



Response to Report 238— Public Hospitals in the Australian Capital Territory

Report
275

Joint Committee of
Public Accounts

THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

JOINT COMMITTEE OF PUBLIC ACCOUNTS

REPORT 275

RESPONSE TO REPORT 238 -
PUBLIC HOSPITALS IN THE AUSTRALIAN CAPITAL TERRITORY

(DEPARTMENT OF FINANCE MINUTE ON THE
COMMITTEE'S 238TH REPORT)

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JOINT COMMITTEE OF PUBLIC ACCOUNTS

FIFTEENTH COMMITTEE

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DUTIES OF THE COMMITTEE

Section 8(1) of the Public Accounts Committee Act 1951 reads as follows:

Subject to sub-section (2), the duties of the Committee are:

- (a) to examine the accounts of the receipts and expenditure of the Commonwealth including the financial statements transmitted to the Auditor-General under sub-section (4) of section 50 of the Audit Act 1901;
- (aa) to examine the financial affairs of authorities of the Commonwealth to which this Act applies and of intergovernmental bodies to which this Act applies;
- (ab) to examine all reports of the Auditor-General (including reports of the results of efficiency audits) copies of which have been laid before the Houses of the Parliament;
- (b) to report to both Houses of the Parliament, with such comment as it thinks fit, any items or matters in those accounts, statements and reports, or any circumstances connected with them, to which the Committee is of the opinion that the attention of the Parliament should be directed;
- (c) to report to both Houses of the Parliament any alteration which the Committee thinks desirable in the form of the public accounts or in the method of keeping them, or in the mode of receipt, control, issue or payment of public moneys; and
- (d) to inquire into any question in connexion with the public accounts which is referred to it by either House of the Parliament, and to report to that House upon that question,

and include such other duties as are assigned to the Committee by Joint Standing Orders approved by both Houses of the Parliament.

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PREFACE

Since 1952 formal procedures have been in operation to ensure that appropriate action is taken in response to each of the Committee's reports.¹ These procedures involve the preparation of a response, known as a Department of Finance Minute, as follows:

1. The Committee's report is tabled in the Senate and the House of Representatives.
2. The Committee's Chairman then forwards a copy of the report to the responsible Minister and to the Minister for Finance with a request that the report be considered and the Chairman subsequently informed of action taken and planned to address the Committee's recommendations.
3. The reply, in the form of a Department of Finance Minute is then examined by the Committee and submitted with comment as soon as possible as a report to the Parliament.

In accordance with the procedures outlined above, this Report documents the Department of Finance Minute which was submitted in response to the Committee's 238th Report.

For and on behalf of the Committee.

R E Tickner, MP
Chairman

M J Talberg
Secretary
Joint Parliamentary Committee of Public Accounts
Parliament House
Canberra
6 May 1987

1. Formal responses to the Committee's Reports are not prepared in the case of discussion papers, handbooks and the Committee's annual report.

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CHAPTER 1

INTRODUCTION

1.1 The Committee's 238th Report, which outlined the findings of the Committee's inquiry into the 'Report of the Auditor-General on an Efficiency Audit - Administration of Public Hospitals by the Capital Territory Health Commission', was tabled in Parliament on 25 November 1985. A summary of the Committee's report appears in Chapter 2. The Committee's recommendations together with the Department of Finance Minute appear in Chapter 3.

1.2 The Committee is satisfied with the Department of Finance Minute, dated 17 October 1986, which was submitted in response to the 238th Report.

1.3 Of the Committee's 27 recommendations, 12 have been complied with and 12 are being complied with or will be complied with upon the installation of the Authority's ADP systems or upon the completion of further review by the Authority. One recommendation is to be considered and implemented in the light of possible deregulation of private hospitals (recommendation 6) and 2 recommendations have not been accepted (recommendations 2 and 8). The more important of the recommendations and the action taken on them are discussed below.

Planning of Hospital Services

1.4 The Committee made several recommendations aimed at achieving better planning of hospital services (recommendations 2 - 7). Although the review by the Authority of its liaison arrangements with the NSW Health Department did not lead to any reduction in expenditure on the arrangements (recommendation 2), the other recommendations have been, or will be, implemented.

1.5 Community representatives are now included on the Authority and its Boards and progress and strategic planning activities will be reported in the Authority's Annual Reports (recommendation 3).

1.6 In its inquiry, the Committee was not convinced that sufficient effort had been directed to the parameters and assumptions used in bed planning. Although the Committee accepted that there was no other urban population in Australia identical to the population of the ACT, it believed that there was still scope and value in comparative review in bed number planning.

1.7 Accordingly, the Committee recommended that the Authority undertake an examination of the possibilities for comparative review of the parameters and assumptions of the Authority's bed-planning formula (recommendation 4). The Authority is currently reviewing its approach to the examination.

1.8 The Authority is in the process of installing a Computerised Administrative Hospital Information System (CAHIS). When CAHIS is in full operation, the Authority will undertake a comparison of prescribed and actual length of stay figures for major resource consuming operations and conditions to identify potential inefficiencies (recommendation 5). In the meantime, the Authority has carried out a manual comparison of lengths of stay.

1.9 The Authority has also examined and implemented strategies for achieving more efficient bed utilisation, taking as the 'ideal' the number of beds indicated by the upgraded bed-planning formula suggested by Audit (recommendation 7).

Clinical Administration

1.10 The Committee made a number of recommendations on various aspects of clinical administration (recommendations 8 - 16). As a result of recommendations 12 and 13 two new committees have been established. The Patient Care Review Committee is responsible for the monitoring of services provided and the Clinical Record Committee, which reports to the Patient Care Review Committee, has been established to monitor the adequacy of clinical records.

1.11 The Authority has also taken action to establish procedures and protocols in respect of its quality assurance programs and is in the process of appointing a Quality Assurance Officer.

1.12 The Committee notes that the Authority has not yet revised the composition of the Clinical Privileges Committee to include the Clinical Superintendents, (recommendation 11), and that the composition is under further review having regard to the Authority's new structure.

1.13 The Authority has implemented the Committee's recommendations on admission arrangements (recommendations 14 - 16) with the result that -

- admission decisions will be subject to review under the Authority's quality assurance program;
- new admission and discharge policy and procedures have been adopted;
- the Authority is encouraging further use of day beds; and
- guidelines on elective admission priorities have been introduced and all clinicians and service related staff are involved in priority setting.

Hospital Resource Management

1.14 During its inquiry the Committee found that there had been significant slippage between planned and achieved ADP project milestones at September 1984 and July 1985. The Committee recommended that the highest priority be placed on the implementation of the Authority's ADP systems (recommendation 17).

1.15 The Authority has given high priority to the implementation of CAHIS and the Human Resource Management System (HRMIS). Following the implementation of HRMIS, the Authority will use the system to review staff usage in relation to workload and identify details of staff usage in individual departments (recommendations 18 and 20).

1.16 The Committee notes that the agreement with the ACT Electricity Authority concerning electrical maintenance at Authority hospitals has still not been signed (recommendation 23). The Authority has advised that negotiations are continuing with regard to the final form of the agreement. However, in September 1984 the agreement was expected to be signed by the end of that year. The Committee is disappointed with the Authority's tardiness on this matter.

1.17 The Committee is also disappointed by the Authority's lack of action on recommendation 25. The Committee recommended that the Authority set annual targets for reducing the costs incurred in the cleaning of Royal Canberra Hospital by the identification and introduction of economies. The Authority has replied that this matter was looked at in 1982 and 1983 and it is intended to have the matter put forward for further review.

CHAPTER 2
SUMMARY OF THE COMMITTEE'S 238TH REPORT

2.1 The Committee found in its inquiry that whilst the Capital Territory Health Commission (which was renamed the ACT Health Authority during the inquiry) generally supported the recommendations of the Audit Report and developments were in progress in some areas, there had only been limited substantive changes in administration following the Audit Report.

2.2 The Audit examined the administration of the Royal Canberra Hospital and the Woden Valley Hospital (RCH and WVH), the hospitals administered by the Authority, in the following three areas:

- planning of hospital facilities;
- use made of hospital services by clinicians; and
- management of hospital resources, in particular, finances and staffing.

2.3 The Audit found that in terms of financial performance the RCH and WVH were comparable to hospitals in Victoria and New South Wales. It also found that the hospitals had achieved a desirable reduction in length of patient stay and compared favourably in terms of low patient length of stay with a group of Sydney metropolitan hospitals.

2.4 However, the Audit identified several areas in which administration of the RCH and WVH could be improved. Particular criticisms were:

- the lack of developed processes for peer review of clinical use of hospital facilities;
- processes for planning the number of public hospital beds appeared to allow an excess supply of staffed hospital beds relative to efficient bed usage;
- despite improvement, patient length of stay at both RCH and WVH was still excessive with resultant inefficiency of bed utilisation;
- weaknesses in systems for identifying financial and staffing requirements and monitoring staff use within the Authority's hospitals i.e. the inadequacy of management information systems;
- under-use of physical facilities, especially accommodation; and
- cleaning services employed at RCH were uneconomical.

2.5 In its report the Committee substantially endorsed the Audit findings and made a number of recommendations dealing with issues arising from the Committee's inquiry.

2.6 One of the Committee's recommendations was that the RCH and WVH begin immediate preparation for assessment leading to accreditation by the Australian Council of Hospital Standards. The WVH applied for accreditation in 1979 but was unsuccessful mainly because its medical staff structure was not based on hospital - based units, but on divisions spanning both WVH and RCH, and because it lacked developed processes of clinical review. The RCH had not applied for accreditation.

2.7 The Committee felt there is value in the accreditation process because of the self examination required of a hospital and associated remedial action in preparation for a survey. The Calvary Hospital and the John James Memorial Hospital have full accreditation and the Committee considered that the two major public hospitals in the ACT should also be accredited.

2.8 The Committee supported the development of a strategic planning process in the health care field, however, it was not satisfied with the pace of the Authority's strategic planning efforts. Although the Authority was committed to the development of a Ten Year Strategic Plan as early as 1980, it was not until June 1984 that a short planning statement was produced in draft form. The Committee also believed that public consultation on strategic planning is essential. Public consultation had ceased in July 1983 at the request of the Minister.

2.9 Accordingly, the Committee recommended that there be early public involvement in the strategic planning process and that subsequent planning steps be expedited. It was also recommended that progress on strategic planning activities be reported in the Authority's Annual Report.

2.10 The report examined the Authority's planning for bed numbers and found that there was scope for more efficient determination of bed numbers. The Committee recommended that the Authority -

- undertake a comprehensive examination of the possibilities for comparative review of the parameters and assumptions of the Authority's bed-planning formula;
- compare prescribed and actual length of stay figures for major resource consuming operations and conditions to identify potential inefficiencies;
- take early action to secure legislation requiring private hospitals to supply morbidity data; and

- examine strategies for achieving more efficient bed utilisation, taking as the 'ideal' the number of beds indicated by the upgraded bed-planning formula suggested by Audit.

2.11 The report also examined the Authority's clinical review activities and found substantial scope for improving those activities. The Committee recommended that in reviewing its quality assurance and review arrangements, the Authority give specific attention to the model for systematic clinical review proposed by the Committee's consultant. Aspects of the model included:

- the establishment of a representative committee to direct the programme;
- the creation of routine statistical reporting systems to provide regular analyses of clinical performance data;
- regular reporting of these analyses to the clinical practitioners, through their specialist departments;
- identification of high-priority issues within each speciality or section of the service, priority being determined on the basis of resource consumption or demonstrable inconsistencies in clinical performance in a given area;
- the introduction of a formal schedule for the review of these priority issues;
- the implementation of clinical review projects to employ objective protocols and examine adequate samples of clinical case material; and
- development of machinery (vested in the committee) to ensure that practitioners are aware of review findings, participate in creating policies to correct deficiencies in practice, and receive feedback through follow-up reviews as to the success of corrective policies.

2.12 The report discussed the Authority's admission arrangements and recommended that the Authority monitor the scope for introducing the review of admission decisions into its quality assurance activities.

2.13 The Committee also felt that the Authority should control elective admissions through a system of specified priorities. Accordingly, the Committee recommended that the Authority develop guidelines on elective admission priorities and ensure that the guidelines are applied at hospital level and sent to clinicians to foster consistency in priority setting.

2.14 The Committee believed that greater use should be made of day-stay beds and recommended that the Authority take steps to encourage the demand for day-only stays. This could be done by encouraging community/patient/clinician acceptance of day-only stays and encouraging morning rather than afternoon operating theatre for minor surgery.

2.15 With regard to the Authority's staffing control procedures, the Committee found there was considerable scope for improvement and, in addition to supporting the Audit recommendations, made the following recommendations -

- the Authority use its ADP systems, once available, to review staff usage in relation to workload;
- the Authority's Establishments and Review Section develop staff to workload matching guidelines for the higher labour cost areas/functions in Authority operated hospitals;
- the Authority undertake, as a matter of priority, a comparison of staff use by main departments against existing indicators as suggested by Audit. Resource allocations should be reviewed if necessary;
- the Authority ensure that the inbuilt relief staff establishment bases applied by the two hospitals for clerical assistant and nursing employment groups are consistent; and
- the Authority participate in information systems providing indicative data on hospital performance.

CHAPTER 3

DEPARTMENT OF FINANCE MINUTE

3.1 In this chapter each of the Committee's recommendations is reproduced in turn and is followed by the responses provided in the Department of Finance Minute of 17 October 1986. The Minute was prepared on the basis of information provided by the ACT Health Authority through the Minister for Territories.

Recommendation 1

The Authority require the Royal Canberra and Woden Valley Hospitals to begin immediately to prepare for assessment leading to accreditation by the Australian Council of Hospital Standards. Application to the Council for assessment should proceed at the earliest opportunity.

Response

3.2 Management and service practices to comply with Australian Council of Hospital Standards are being introduced to enable the Authority's hospitals and nursing homes to apply for accreditation in 1987.

Recommendation 2

The Authority review arrangements for liaison with the NSW Health Department to reduce unnecessary expenditure. In the Committee's view, the review should be neither protracted nor expensive.

Response

3.3 The "liaison arrangements" referred to are the four meetings held each year by the Regional Liaison Committee, supported by follow-up meetings at officer level. These arrangements were reviewed and are not considered by the Authority to be excessive.

Recommendation 3

There be early public involvement in the strategic planning process once the new Health Authority structure is operating and that subsequent planning steps be expedited. Progress on strategic planning activities should be reported in the Annual Report to the Parliament of the ACT Health Authority.

Response

3.4 Community representatives are included on the Authority and its Boards. Public involvement is an integral part of the strategic planning process which will form a major Authority activity in 1986 and 1987. Progress will be documented in Annual Reports.

Recommendation 4

The Authority undertake, and document in detail, a comprehensive examination of the possibilities for comparative review of the parameters and assumptions of the bed-planning formula.

Response

3.5 An approach is being reviewed and will involve comparisons of the parameters and assumptions. Long term bed-planning will move to a needs based approach, while short-term planning will rely on resource availability.

Recommendation 5

The Authority compare prescribed and actual length of stay figures for major resource consuming operations and conditions to identify potential inefficiencies. Where necessary, appropriate clinical review studies and associated discussion amongst clinicians should be encouraged subsequently.

Response

3.6 The comparison of lengths of stay is one of the useful tools in detecting potential inefficiencies and in clinical reviews. Once the Computerised Administrative Hospital Information System (CAHIS) is in full operation, up to date data should be available and should allow timely examination and comparison. In the meantime, a manual exercise replicating Dr Ireland's exercise, has been carried out by the Authority.

Recommendation 6

The Authority take early action to secure legislation requiring private hospitals to supply morbidity data.

Response

3.7 This is to be considered and implemented in the light of possible deregulation of private hospitals. See also response to Recommendation 7.

Recommendation 7

Audit recommendation 10 be pursued ie the Commission should examine strategies for achieving more efficient bed utilisation, taking as the 'ideal' the number of beds indicated by the upgraded bed-planning formula suggested by Audit.

Response

3.8 The Commission has examined and implemented strategies for achieving more efficient bed utilisation. The level of bed provision in the ACT is now based on the bed planning formula suggested by the Australian Audit Office. At present the number of beds is below the formula-derived level but strategies are in hand to lift the number of beds to this level.

Recommendation 8

Any by-laws that are introduced be processed promptly.

Response

3.9 The absence of by-laws is not considered an impediment to the management of the Authority's hospitals.

Recommendation 9

The Authority take early action to finalise the proposed amendments to the Health Services Ordinance 1975 concerning the granting of Visiting Medical Officer status at Authority hospitals. The proposed amendments should be submitted to the Minister for Health for approval at the earliest opportunity.

Response

3.10 The Health Authority Ordinance 1985 includes amended provisions concerning the granting of Visiting Medical Officer status.

Recommendation 10

That the former Commission's 'Administrative Arrangements' be updated.

Response

3.11 The Administrative Arrangements have been up-dated to reflect the revised Ordinance and structure.

Recommendation 11

The Authority no longer delay taking the necessary procedural step of revising the composition of the Clinical Privileges Committee to include the Clinical Superintendents.

Response

3.12 The composition is under further review having regard to the Authority's new structure. This will be discussed at the next medical committee meeting and a result is expected by the end of October.

Recommendation 12

In reviewing its quality assurance and review arrangements, the Authority give specific attention to the model for systematic clinical review proposed by the Committee's consultant, Dr Ireland. Aspects of this model include:

- the establishment of a representative committee to direct the programme. There must be clear lines of communication and accountability between this committee and clinical practitioners on one side, and the committee and the executive of the institution on the other;
- the creation of routine statistical reporting systems to provide regular analyses of clinical performance data;
- regular reporting of these analyses to the clinical practitioners, through their specialist departments;
- identification of high-priority issues within each speciality or section of the service, priority being determined on the basis of resource consumption or demonstrable inconsistencies in clinical performance in a given area;
- the introduction of a formal schedule for the review of these priority issues;
- the implementation of clinical review projects to employ objective protocols and examine adequate samples of clinical case material; and
- development of machinery (vested in the committee) to ensure that practitioners are aware of review findings, participate in creating policies to correct deficiencies in practice, and receive feedback through follow-up reviews as to the success of corrective policies.

Response

3.13 The Hospitals Services Board has established a Patient Care Review Committee which is responsible for the monitoring of services provided and action has been taken to establish procedures and protocols in respect of quality assurance programs. A Quality Assurance Officer is in the process of being appointed to the Authority who will in turn produce the procedures and protocols for the quality assurance programs.

Recommendation 13

The Authority review the clinical care issues arising from the Efficiency Audit's consultancy study.

Response

3.14 A Clinical Record Committee has been established to review and monitor the adequacy of clinical records. This Committee reports to the Patient Care Review Committee.

Recommendation 14

The Authority monitor the scope for introducing the review of admission decisions in quality assurance activities as the standard of such activities and the co-operation of the profession develop.

Response

3.15 The Authority has adopted new admissions and discharge policy and procedures. The quality assurance program will cover review of admission decisions.

Recommendation 15

The Authority take steps to encourage the demand for day-only stays by encouraging, for example:

- community/patient/clinician acceptance of day-only stays; and
- morning rather than afternoon operating theatre for minor surgery.

Response

3.16 The Authority now has 32 day beds and is encouraging further use.

Recommendation 16

The Authority develop guidelines on elective admission priorities and ensure that these guidelines are applied at hospital level and sent to clinicians to foster consistency in priority setting.

Response

3.17 With the introduction of new admissions and discharge policy and procedures all clinicians and service related staff are involved in priority setting. A copy of the Guidelines is at Appendix A.

Recommendation 17

The Authority place the highest priority on implementing proposed ADP (automatic data processing) hospital management systems. The Authority should report in detail on ADP systems implementation in its Annual Report to the Parliament and significant project delays should be explained.

Response

3.18 High priority has been placed on the implementation of CAHIS. Details are included in the Annual Report and will continue to be so included.

3.19 The Authority's 1986 Information Technology Strategic Plan will identify future relevant developmental needs in detail.

Recommendation 18

The Authority use its ADP systems, once available, to review staff usage in relation to workload.

Response

3.20 A Human Resource Management Information System (HRMIS) will be used to review staff usage against workloads. This system has a high priority in the Authority's Information Technology Strategic Plan.

Recommendation 19

The Authority's Establishments and Review Section develop staff to workload matching guidelines for the higher labour cost areas/functions in Authority operated hospitals.

Response

3.21 Under the revised Authority structure, the Systems and Methods Section has been set up within the Hospital Services Division. This section is responsible for hospital services, computer systems and organisation and method matters. Part of the Section's organisational responsibilities is to develop workload indicators for the various functional units.

Recommendation 20

The Authority undertake, as a matter of priority, a comparison of staff use by main departments against existing indicators as suggested by Audit. Resource allocations should be reviewed if necessary.

Response

3.22 The HRMIS will allow details of staff usage in individual departments/sections to be identified.

Recommendation 21

The Authority ensure that the inbuilt relief staff establishment bases applied by the two hospitals for clerical assistant and nursing employment groups are consistent.

Response

3.23 See response to Recommendation 19.

Recommendation 22

The Authority participate in information systems providing indicative data on hospital performance.

Response

3.24 See response to Recommendation 20.

Recommendation 23

The Authority ensure that the agreement with the ACT Electricity Authority concerning electrical maintenance at Authority hospitals be signed without further delay.

Response

3.25 The agreement has not yet been signed but negotiations are continuing with regard to the final form. The ACT Electricity Authority's service continues to be satisfactory.

Recommendation 24

The Authority take early action to encourage the co-operation of the medical profession in the introduction of the computerised doctors' claims system.

Response

3.26 The claim form is being used by doctors to claim payments. The further use of the data for computer-based analysis of treatment patterns is extremely time consuming and a cost-benefit analysis will be carried out to determine whether it should go ahead.

Recommendation 25

The Authority set annual targets for reducing the costs incurred in the cleaning of Royal Canberra Hospital (RCH) by the identification and introduction of economies. Although the Committee is aware that cost should not be a primary constraint in the cleaning of hospitals, the scope for using contract labour at the RCH should be reviewed.

Response

3.27 This matter was addressed in some detail in 1982 and 1983. The Systems and Methods Section in the Hospital Service Division, which has responsibility for reviewing methods in this area, intends to have the matter put forward for further review.

Recommendation 26

The Authority disband the working party examining common procurement and storage procedures.

Response

3.28 The working party examining common procurement and storage procedures is no longer operating and has been disbanded.

Recommendation 27

The Authority conduct a detailed review of the scope of reducing outstanding patient debts.

Response

3.29 The new computer based debtor systems (part of CAHIS) are being installed. Additional resources have been allocated to debt recovery by the hospitals.

APPENDIX A

JULY 1986

ADMISSION AND DISCHARGE POLICY

ROYAL CANBERRA HOSPITAL AND WODEN VALLEY HOSPITAL

1. ADMISSION POLICY

1.1 Patient Categories

The policy recognises the following categories of patients.

A. Emergency and urgent patients - patients, because of their medical condition, require admission within 24 hours.

NB This decision will be the responsibility of the Admitting Officer.

B. Patients whose admission is essential at set times in the future to conform with a regular or programmed treatment schedule.

C. Semi-urgent patients - patients whose admission is not required immediately but is necessary within three weeks because of their medical condition. On occasions patients in this category may have to wait longer.

D. Elective patients - patients whose medical conditions does not necessitate their admission within three weeks.

E. Patients for admission to a designated Day Care Ward.

The relative priority for admission would be A., B., C., D. If it was necessary to close a Day Care Ward then the individual patients admission priority in Category E would be determined with regard to their medical condition.

1.2 Control of Admissions

It was accepted that placing of patients in one of the above categories required a medical decision.

1.2.1 The nominated Admitting Officer at each hospital would be responsible for controlling all emergency or urgent admissions (Category A).

1.2.2 Patients booked for essential procedures on set dates (Category B) are to be booked by the Bed Allocation Clerks and Theatre Booking Clerks as appropriate, acknowledging that these patients have a similar priority to patients in the urgent category.

1.2.3

Patients designated as requiring semi-urgent admission (Category C) would be booked with the Bed Allocations and Theatre Booking Clerks. These clerks, operating under the direction of the Clinical Superintendent, would then arrange the admission of these patients together with other booked patients. The number of booked admissions would be subject to a ceiling, to be determined by the Clinical Superintendent. Recommendations on the ceiling would be provided by the Monitoring Committee, with a view to matching workloads with staff available.

The booking clerks would arrange admissions in accord with the medical requirements of the patient as advised by the admitting doctor with the Clinical Superintendent intervening in cases of dispute.

Within this framework, increased numbers of semi-urgent admissions would necessitate a reduction in elective admissions. In the case of surgical patients current arrangements whereby semi-urgent patients substitute for elective patients would apply. Similarly with medical patients, substitutions would occur depending on the relative urgency of the patients condition.

1.2.4

Elective admissions (Category D) are to continue to be booked through the Theatre Booking Clerks and Bed Allocation Clerks, the numbers being subject to determination by the Clinical Superintendent, assisted by recommendations of Workload Monitoring Committee.

Within this category patients for a particular doctor would be booked in the order of receipt of the Request for Admission forms. On the basis of the patient's medical condition the admitting doctor could review this order. Patients previously cancelled by the hospital would have priority.

1.2.5

Day Care Ward Patients (Category E) are to continue to be booked in accord with the capacity of the Day Care Ward.

1.3 Admission Procedures

- 1.3.1 The request for admission form must be completed by the doctor indicating the category of patient and the expected duration of stay.
- 1.3.2 All emergency admissions are to be assessed in the Accident & Emergency Departments if they have not, been seen by the specialist who will be caring for them in hospital.
- 1.3.3 All emergency admissions are to be admitted through the Accident and Emergency Department to enable appropriate ward allocation.
- 1.3.4 Accurate information on admissions is to be provided to the ward charge nurse as soon as possible.
- 1.3.5 After hours the nursing supervisor is to be consulted on bed allocations for emergency admissions.

The above Admission Policies and Procedures apply at each hospital, and are supplemented as necessary with Policies and Procedures for specific types of patients, for example paediatric, neonatal patients.

2. DISCHARGE POLICY2.1 General Aspects

- 2.1.1 There must be a discharge plan prepared for all patients. This would commence as early as possible in the patient's stay and could begin prior to admission in the case of elective patients.
- 2.1.2 The discharge plan is to facilitate multi-disciplinary staff co-operation taking into account various aspects such as the patient's diagnosis, length of stay, social circumstances, and involvement of outside services e.g. Community Nursing.
- 2.1.3 Notice of the intention of the medical officer to discharge a patient must be communicated to the ward at least 24 hours prior to the actual discharge.
- 2.1.4 All patients should where possible be discharged from the hospital in the morning, preferably between 9.00am and 12.00 midday.
- 2.1.5 Allied health professionals should be consulted and involved in the detailed aspects of discharge planning.

2.2 Specific Aspects2.2.1 Ward Displays

Each ward is to maintain a list of patients, indicating the planned date of discharge. The purpose is to have all those staff involved in preparing for patient discharge, including the patient, aware of the likely day of discharge.

2.2.2 Timing of Doctors Ward Rounds

Doctors ward rounds should be both predictable and occur at a time convenient for the patient, nursing staff and medical team. Consultation by individual doctors and units with ward charge sisters to enable satisfactory schedules to be developed and adhered to is required.

2.2.3 Location of Patients

Patients under the care of a doctor or a group of doctors should be located on the same ward to enhance the medical and nursing care of the patient. This would entail some movement of both patients and staff and would also assist in achieving predictable and convenient ward round times.

Doctors or units would be allocated to wards rather than beds being allocated to individual doctors or units, however, this will not be used to prevent the admission of patients under particular doctors.

2.2.4 Length of Stay

The medical staff should set criteria for length of stay for commonly occurring conditions to assist in discharge planning and review processes.

2.2.5 Long Stay Patients

Applicable criteria should be developed to identify patients at high risk of extended hospital stay so that the Social Work Department is involved early in discharge planning.