges. Best practice should underpin the development of bed management policies to enhance the effective management of emergency and elective admissions and discharges.

The events of admission and discharge are pivotal in an integrated approach to bed management, together with the central position of the patient in the decision making process. [13] This requires an integrated multidisciplinary team approach to care delivery, necessitating the development of care pathways, clinical protocols and standards, which can be audited and evaluated to demonstrate clinical effectiveness /patient outcomes.

Emergency Department (ED) admissions

Principles for admitting Emergency Department admissions

Only emergency patients should be admitted to hospital through the Emergency Department. This may require a subtle shift of emphasis from "semi elective" admission to more rigorous assessment to ensure the appropriateness of hospital admission and to maximise the number of beds available for elective admissions. The philosophy of care must shift emphasis from admission to assessment to ensure appropriateness of admission and maximise bed availability for elective admissions.

What are the important factors in admitting patients from the Emergency Department (ED)?

- Extended access to rapid assessment clinics and outpatient radiology and pathology services.
- Rapid assessment and extended access to diagnostics (unnecessary delays in admitting and/or discharging patients from hospital may arise from avoidable delays in patient assessment by specialists, duplication of tests or the absence of high or low dependency beds).
- Early Senior Medical decision making available at the point of admission.
- Close multidisciplinary team work.
- National agreed standardised triage processes to ensure clinical prioritisation of patients on their arrival in the Emergency Department and to ensure timely and appropriate care is delivered.
- Patients should be streamed into the following categories:
  - resuscitation;
  - minor illness and injury stream (patients who are unlikely to be admitted);
  - paediatric cases;
  - specialised medical/surgical team assessment for patients who may require admission; and
  - psychiatric case assessment service.
- Care pathways to minimise delays in the Emergency Department if admission is definite. These pathways should be developed in consultation with the relevant professionals and stakeholders.
- Rapid access facilities such as Medical Assessment Units (MAU) requiring robust, specific and auditable operational policies.
- Protocols for transfer of patients within and between regional areas and tertiary units to continue to be developed and implemented with pre-hospital emergency care, trauma teams and other relevant parties.
- Nurse led services i.e Advanced Nurse Practitioners (ANPs).[2,14]
- Short Stay observation wards or Clinical Decision Units (CDUs) are advocated in emergency patient care. Such units should be directly adjacent to the Emergency Department and should be supervised by Consultants in Emergency Medicine. The length of stay should not be greater than 24 hours.[2,14]
- Chest Pain Clinics, geriatric, respiratory clinics and in-house specialist services should be used to fast track patient management where possible.[2]
- Information Systems should be used to provide comprehensive comparable and reliable data on activity waiting times.

- Decision support systems enhance consistency of decision making such as nurse led telephone triage can be used to enhance consistency of medical and nursing decision making. (e.g. NHS direct telephone advice service).
- There should be regular and influential audit of clinical activity.
- The critical role of Health Care Staff should be acknowledged with appropriate support for professional development and influence in decision making at all levels.

Elective admissions

What are the key principles in planning elective hospital admissions ?

A patient's episode of care should be planned before his/her admission and should take account of the entire "journey" up to and after discharge from hospital. Patient's and their carers should be partners in this planning. Bed management should be overseen by a Hospital Bed Manager (HBM) who has the authority to implement the bed management policy and to co-ordinate the bed management team. The bed management service should operate on a permanent basis, i.e. for 24 hours on every day of the year. The bed manager reports to a senior member of management. Part of their role would include continuous analysis and the provision of reports and forecasts.

The function of allocating beds to patients should be centralised and the Hospital Bed Manager should have authority over the access to all hospital beds. There should be an awareness of the bed designation ration as set out by the Department of Health and Children. The Hospital Bed Manager should work within the notional allocation of beds to each speciality to ensure that patients are accommodated in the most appropriate bed available at the time of their admission, and to ensure that patients are cared for by staff with the appropriate expertise.

What are the key processes for effective elective admissions?

The following key requirements have been identified to facilitate effective elective admission practices:

- Centralised waiting list management and agreement on the parameters for scheduling theatre lists with clinicians.
- Pre-admission assessment should be a standard requirement for all elective admissions to ensure appropriate planning of the entire patient journey.

- The anticipated length of stay (this should be indicated as early as possible to facilitate scheduling) for elective admissions should be indicated as early as possible to facilitate scheduling.
- Increased day surgery can also be supported by before admission assessment to ensure appropriate scheduling and to minimise transfer to inpatient beds.
- Discharge lounges may be used to facilitate early discharge as well as accommodation for "*day of surgery*" arrivals and timely commencement of theatre lists.

Discharges

Discharge planning should commence pre-admission. On admission, the patient's pre-morbid and functional status information are documented in order to inform discharge planning and to identify patients at risk on returning home. In this way, referrals to inter-hospital and community services are initiated in a timely manner.

What are the principles of effective discharge planning?

The core principles for effective discharge planning are:

- A patient's use of a hospital bed and their discharge should be planned before their admission, where possible.
- The estimated date of discharge should be documented and communicated to the patient and relevant personnel within 24 hours of admission.
- Discharge should be "streamlined" (e.g. prescriptions and letter should be completed in a timely manner, transport booked and test results made available promptly).
- Complex discharges should be discussed at a regular multidisciplinary forum to ensure discharge is expedited.

What are the processes required for effective discharge planning?

- There should be an organisation led commitment to manage all hospital beds.
- Resources such as a discharge co-ordinator to ensure delays are minimised and extensive patient and family involvement in decision making processes.
- Referrals to physiotherapy, occupational therapy should be identified as early as possible with access to aids and appliances as appropriate.
- Discharge documentation should be audited to ensure compliance with hospital protocols.

- Analysis of trends and data should be undertaken by the discharge co-ordinator/bed manager and communicated to the emergency services planning forum at local level. Performance measures and indicators of effective case management are developed, monitored and reviewed.
- Multidisciplinary teamwork is the key to success with discharge planning. A patient's discharge plan is co-ordinated by a nominated member of the multidisciplinary team. General practitioners, Primary Care Teams and community providers are involved in the discharge process.
- Patients and their carers should be partners in the discharge planning process.
- Discharge planning should be continually updated and improved.
- Use of the Discharge Lounge should be used to facilitate the early availability of acute beds.
- A bed management forum should be established to identify and resolve bed management problems with the support of the hospital executive.
- Early involvement of pharmacy would increase compliance with medication.
- Patients should co-sign their own discharge letter ensuring that their discharge instructions have been clearly explained to them.

Conclusion

Management of inpatient admissions and discharges is essential to enhance the quality of patient care across all sectors of healthcare.

Team working and partnership at all levels of health care service delivery must be encouraged to ensure that health care is planned, managed and delivered based on a patient centred approach which ensures quality and fairness for all.

It may be necessary to extend the roles and responsibilities of bed managers, improving co-ordination between different professional groups quality of patient care.[3]

A "whole systems approach" is essential to admission planning and is underpinned by high quality communication and information systems. This ensures that the patient's journey is streamlined and underpinned by best practice.

These guidelines endeavour to reflect best international practice in relation to hospital admission and discharge planning. It is hoped that they will assist in the planning of hospital patient care throughout the country and will help to provide a framework for management and measurement of a constantly improving service to our patients.

Therefore it is strongly recommended that services should be delivered in adherence to these guidelines. It is now planned that they will be used as a measurement tool to evaluate the effectiveness of admissions and discharges nationally and the outcomes achieved relative to the aims set out in the document.

Bibliography

1. Department of Health and Children (2001) **The National Health Strategy: Quality and Fairness - A Health System for You.**
2. Comhairle na nOspideal (2002) **Report of the Committee on Accident & Emergency Services.**
3. National Audit Office NHS Executive (2000) **Inpatient Admissions and Bed Management in NHS acute hospitals.**
4. Scottish Accounts Commission (1998) **Managing Hospital Admissions and Discharges.**
5. Royal College of Physicians (1997) **Tackling NHS emergency admissions: Policy into Practice.**
6. British Medical Association (2002) Waits and Measures. Improving emergency care for today's patients.
7. British Association of Accident & Emergency Medicine (1998) **The Way Ahead.**
8. Audit Commission (2003) **Waiting for Elective Admission: Acute Hospital Portfolio. Review of National Findings.**
9. House of Commons Health Committee (2001-2002) **Delayed Discharges.**
10. The Audit Commission (2001) **Accident and Emergency – Guide to the Indicators.**
11. Department of Health and Children (2001) **Primary Care. A New Direction.**
12. Commonwealth Department of Health and Family Services, Australia (1999) **Managing beds better, Balancing supply and demand. The NDDHP –2 experience.**
13. Capita Consulting (2003) **National Review of Bed Management Function : Final Report to the Employers and Unions.**
14. Department of Health and Children (2003). **Report of the National Task Force on Medical Staffing.** (Hanly Report).

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