Elective admission policies in New South Wales public hospitals

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Abstract

Objective: *To assess the existence and content of elective admission policies in New South Wales acute public hospitals.*

Methods: *A questionnaire was sent to managers of all acute public hospitals (n = 76). Copies of elective admission policies were sought from respondents. Results were analysed with EpiInfo 5.01b and policy content by thematic analysis.*

Results: *Survey response was 91% (69/76). Policies existed in 71% (49/69) of hospitals. Of these, 96% (47/49) disseminated their policy, with 23% (11/47) disseminating it at least annually, 41% (19/47) only when updated, and 32% (15/47) infrequently, with one policy being new (2%) and one hospital not stating its frequency (2%). Policy compliance was assessed in 86% (42/49) of hospitals and guidelines reviewed periodically in 92% (45/49) of hospitals. Twenty per cent (10/49) of the policies had been developed since a departmental instruction of May 1994. Of the 20 acute hospitals with no policy, 75% (15/20) were rural and 85% (17/20) thought they should have a policy. Analysis of policy content revealed emphases on resource availability and clinical need as determinants of elective admission, an institutional rather than a patient focus, and a high level of senior nurse manager involvement in admission decisions in rural hospitals.*

Conclusions: *Despite a specific departmental instruction, nearly one-third of hospitals still had no admission policy 18 months later. This could be indicative of*

miscommunication between hospitals and NSW Health or perceived irrelevance of department guidelines by hospital managers. Existing policies were mostly institutionally focused and dominated by perceived resource limitations. NSW Health might consider other medico-social factors and manager involvement in future policy development.

Introduction

In Australia there has been continuing concern by health professionals and ministers, the press and the public about hospital elective admission access. Recent State Government strategies in New South Wales have included providing public money to allow more elective operations, with prominent political figures promising to resign if waiting lists were not reduced within specified times.

In addition, State public hospitals have been required, since May 1994, to have elective admission policies (NSW Health 1994a). NSW Health guidelines outline principles of waiting list management, specifying hospital staff roles and responsibilities, with hospital managers nominated as being responsible for policy development.

These State health initiatives represent a newer approach to dealing with the difficulties of hospital resource access. One and a half years after the government directive, it was decided to investigate the existence of policies for elective admissions and the content of policies that had been produced. The report of that study forms the basis of this paper.

Methods

A survey questionnaire about elective hospital admission policies and an accompanying consent card were piloted on eight hospital managers in October 1995, sampled from each NSW Health acute general public hospital category (NSW Health 1996). Specialty and community hospitals were excluded from the study.

The refined questionnaire was sent to each manager of the remaining 76 metropolitan and rural acute general hospitals in November 1995. Managers themselves were asked to complete the questionnaires. Signed consent cards were sent back separately from completed questionnaires to ensure confidentiality. Two telephone follow-up reminders were made to non-responders in December 1995 and January 1996. Formal written policies were also sought from each hospital.

The questionnaire surveyed managers regarding the existence of an elective admission policy, its development, methods of compliance and dissemination, content and review mechanisms. Managers of hospitals with no policy were asked to describe the type of policy they thought their hospital should have. Survey results were coded and analysed with EpiInfo 5.01b (CDC 1991). Thematic analyses (Kellehear 1993) of policy content were also undertaken.

Results

Policy survey

Completed questionnaires were returned from 69 of 76 (91%) hospitals. The 7 non-responder hospitals were 3 metropolitan (1 major referral, 2 district) and 4 non-metropolitan (3 large district and 1 small district).

Hospital managers completed 33% of surveys themselves, others being completed by personnel nominated by managers. Forty-nine hospitals (71%) reported that they had an elective admission policy (although 4% thought their policies were inadequate). Twenty hospitals (29%) stated that they had none. Seventeen of these thought they should have a policy and four of these were in the process of developing one. The remaining three thought a policy was unnecessary as they stated that they never had waiting lists.

Ninety-six per cent (47/49) of hospitals disseminated their policy, with 23% (11/47) disseminating it annually or more frequently, 41% (19/47) only when updated, and 32% (15/47) infrequently, with 1 policy being new (2%) and 1 hospital not stating its frequency (2%). Ninety-eight per cent (46/47) stated that their method of policy dissemination was through the availability of the Policy and Procedure Manual, although only 45% (21/47) were actively circulated. Responsibility for dissemination rested with a single person in 62% (29/47) of hospitals. Staff to whom policies were disseminated are shown in Table 1. Twenty per cent (10/49) of policies had been developed since the 1994 departmental instruction. Others had been developed in the early 1990s (40%), 1980s (28%), before 1980 (4%), and date unknown (8%).

Compliance with the policy was assessed in 86% (42/49) of hospitals by daily monitoring of admissions (29%), audits of medical records (16%), audits of the elective admission process (12%), regular hospital staff meetings (10%), patient complaints (8%), infrequent monitoring of admissions (6%), monitoring casemix (5%), ad hoc problem-solving (2%) and patient satisfaction surveys (1%) (categories not mutually exclusive).

Policies were reviewed periodically in 92% (45/49) of hospitals (Table 2), and in 40% (18/45) the policy was reviewed by those who had developed it.

Table 1: Development and feedback process of admission policy (n = 49)

	Number	Percentage
Personnel responsible for development[1]		
Administrators	29	59
Clinicians	28	57
Nursing staff	23	47
Allied health staff	1	2
Committees	4	8
Missing data	2	4
Personnel to whom policy distributed[1]		
All staff (unspecified)	10	20
Administrators	26	53
Clinicians	33	67
Nursing staff	28	57
Allied health staff	4	8
General practitioners	3	6
Hotel services	1	2
Not disseminated	1	2
Unknown	1	2
Personnel involved in policy reviews[1]		
Administrators	35	71
Clinicians	31	63
Nursing staff	26	53
Allied health staff	3	6
Community health	1	2
Committees	3	6
Health Department district office	1	2
Not reviewed	4	8

Note:
1. Categories not mutually exclusive.

Table 2: Policy review frequency (n = 49)

Hospitals	Active policy[1]	Passive policy[2]	Not reviewed	Unknown
Metropolitan				
Principal referral (n = 5)	5	–	–	–
Major referral (n = 6)	4	2	–	–
District (n = 10)	7	2	1	–
Non-metropolitan				
Major referral (n = 4)	4	–	–	–
Large district (n = 9)	4	3	2	–
Small district (n = 15)	3	9	1	2

Notes:
1. Active policy – reviewed more frequently than every two years.
2. Passive policy – reviewed less frequently than every two years.

Subsequent to the most recent review, 11% (5/45) of admission policies remained unchanged, 36% (16/45) of policies underwent 'major' changes, 20% (9/45) underwent 'minor' changes, and 33% (15/45) were unclear as to change extent. Changes included revision and updating of policy (31%, 14/45), changes to pre-admission procedure (7%, 3/45), introduction of a pre-admission clinic (4%, 2/45), change in waiting list management (2%, 1/45), increased surgical throughput (2%, 1/45), reduced length of stay (2%, 1/45), more efficient utilisation of hospital resources (2%, 1/45), staff education (2%, 1/45), and introduction of a continuum of care model (2%, 1/45).

Respondents were asked whether there were any elective procedures that their hospital would not undertake as a matter of policy (Table 3). While most hospitals responded in general terms, a few indicated specific procedures that were not undertaken.

Twenty hospitals had no policy (15 rural and 5 metropolitan), although 17 of these expressed a need for a policy. Recommended methods for policy development included the use of a selected (n = 6) or elected (n = 6) small committee, a medical staff council (n = 1) or involving all hospital staff (n = 3). Recommended methods of measuring policy compliance included auditing of the admission process (n = 13), use of patient questionnaires (n = 1), or using both audit and patient questionnaires (n = 1).

Table 3: Non-allowed elective procedures (n = 49)

Hospital responses[1]	Percentage
All procedures are allowed	39
All procedures allowed within the hospitals' level of service provision or their visiting medical officers' accreditation level	51
No procedure undertaken which is contrary to religious philosophy of institution[2]	2
No cosmetic surgery	4
No 'nursing home' type patients	2
No patients from outside hospital's catchment area	2
Any procedure allowed for which beds and theatres are available	2

Notes:

1. All responses mutually exclusive except for response 3, which was given by one of the hospitals in response group 2.
2. For example, terminations of pregnancy.

Policy content

Of the 49 hospitals with policies, 39 (80%) provided a copy upon request. Of these, 5 were small rural hospitals that used their major referral hospital's policy and 2 were small metropolitan hospitals that used their health area's policy. The 10 non-responder hospitals were 6 metropolitan, (3 large and 3 district) and 4 non-metropolitan (3 large and 1 small). (Large hospitals include principal and major referral hospitals.)

Examination of the policies was undertaken without predetermined categories to allow exposition of unanticipated themes. Table 4 shows the predominant themes that emerged for metropolitan and rural hospital policies respectively. Frequencies indicate number of policies that contained each theme.

No policy identified admission priorities between different clinical procedures. Rather, priorities were mostly worded with regard to the general issues of resource availability, clinical need, the hospital's catchment area and deferred patients. Thirty-one per cent of policies stipulated the necessity of pre-operative tests being undertaken before admission as a means of freeing up hospital resources.

Objectives of rural district policies related to regional health care needs, in contrast to city and rural major referral hospitals whose objectives were operational and patient-focused.

Table 4: Policy themes

	Metropolitan hospitals		Non-metropolitan hospitals		
	Large+	District	Major referral	Large district	Small district
	(n = 8)	(n = 7)	(n = 4)	(n = 6)	(n = 14)
Objectives and principles					
Operational*1	2	2	2	–	–
Patient-focused*2	2	2	–	–	2
Health needs of area	–	–	–	1	3
Admission priorities*3					
Resource availability	7	4	3	–	11
Clinical need	–	3	–	–	5
(Not insurance status)	2	2	–	–	3
Limited to hospital area	6	–	–	–	4
Deferred patients	4	4	1	2	3
Hospital staff	1	–	–	–	–
Pre-operative tests required	1	2	3	1	5
Hospital authority on admission decisions*4	6	2	4	5	7
Nursing authority to admit*5	2	1	1	2	2
Late night discharge (after 11pm)	–	1	–	–	–
Rural issues					
Distance	–	–	–	–	1
Communication with GPs	–	–	–	–	2

\+ Large hospitals = principal and major referral hospitals

*1. Policies whose content mostly described operational procedures.

*2. Policies which included sections that prescribed the manner in which patients should be approached and related with by hospital staff.

*3. Policies which examined criteria that influenced admission priorities, for example:
- resource availability: relates to availability of beds, staff theatres and intensive care unit facilities
- clinical need: some policies stated explicitly that patients should be admitted according to clinical need and not health insurance status
- deferred patients: usually incorporating NSW Health guidelines that patients deferred twice should gain priority for admission.

*4. Where the policy allows for a nominated employee to decide on conflicts over admission priorities.

*5. Where the policy allowed for senior nursing staff to have unilateral or equal authority to admit patients.

Across all hospitals, 62% (24/39) empowered senior nursing staff to make admission decisions and in 21% (8/39) staff had authority to decide on admission priorities. Policies of 3 small rural hospitals made allowances for patients who had to travel large distances to stay in hospital (1) and emphasised communication with country general practitioners who operated with minimal support (2).

Discussion

Hospital admission policies should ideally provide for equitable patient admission, setting out patient rights and difficulties faced by institutions, and identifying desirable outcomes using key performance indicators. Many of the policies studied were institutionally and activity-focused rather than patient and health-focused, with few considering the rights and needs of patients for timely quality care. Exceptions to this were the insistence in many policies that deferred patients should have priority for future admissions and that patients should be admitted on the basis of clinical need rather than insurance status. However, it is of concern that two policies diminished patient equity by allowing for late night discharge and giving admission priority to hospital staff.

Despite ministerial statements and written departmental directives requiring a written policy (NSW Health 1994b), 29% of hospitals did not have one. This indicates some incongruity between political objectives and hospital cooperation in that these directives were not readily responded to by these hospitals. This raises questions about the ability of government to implement future guidelines if there is any entrenched resistance at the service level. In the absence of a policy, one could speculate on how these hospitals make the inevitable choices that arise every day in deciding between the competing requests for admission. It is possible that there are informal rules which control admissions, but it would be preferable that such rules be made explicit and open to critical examination. That six metropolitan hospitals which had stated that they had a policy did not produce one is also of concern. While this could simply indicate that they declined to respond to a research request, it is also possible that no codified policy existed.

Contrary to the departmental instruction, many hospital managers did not see themselves as responsible for policy development. While this may indicate that the nominated personnel were more appropriate, the fact that one manager of a hospital without a policy stated that he should develop it may be indicative of miscommunication between NSW Health and hospital management, or that some hospital policies are developed independently of NSW Health.

That some small rural hospitals used their large area hospital's or health area policy and two small city hospitals used their health area's policy may reflect their own priorities for resource use, but large sections of such a policy would probably be inappropriate for small hospitals.

For those hospitals with a policy, compliance was not measured in almost one in six. For a small proportion it was only measured infrequently or via patient complaints, the latter not being ideal, dependent as they are on empowerment. In addition, a sizeable proportion of policies were disseminated infrequently, mostly as part of a manual which might not provide for optimal staff incorporation.

A substantial number of hospitals had infrequent policy reviews and the fact that 90% of policies underwent some change after their latest review may indicate that more frequent reviews are required, especially in the context of the dynamic nature of changing medical and hospital systems. Although some staff other than the policy developers were involved in policy review, it may be appropriate to use larger proportions in future reviews to reduce the possibility of bias.

The fact that some hospitals thought their policy was inadequate may reflect that the departmental guidelines have limitations for developing appropriate individual hospital policies. For example, many policies had incorporated NSW Health guidelines regarding deferment of admissions of up to twice, yet this may still be an unsatisfactory situation for patients. In this way, the guidelines may be a mechanism for managing potential inadequacies rather than actually improving patient care. While reasons for deferment were mostly attributed by hospitals to resource lacks (beds, theatre time, staff, intensive care unit), other potential factors such as surgeon volume (Arndt, Bradbury & Golec 1995), clinician remuneration levels and patient cost contributions may also influence resource availability. In addition, while demands for pre-admission workup may reduce congestion in the hospital system, this may not be appropriate for some types of patients and represents a form of short-term cost-shifting from the State to the Commonwealth.

Medical practitioners and their representatives might like to consider the implications of a nominated doctor or nurse authority to override clinical decisions of patients' visiting medical officers. While this might not occur often, it is probably important for differences to be settled by discussion and mediation where possible.

Recent State Government responses to the difficulties in hospital access have been to supply short-term funding and to implement guidelines regarding waiting list management. However, these strategies may not address the issues of demand

and supply in the long term, and the departmental guidelines may be more a document in the attempted management of available resources than a means of addressing the issues of service availability and health outcomes. While it is probably important to document the extent and nature of waiting lists as a first step, the current guidelines may not be sufficient to elucidate the possible role of other determining factors. For example, there is evidence to suggest that patients may be put on waiting lists for non-medical reasons – to give patients a sense of hope for non-operable conditions, on multiple lists to ensure hospital access (Rees & Gibbons 1986) or to satisfy physicians' personal requirements (Burns & Wholey 1992a; 1992b). In addition, it may be inappropriate to implement universal guidelines across all hospitals, which may vary significantly in individual character.

NSW Health might include closer involvement of hospital managers and patients in future guideline development. In this way, it could assist hospitals to become more involved in developing realistic and patient-centred admission policies.

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