AUSTRALIAN MEDICAL ASSOCIATION
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Dear Ms Ross

Draft Direct Admission to a Hospital Inpatient Unit Policy Guideline for Consultation

The AMA(SA) appreciates the opportunity to comment on the above policy regarding direct admissions.

The AMA(SA) approves in principle of direct admission where this can be achieved in a safe and efficient manner without delays in necessary treatment or any unintended impact on the inpatients at the time of the transfer/admission. Such impact would result from a diversion of necessary medical and nursing resources to the incoming patient at a time other inpatient needs are more critical.

This document states, *'Consultants, Senior Registrars and Fellows can authorise admission'.* The level of authorisation may in practical terms be too 'top heavy' for efficient administration. Whilst there needs to be a control over bed access, it should be acknowledged that in some settings about 80% of admissions are with more junior registrars.

Therefore the practical implementation needs to be tested/examined in more detail or this policy may fail as a consequence of the delegated persons criteria. Also there may be an unintended and unnecessary delay in arranging the transfer if the referring doctor needs to wait for this level of seniority. Such delays would lead to increased frustration by the referring doctors as well as taking them away from more necessary clinical duties to their patients.

In principle therefore, the 'medical trigger' to initiate transfer and provide necessary clinical information should be the main tasks of the clinician. The administration duties, finding beds, tracking down the necessary delegated doctor to receive a patient, should be the task of administration staff if direct contact between senior medical staff is not possible or a time delay is expected.

There is also a comment from our members that staffing resources need to be directed to activity. If the wards are going to be involved in more direct admissions, then this must be recognised with the redirection of staffing hours (medical hours and level of staffing) to accommodate the increased activity. Whether this is a re-direction from the Emergency Department, or if such ED staff are 'quarantined', then additional medical staffing at the necessary senior level being rostered in the wards is a matter requiring further examination.

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Whatever the outcome of that analysis, enough medical resources/staff of the necessary level of training and expertise need to be provided to match any increase in expected workload as a result of the policy. Presently, there are areas of overwork and demand stress on medical staff, particularly out of normal hours. Overworked ward teams will not be able to cope without proper additional staff being available.

The requirement to see a patient within one hour is onerous. Many of these patients are stable and 'up-transfers'. When a single resus may take 1-2 hours these patients may have to wait as a matter of clinical priority, particularly in our more 'major' rural hospitals. At such times, qualified registered nursing staff are skilled and should be able to monitor a patient transfer and call for the necessary medical support depending on the patient's clinical condition.

As a general comment, consideration must be given to the circumstances in rural hospitals where GPs provide much of the inpatient care. The transfer of the policy to this setting is worthy of consideration and more consultation with the rural doctors.

Yours sincerely

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CHIEF EXECUTIVE