ADMISSIONS POLICY
PROCEDURES AND
GUIDELINES

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 Ratified by: Management Board (Chairman’s Action)
 Date: June 2005
 Update: November 2014
 Review: November 2016

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## GLOSSARY OF TERMS

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<tr>
<td>AECU</td>
<td>Ambulatory Emergency Care Unit</td>
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<td>ASPH</td>
<td>Ashford and St Peters Hospital</td>
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<td>BACU</td>
<td>Birch Acute Coronary Unit</td>
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<td>CAT</td>
<td>Capacity Action Team</td>
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<td>CDU</td>
<td>Clinical Decision Unit</td>
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<td>Clinical Site Nurse Practitioner</td>
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<td>DTA</td>
<td>Decision to Admit</td>
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<td>DSU</td>
<td>Day Surgery Unit</td>
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<td>ED</td>
<td>Emergency Department</td>
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<td>EPU</td>
<td>Early Pregnancy Unit</td>
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<td>FY2</td>
<td>Foundation Year 2</td>
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<td>GAU</td>
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<td>HASU</td>
<td>Hyper Acute Stroke Unit</td>
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<td>HDU</td>
<td>High Dependency Unit</td>
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<td>ICU</td>
<td>Intensive Care Unit</td>
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<td>LOS</td>
<td>Length of Stay</td>
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<td>MAU</td>
<td>Medical Assessment Unit</td>
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<tr>
<td>MRSA</td>
<td>Methicillin Resistant Staphylococcus Aureus</td>
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<td>NIV</td>
<td>Non Invasive Ventilation</td>
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<td>NOF</td>
<td>Neck of Femur</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>ODP’s</td>
<td>Operational Departmental Practitioners</td>
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<td>Out Patient Department</td>
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<td>RAG</td>
<td>Red Amber Green</td>
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ADMISSIONS

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See Also:-

Acute Hub Operational Policy
Coronary Care Unit / Birch Unit Policy
Critical Care Operational Policy
Day Surgery Operational Policy
Infection Control Policy
Paediatric Admission Policy
Patient Flow & Escalation Plan
Infection Control Policy
Surgical Assessment and Short Stay Unit (SASU) Operational Policy
Admissions

1. Patient Flow and Capacity Management

Aims

To ensure that:

- Patients are admitted to Ashford & St Peter’s Hospitals for appropriate clinical reasons. Patients should not be admitted due to lack of social support.
- There is minimum disruption to planned elective admissions whilst responding positively to emergency admission requirements.
- Patients are provided with the bed placement that is most appropriate to their medical need and which takes into account any additional special needs throughout their inpatient stay.
- If a patient’s medical needs change they may be moved to a more appropriate ward.
- If a move occurs, continuity of care needs to be maintained and effective communication of treatment/care protocols are a priority. All internal moves will be recorded by the CSNP Team.
- All staff utilise the RealTime system.

Principles of Patient Flow and Capacity Management

The Patient Flow Team are responsible for:

- Co-ordinating the movement of patients through admission and transfer processes
- Ensuring appropriate communication between the medical staff, Assessment Areas, Emergency Department (ED) and the wards.
- Liaison with the relevant managers/clinicians in respect of prioritising admissions and to initiate contingency plans, if necessary.
- Children, pregnant women and post-natal mothers and babies will always be admitted to the appropriate clinical unit for their age and condition.
- Patients will be referred to specialist nursing/therapy departments as soon as a need is identified.
- Discharge planning will commence prior to admission for planned admissions and on admission, or as soon after admission as possible, for emergency admissions.
- If a patient does not warrant admission on clinical grounds, but it may be unsafe to discharge them because of their social situation from ED.
or an Admissions area then an Occupational Therapist Care Manager or the Rapid Response Team should be informed in an attempt to facilitate immediate discharge.

- If a patient from ED or Assessment area does not require admission and has been assessed by Occupational Therapist, but will be needing rehabilitation, Rehab coordinator (8807) and out of hours CSNP needs to be informed to facilitate transfer to Ashford Hospital or Community rehab hospital.

- Where a patient is living alone with no immediate support, during office hours the Rapid Response Team or Duty Case Manager (dependent on whether the concern is nursing or social) should be contacted in the usual way.

- Out of office hours, when a need for services is identified, the Emergency Duty Team and the Rapid Response Team should be informed at the earliest opportunity (on-call contact numbers can be obtained via switchboard).

Single sex accommodation

- Patients requiring admission will be accommodated in single sex compliant beds.
- Any patient in a critical care bed and no longer requiring that level of care will be stepped down to an appropriate single sex compliant bed.
- Any breaches of SSA will be escalated, recorded and reported by the CSNP Team.

Bed Management Processes

- There will be a minimum of three bed states obtained daily. As per Patient Flow & Escalation Plan bed states will be assessed routinely at:
  09:30 CAT meeting (CSNPs, Rehab Coordinator, SSM & ED shift leader)
  12:30 CAT Meeting with divisional representatives and Deputy Chief Executive if status is Red/Black
  14:30 CAT meeting (CSNPs, Rehab Coordinator, SSM & ED shift leader)
  16:30 CAT Meeting (CSNP, SSM)

- All wards must ensure the CSNPs are kept up to date regarding the current bed status.
- All ward rounds should be planned early in the day in order to expedite progression of patients through the hospital system.
- It is the responsibility of the Shift Leader to ensure that trained nurses are aware of the current bed-state and the forecast for the next 12 hours, including all outliers on the ward.
- All wards must ensure that “Real Time” and RADAR are updated with their current bed state.
- When confirming a bed state, empty beds must be declared even when they
are identified for expected patients. The nurse confirming the bed-state should inform the CSNP that they are expecting a patient for a particular bed (this includes patients expected from other hospitals).

- It is the responsibility of the admitting Consultant, or their deputy to identify all patients requiring admission.
- The responsibility of locating vacant beds for emergency patients lies with the CSNP. The CSNP will liaise with the Nurse in charge of ED or Admission Area when a suitable bed has been identified.
- ED performance measures are in accordance with NHS guidelines as outlined Emergency Care Weekly Situation Report (April 2014). It is the responsibility of the ED shift leader to measure waits. Patients are moved out according to how long they have been in the department following a decision to admit and according to clinical priority.
- The elective admissions list will be RAG rated as a guide for elective and trauma admission cancellation.
- The CSNP must record all cancelled admissions. All patients who are cancelled on the day of admission should be offered a re-admission date within 28 days. No patient under the 28 day rule will be cancelled.

Escalation

- If bed shortages are anticipated, actions should be taken according to the Patient Flow & Escalation Plan

Doctor’s Responsibilities Regarding Patient Flow

- Ensure that the CSNP is informed of ALL patients requiring admission or transfer from any area within or external to the hospital.
- Identify the priority of patients for admission (using clinical and social criteria as appropriate) during the out-patient consultation. Ensure patients are informed of anticipated length of stay.
- Visit highlighted in-reach & ‘outlying’ patients daily.
- Ensure that the medical contribution to each patient’s discharge is directed at achieving a problem free discharge and that discharges are planned a minimum of 24hrs in advance.
- Ensure that all patients for discharge are reviewed as a priority every morning, except when urgent clinical need dictates otherwise.
- Ensure all post-take ward rounds take place at and that a discharge date, including plan of action is clearly documented.

Transfer of patients

Patients may be transferred for treatment to or from other hospitals. Reasons for transferring patients include:

- Patient to receive private treatment
- Tertiary referrals
Escorts for patient transfers to other hospitals

ODP’s are expected to act as escort in support of anaesthetist if the patient has a compromised airway. ODP’s should not be asked to substitute for nurses in escort situations. Following individual assessment suitably competent escorts need to be provided if required.

Patient repatriation

Patients admitted for treatment to another hospital should be repatriated to a hospital of their own residence, avoiding unnecessary delays.

All inter-hospital sites are programmed to occur during the working day so that patients transferred from a ward in another hospital to a ward within the Ashford & St Peter’s Hospitals should arrive at a time that allows for the ward based team to make a formal assessment of the patient and programme a planned course of action required to cover specific needs. In the event of an out of hours transfer the on-call team will be asked to clerk the patient.

All teams receiving patients from inter-hospital transfer should insist on a full documentation of patient’s clinical state prior to transfer and should be aware if patients are being transferred in a clinically critical condition.

If patients are deemed to be potentially unstable or require immediate assessment for the possibility of subsequent speciality involvement.

High Priority Patients

- Patients transferred from secondary care to tertiary centres for specialist treatment
- Patients transferred to another hospital for intensive care for immediate capacity reasons

Medium Priority Patients

- Patients admitted to another hospital under a ‘treat and transfer’ arrangement, who have continuing clinical needs
- Local residents admitted to another hospital, who are actively under the host hospital for a related condition and who have continuing clinical needs

The receiving hospital has a clear responsibility for these patients and is obliged to respond promptly. The patients should be repatriated within 48 hours of the request.

Standard Priority Patients

- Local residents, admitted to another hospital, who are not known to the host hospital, but who have continuing clinical needs
- Local residents admitted to another hospital that have continuing or complex care (as distinct from clinical) needs that are best organised by the receiving hospital prior to discharge.
- The receiving hospital has responsibility for these patients. They should be repatriated within 7 days of the request
Local residents being repatriated from abroad

- If the patient is a relative of local resident (e.g. parent) the patient may not have the right to access free NHS care depending on their circumstances. Unless it is clear that a patient being repatriated is a UK resident citizen with rights to NHS care, contact should be made with the overseas patient manager before being accepted.

- If the host hospital has the facilities needed, the patients should be accepted for repatriation within 48 hours

- If admission to a specialist unit is needed, the host hospital should accept within 48 hours and make the tertiary referral, although the patient may go directly to the specialist centre

- The requirement is for the host hospital to be involved in the referral so that subsequent repatriation is more easily achieved. At the appropriate time, repatriation to the host hospital should proceed in line with the timetable for such moves i.e. within 24 hours to the request.

The Process

Consideration must be given to pressures within the ED, MAU/SASU and to elective activity. Patients should be placed according to previous consultant episode. In all cases, the relevant clinician must first authorise the repatriation

- Patients who live within the Ashford & St Peter’s Hospitals catchment area, who are admitted as an emergency into “out of area” hospitals, require Registrar to Registrar referral.

- Liaison thereafter should be between the respective CSNPs.

- With repatriation following an ICU transfer, the aim should be to transfer directly from the ICU of the host hospital to the receiving hospital’s general ward, HDU or ICU.

- Orthopaedic wards require the patient to have one MRSA screening clearance or 3 if contact has been involved.

- In all cases, it is the responsibility of the hospital seeking the repatriation to make contact with the appropriate Capacity Manager at the receiving hospital and to provide all relevant clinical and social information

- Hospital MRSA screening policies should not prevent them from meeting their obligations under this protocol

- The time limits should be observed at the weekends as well as during the week. Although it is recognised that local Capacity Management arrangements and the availability of the accepting clinical team at the weekends may have an influence

Transfer to a Rehabilitation Hospital

All transfers of patients to Rehabilitation (Woking, Walton, Ashford Hospital) will be organised by the Rehab Coordinator (Pager 8807), ensuring they meet the relevant admission criteria. Referral forms and necessary documents must be faxed to Woking and Walton Rehab Hospital. Transfer must be discussed with patients, relatives, carers and the patient’s medical condition must be stable.
Transfer to another acute NHS trust for special treatment

All transfer of patients to a tertiary hospital will be coordinated by the nurse in charge of the transfer ward and patient’s Consultant. Patient must have been accepted for transfer by a Consultant at the receiving hospital. The receiving hospital’s CSNP and ward sister should be contacted to ensure a bed is available. The patient and their relative or carer will need to consent to the transfer. All transport will be booked via hospital ambulance service.

2. Admission Policies by Location

All Emergency Admissions

- All Emergency admissions will be admitted via the ED/MAU/SASU. Gynaecology patients may be admitted via the Early Pregnancy Unit (EPU). ED shift leader and CSNP must monitor all patients in ED to create beds for patients referred to that speciality and those requiring admission.

- Surgical patients accepted by the clinicians, should be transferred to SASU. Orthopaedic patients, to Orthopaedic Assessment Unit in Swan and for Gynaecology to Gynaecology Assessment Unit (GAU) in Kingfisher.

- Patients admitted as Emergencies will be admitted under the care of the admitting team and should be transferred to the care of the Consultant specialising in the patient’s particular condition via a formal referral process.

- Where possible all Surgical/Orthopaedic patients will be admitted to their speciality ward area.

- Patient Centre will be used to track all patient wait times from arrival, patient has to be referred to speciality on time, in the event of delay the Shift leader will inform CSNP. CSNP to escalate to appropriate divisional team to ensure patient transferred before 4 hours from arrival in ED.

Transfer from Emergency Department

Following a “decision to admit”, all patients will be transferred as soon as possible from the ED dept. to a ward appropriate for their ongoing, specialist needs. Handover will take place on the ward.

Medical Admissions

Sources of medical admissions are:

- Acute referral to ED/ MAU
- GP referral
- Arranged review in the AECU
- Admission via Out-Patient Department
  - Acutely ill patients will be initially assessed by the on-take team. Following a DTA, patients must be transferred to a bed according to their speciality need.
  - Patients may be admitted from ED for further observation and
assessment. These patients should be transferred to MAU. Plans for investigation and early referral for relevant investigation should be initiated within the first 24 hours of admission.

- All attempts should be made to avoid admission of patients who are medically stable but do not have sufficient support to return to the home environment. Such patients should be referred to the Rapid Response Team to see if direct discharge can be facilitated. If these patients are admitted, early involvement of social services. For further information, please refer to the Discharge Policy.

Acute Admissions from the Outpatient Department (OPD)

- Acute admissions from the Outpatient Department must be sanctioned by a Registrar or a Consultant
- These acute admissions will remain under the care of the admitting team, unless a formal referral to another team/speciality is made.
- All admissions from the OPD must be admitted direct to an appropriate ward area via the Clinical Site Nurse Practitioner

NB: If a patient’s condition is such that intensive immediate treatment is required the patient should be transferred to ED
CSNP must ensure clinics are informed of transfer time to ward before 5pm

Planned Medical Admissions

In-patient admission for investigations or observation is sometimes required. Where possible, tests should be pre-booked to limit in-patient stay. All routine admissions must be sanctioned at consultant level. The Admissions Office and CSNP must be notified in advance of the expected admission date. Patient will usually be admitted via the Admission Lounge.

Medical Assessment Unit (MAU)
(See Acute Hub Operational Policy)

MAU admissions include patients been accepted by the medical team via
- GP referral
- Patients referred from ED
- Clinic referrals requiring medical assessments

N.B In the event GP medical patients arrive in ED they should be triaged (within 15 mins.) by the Senior Consultant or the ENP prior to transfer to MAU.
- Stroke patients, STEMI/NSTEMI, Resus and High dependency patients should not be admitted to MAU.
- All GP accepted patients will come directly to MAU and be clerked using the Medical clerking profoma
- All patients from ED should have the copy of the front sheet of the ED cascade plus the medical clerking proforma
- After post take review of the patients and identification of pathway (See appendix for MAU pathway)
- Discharge home
- Transfer to Medical Short Stay Unit (MSSU) if length of stay (LOS) is <72 hours
- Transferred to speciality ward if LOS is >72 hours
- Transferred to specialist hospital
N.B Patients who are waiting to be transferred to a ward will remain under the care of the MAU doctors until transferred to a speciality bed.

- Shift leader will notify CSNP of all patients requiring admission.

**Stroke patients**

- CSNP to be informed by ED Team leader /Stroke nurse as soon as potential thrombolysis candidate attends ED.
- CSNP to liaise with Hyper Acute Stroke Unit (HASU) in order to facilitate a bed for any thrombolysed patient, also taking into account suitable staffing (1:1 ratio for thrombolysed patient in first 24 hours), in order to admit the patient from ED to the HASU within four hours of arrival.
- If there is no acute bed on HASU or inadequate staffing, patients are to stay in ED until appropriate bed/staffing is available. Staff in other wards may be moved to achieve 1:1 staffing to patient ratio for thrombolysed patient.

**Non Invasive Ventilation (NIV) and Neck Breathers**

- Patients requiring NIV from ED and other wards should only be treated in Aspen Ward, if a higher level of care is required, the patient will be transferred to Birch Acute Cardiac Unit (BACU)/HDU/ITU.
- Any patient, who has a long term tracheostomy/laryngectomy, is self-caring from this aspect and needs to be admitted due to other clinical reasons and can be treated in a general medical/surgical ward. Outreach to be informed of any such admissions.
- Neck breathers with related acute needs can only be admitted to Aspen Ward/HDU/ITU. Outreach referral to be made for this group of patients.

**Cardiac Admissions**

(see: Coronary Care Unit/Birch Unit Policy)

- Any patient with NSTEMI, ACS, Post PCI, Large PE, Acute LVF, myocarditis/pericarditis/endocarditis, ongoing chest pain, flecainide test (for other cardiac conditions see BACU policy) requires admission to BACU.
- All patients requiring BACU from ED, MAU, clinic or other wards must be communicated to CSNP and BACU shift leader.
- BACU takes direct admissions from the ambulance service for patients with suspected ACS
- Patients can be accepted from Epsom hospital after discussion with CSNP. Patients from Epsom should not wait for > 72 hours, they should be MRSA screened, no diarrhoea and vomiting in last 24- 48 hours. Once patient’s intervention is completed or patient is stable they should be transferred back to EPSOM.
- Non- cardiac admissions should only be admitted in the absence of any other bed and should be repatriated to the appropriate ward as soon as a bed becomes available.
3. Admissions Policy for the Surgical, Trauma & Orthopaedic Directorates

Surgical Assessment and Short Stay Unit (SASU)

(See Surgical Assessment and Short Stay Unit (SASU) Operational Policy)

- SASU is for patients requiring surgical emergency assessment including general surgery, vascular and urology via GPs, Outpatient Department and ED.

- SASU Ambulatory bay should be for patients that have been accepted by surgeons and who have been initially triaged by ED or GP. Patients should be clinically stable and able to sit on the chair. Ambulatory SASU will stop receiving referrals by 8pm, patients attending overnight will be allocated to assessment trolleys.

- If a patient needs to be admitted and LOS is no longer than 24/48 hours, the patient should remain on SASU. If LOS is >48 they should be transferred to speciality bed.

- Shift leader will notify CSNP of all patients requiring admission and needing to be transferred to speciality wards.

Trauma & Orthopaedic Division

Fracture Neck of Femur (NOF)

Patients from ED and other wards who have been diagnosed with fracture NOF should be treated in Swan Ward. Once patient is clinically stable and requiring rehab/placement, patient can be stepped down to Fielding ward in Ashford. Rehab Coordinator, CSNP and Clinical Lead Nurse in Ashford need to be informed to facilitate transfer.

Pre Admission Clinic

Pre-admission clinics are held to avoid cancellations of unfit patients by addressing the problem prior to admission and to identify any clinical/social concerns before admission. Also to ensure patients receive a full pre-operative assessment and to advise patients, relatives and carers, so that on admission they are informed of what is to happen and their expected length of stay.

The aim is to have all Elective Surgical, Orthopaedic, Inpatients and Day cases attend Pre-admission clinics 3 – 6 weeks prior to their planned date of admission.

All patients who require inpatient planned surgery are pre-assessed to:

- Assess if surgery is necessary, and whether the patient is fit to undergo the planned surgery.

- Provide information about the planned surgery and length of hospital stay, and minimize any anxiety regarding their admission and recovery.

- Involve other health professionals as appropriate as to the patient’s needs, at the earliest opportunity to ensure smooth provision of care and prevent delayed discharge.

- Involve the patient and carer where appropriate and with the patients
consent, in the assessment process to help their understanding, and involve them in the care and support of the patient.

Day of Admission

- Patients are admitted to the Admission Lounge and will go to theatre/dept from there. CSNP will locate and allocate a suitable bed for post procedure care.

Gynaecology Assessment Unit (GAU)

GAU can accommodate 2 patients requiring assessment via ED referrals, following triage in ED. The area should be used for assessment and emergency treatment only. On-going management must be given on the ward after admission.

Authorisation to transfer patient to GAU should be through the Gynae Emergency FY2 (Bleep 5190)

All patients transferred to GAU should be haemodynamically stable with MEWS <4.

Gynaecological Symptoms

- Lower abdominal Pain
- PV Bleeding

Early Pregnancy Symptoms

- PV Bleeding
- Unilateral abdominal pain
- Crampy central lower abdominal/suprapubic pains
- Hyperemesis gravidarum (with ketonuria)

Referral and Admission of Patients Attending the Early Pregnancy Unit (EPU)

- The early pregnancy unit is open from 0900-1300 for review of emergency patients and follow up patients up to 1500
- The unit will accept patients with problems in early pregnancy, i.e. bleeding/pain from conception, with a positive pregnancy test until 1st trimester screening scan at around 13 weeks.
- Review patients whose miscarriage is treated conservatively.
- Arrange surgical management of miscarriage.
- Manage pregnancy of unknown location (POUL) with serial BHCG.
- Manage patients with confirmed ectopic pregnancy either conservatively or medically.
- Arrange admissions for confirmed ectopics that are to be treated surgically.
- Review patients with recurrent miscarriage in a dedicated clinic within EPU.
- Review patients who have Laparoscopic Salpingostomy, for Ectopic Pregnancy.

Out of hours referrals are seen in ED or GAU (Gynaecology Assessment Unit) dependent upon the source of referral.

If a bed is required for a patient post assessment the Clinical Site Nurse Practitioner should be contacted immediately. Patient with hyper-emesis should be transferred, where possible, to Joan Booker ward. Patients who may require surgery should be sent to a bed on Kingfisher ward.
For gynaecological patients requiring admission who are seen at Ashford Hospital, the on call Registrar should be contacted to accept the patient. The Registrar should contact the CSNPs at St Peters.

**Admission to the Day Surgery Unit (DSU)**

(See Day Surgery Operational Policy)

4. **Critical Care – ICU and HDU**

(See Critical Care Operational Policy)

5. **Paediatrics**

(See Paediatric Admission Policy)

6. **Admission of Infected Patients**

Please see the Infection Control Policy and Procedure Manual for information regarding different infection types.

**Emergency**

All patients admitted via the GP or through ED with a known or suspected communicable disease must be placed in a single side room where possible. The Infection Control Team must be notified. Patients known to have had previous healthcare associated infection should be isolated if appropriate and infection control notified. All patients should be assessed for the risk of cross infection and vulnerability to infection with the assessment appropriately documented. This includes checking microbiology results for any past history of cross infection risk e.g. ESBL.

**Planned**

All planned admissions must be MRSA screened at pre-assessment or the appropriate clinic. If the results are positive this must be communicated via the consultant’s secretary to theatres or the receiving ward and also recorded on PAS.

**Discharge/Transfer from hospital**

The host healthcare provider must ensure that they provide suitable and sufficient information on each patient’s infection status whenever the patient is moved from one organisation to another so that the risk of cross infection may be minimised.

All relevant healthcare facilities and social agencies involved in the delivery of the patient’s continued care must be informed verbally and in writing of the patient’s current cross infection/colonisation status.

When required there should be joint planning between the Infection Control Team, the CSNP’s and the Discharge Team for planning patient admission, transfer, discharge and movement between departments and other healthcare facilities. Where necessary Ambulance Trusts may need to be involved in such planning.
NB. Please refer to the Infection Control Policy and Procedure manual for further details. If you have any queries please contact: The Infection Control Team on Ext 2128/3052 or out of hours on call Consultant Microbiologist for further advice.

7. Policy for Patients Admitted with Physical/Learning Disabilities

Routine Planned Admission

The admissions department will send out a date for admission to hospital as soon as a referral has been received. Pre Op assessment should take place in a timely manner to allow the patient to process information and discuss care needs when it is felt that the individual may require extra support. The CSNP can be contacted prior to admission to arrange a side room if a carer is going to support or to reduce anxiety in a busy ward environment.

Prior to any planned admission or hospital appointment the individual’s carer, support worker, community learning disability nurse or the hospital Acute Liaison Nurse will ensure that the person is offered the appropriate individual support required to facilitate the visit.

When support is required this will include providing the relevant information about the individual
- Hospital/care passport
- Medication charts or details of medication
- Guidelines if appropriate that are required to support the person
- On occasions it may be necessary to discuss sedation to reduce anxiety and may have already been discussed with the individual’s GP
- Any previous medical history if available or known

Urgent or Emergency Admissions

Urgent admissions are usually via ED or as a result of attending an outpatient appointment. It is hoped the patient will have their hospital/care passport with them but if not then the carers can be contacted to bring in or complete a fresh one as soon as they can. Copies of the passport can be found on the trust intranet or on www.surreyhealthaction

In an emergency admission the Learning Disability Nurse should be contacted or in her absence then social services on duty can be contacted to gain more information especially if the patient is not supported. The CSNP will ensure that the appropriate Associate Director of Nursing is notified of any patient admitted to their area.

Carers should stay if present until at least patient is transferred to a ward and if special extra care is required i.e. 1:1 then this to be discussed with the ward clinical leader and care provider.
N.B Not all people with a learning disability are known to the local Community Learning Disability Team as the team work on referral basis. Contact the Learning Disability Liaison Nurse if in doubt for advice.

Anyone with a disability may reasonably expect-

- That the disabilities they experience are not increased by inflexible regulations or routines.
8. Admission of Overseas Visitors

Admissions via ED

There is no exemption from charge for ‘emergency’ treatment (other than that given in ED or CDU). The trust will always provide immediate necessary treatment to save a patient’s life. Treatment must not be delayed whilst the patient’s chargeable status is determined. Failure to do so is in direct breach of the Human Rights Act 1998.

If a patient has indicated that they are visitor to the UK or they are on holiday, the overseas address must be entered onto the PAS system as the permanent address and the UK address as the temporary address. Hospital Attendance Form must be completed, dated and filed. Overseas Visitor Manager or Stage Two Officer needs to be arranged as soon as possible before patient admission.

Elective Admissions

If the patient is chargeable, the trust should not initiate any treatment process, e.g. by putting the patient on a waiting list, until a deposit equivalent to the estimated full cost of treatment is obtained. If no deposit is obtained then the trust should not perform the procedure. A patient from a European Economic Area (EEA) member state can be added to a waiting list in the same way as an NHS patient, however if the diagnosis is on the Payment by Results (PbR) Tariff then this should be transmitted to the Department of Health in the same way as PbR. If the diagnosis is not on the PbR tariff then an IGA Form is completed by the Finance Department and sent via the portal to the Overseas Healthcare Team at the Department of Work and Pensions. The entitlement status of all elective patients, and where relevant that full payments have been received should be double checked during the pre-op assessment.

Tertiary Referrals

When a Consultant accepts a tertiary referral the patient’s status should be established prior to admission unless the patient has life threatening condition or is in need of immediately necessary treatment. If this is not possible due to patient’s condition the patient’s status should be identified as soon as the patient is stable (in the clinician’s view) and informed of their eligibility for free of charge NHS treatment.

6. Admission of Infected Patients

Please see the Infection Control Policy and Procedure Manual for information regarding different infection types.

Emergency

All patients admitted via the GP or through ED with a known or suspected communicable disease must be placed in a single side room where possible. The Infection Control Team must be notified. Patients known to have had previous healthcare associated infection should be isolated if appropriate.
and infection control notified. All patients should be assessed for the risk of cross infection and vulnerability to infection with the assessment appropriately documented. This includes checking microbiology results for any past history of cross infection risk e.g. ESBL.

Planned
All planned admissions must be MRSA screened at pre-assessment or the appropriate clinic. If the results are positive this must be communicated via the consultant’s secretary to theatres or the receiving ward and also recorded on PAS.

Discharge/Transfer from hospital
The host healthcare provider must ensure that they provide suitable and sufficient information on each patient’s infection status whenever the patient is moved from one organisation to another so that the risk of cross infection may be minimised.

All relevant healthcare facilities and social agencies involved in the delivery of the patient’s continued care must be informed verbally and in writing of the patient’s current cross infection/colonisation status.

When required there should be joint planning between the Infection Control Team, the CSNP’s and the Discharge Team for planning patient admission, transfer, discharge and movement between departments and other healthcare facilities. Where necessary AmbulanceTrusts may need to be involved in such planning.

NB. Please refer to the Infection Control Policy and Procedure manual for further details. If you have any queries please contact:
The Infection Control Team on Ext 2128/3052 or out of hours on call Consultant Microbiologist for further advice.
## EQUALITY IMPACT ASSESSMENT

### Equality Impact Assessment Summary

**Name and title:** Admissions Policy Procedures and Guidelines

<table>
<thead>
<tr>
<th><strong>Background</strong></th>
<th>Who was involved in the Equality Impact Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>The authors completed the EIA.</td>
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<table>
<thead>
<tr>
<th><strong>Methodology</strong></th>
<th>A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>The data sources and any other information used</td>
</tr>
<tr>
<td></td>
<td>The consultation that was carried out (who, why and how?)</td>
</tr>
</tbody>
</table>

The effects to different race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation and age have been considered.

<table>
<thead>
<tr>
<th><strong>Key Findings</strong></th>
<th>Describe the results of the assessment</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Identify if there is adverse or a potentially adverse impacts for any equalities groups</td>
</tr>
</tbody>
</table>

This policy does not have an adverse effect on any equalities group.

<table>
<thead>
<tr>
<th><strong>Conclusion</strong></th>
<th>Provide a summary of the overall conclusions</th>
</tr>
</thead>
</table>

This policy does not have an adverse effect on any equalities group.

<table>
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<tr>
<th><strong>Recommendations</strong></th>
<th>State recommended changes to the proposed policy as a result of the impact assessment</th>
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<tbody>
<tr>
<td></td>
<td>Where it has not been possible to amend the policy, provide the detail of any actions that have been identified</td>
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<td></td>
<td>Describe the plans for reviewing the assessment</td>
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