**Discharge (event end)**

A discharge (event end) is defined as:

* a patient physically leaving a healthcare facility (eg, discharged, transferred or died)
* the process of documentation that changes the status or service provided to a patient during an admitted episode of care (eg, statistical discharge).

**Please note:** the following definitions and event end types apply to NMDS only, as definitions and application of some event end types may differ when reporting to other national collections (eg, NNPAC, PRIMHD).

**DA Discharge to an acute facility**

DA – introduced in 1995 with definitions that related to specific diagnosis related groups (DRGs).

Event end type DA is to be used where an admitted patient is discharged/transferred to an acute healthcare facility. Where patients are discharged/transferred to one of the listed facilities, event end type DA should be used.

Facility name and code:

* Auckland City Hospital (3260) – facility code 3260 should be used for ‘transfers to’ and ‘transfers from’ Starship Hospital. Please do not use facility code 3239 for NMDS reporting.
* Christchurch Hospital (4011)
* Dunedin Hospital (4211)
* Gisborne Hospital (3411)
* Grey Base Hospital (5911)
* Hawkes Bay Hospital (3612)
* Hutt Valley Hospital (5812)
* Middlemore Hospital (3214)
* Nelson Hospital (3911)
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* Southland Hospital (4511)
* Taranaki Base Hospital (4711)
* Tauranga Hospital (4911)
* Timaru Hospital (4411)
* Waikato Hospital (5311)
* Wairarapa Hospital (5511)
* Wellington Hospital (5811)
* Whanganui Hospital (5711)
* Whangārei Hospital (4111)

DA **is not** to be used for discharge/transfers to another healthcare facility that **is not listed**. Event end type DT or one of the other event end types should be used if applicable.

The event end datetime for a discharge/transfer to an acute healthcare facility is when the patient physically leaves the healthcare facility. There will be a gap between these events, which is the time taken to transfer from one facility to another. It is not expected that these events are contiguous. This also applies to patient retrievals where a retrieval team is sent to another facility to retrieve and transport a patient back to their facility.

See also Event end type ‘DTDischarge of non-psychiatric patient to another healthcare facility’.

Patients transferred to an acute healthcare facility for a sameday procedure do not need to be discharged and readmitted when the patient is returning sameday during an admitted episode of care. For example, a patient in facility A transfers to facility B for a procedure (eg, investigation and/or treatment with or without GA) and transfers back to facility A sameday. Facility A does not need to discharge and readmit the patient.

Where a patient transfers to another acute healthcare facility for a procedure (eg, investigation and/or treatment with or without GA) that requires an overnight stay, the patient will need to be discharged/transferred. If the patient is transferred back to the original acute healthcare facility a day or so later this will be a new admission.

Procedures performed at another hospital during an admitted episode of care (transfers).

Same day procedures performed at another hospital during an admitted episode of care may be reported to either NNPAC or NMDS but not both national collections, as this would result in duplicate reporting. Each hospital will only report to the national collection the service/treatment they provide to the patient. Do not report the service/treatment provided by another public hospital (they will do their own reporting). For example, patient in facility A transfers to facility B for a PET Scan and transfers back to facility A sameday. Facility B will report the PET Scan activity to NNPAC, unless it is performed under GA, a sameday admission/discharge will be required.

Where a patient transfers to another acute facility for a sameday procedure and is discharged directly from the other acute facility, the patient will need to be discharged on the datetime of transfer and the other acute facility may need to create an admission. For example, a patient in facility A transfers to facility B for a sameday procedure (eg, investigation and/or treatment with or without GA) and is discharged from facility B. Facility A needs to discharge/transfer and facility B may need to admit and discharge as per the NMDS admission rule (ie, event duration is three hours or more or requires a GA).

**DC Psychiatric patient discharged to community care**

Event end type DC is used where a mental health patient has been discharged to community care.

**DD Died**

Event end type DD is used where a patient has died during an admitted episode of care.

The event end datetime is the datetime of death from the hospital record of the death certificate or the date of completion of organ procurement.

When a patient dies and they remain on the ward/unit for several hours after (including overnight) the event end datetime is the datetime of death from the hospital record of the death certificate, not the datetime the deceased patient was moved from the ward/unit.

**DF Change of funder**

DF – introduced 1 July 2000. Event end type DF is a statistical discharge used to record a change in funder for an admitted episode of care (inpatient event).

Event end type DF is used when the funder during an admitted episode of care changes for example, an arranged or elective admission is funded by a private insurer (06) or ACC (A0) and a complication of the surgical/medical care arises, and the patient requires further hospitalisation beyond the care required for the private insurer or ACC funded event.

The event end datetime for the private or ACC funded event is what the clinician reports as the end of the required hospitalisation for the private or ACC funded admitted episode of care.

**DI Self-discharge from hospital, indemnity signed**

Event end type DI is used when a patient self-discharges against clinical advice during an admitted episode of care and signed an indemnity before leaving.

**DL Committed psychiatric patient discharged to leave for more than 14 days**

Event end type DL is used where a committed mental health patients’ period of leave has ended. The committed mental health patient will be put on leave and the event end type DL is used when the period of leave (more than 14 days has ended). When using event end type DL, psychiatric leave end date and leave end code should also be reported.

Where the committed mental health patient returns from leave after 14 days (planned or unplanned) and is readmitted into the psychiatric inpatient ward at the same facility the admit type ‘RL Psychiatric patient returned from leave of more than 14 days’ should be used. As per the Mental Health Act 1992 Section 31 Leave for Inpatients, the leave may be cancelled at any time.

**DN Psychiatric remand patient discharged without committal**

Event end type DN is used where a court or clinician has made the decision that a patient be remanded/detained in hospital for assessment (medical report) and/or treatment and is then later discharged.

**DO Discharge of a patient for organ donation**

DO – introduced in 1997. Event end type DO is a statistical discharge used to record a change in the status of the patient during an admitted episode of care (inpatient event).

Event end type DO is used where a patient is declared brain dead and is for organ procurement (donation). The event end datetime for a patient statistically discharged for organ procurement is the datetime the patient is declared brain dead from the hospital record of the death certificate.

All events with event end type DO will have another inpatient event for the organ procurement, even if the organ procurement is unsuccessful. The subsequent organ procurement event will have an event end type DD and the event end datetime is when organ procurement is complete.

**DP Psychiatric patient transferred for further psychiatric care**

Event end type DP is used where a mental health patient has been discharged/transferred to another healthcare facility for mental health care.

**DR Discharge ended routinely**

Event end type DR is used where a patient is discharged from an admitted episode of care to their home (including hospital in the home) or to their usual place of residence (eg, rest home/aged care facility).

**DS Self-discharge from hospital, no indemnity signed**

Event end type DS is used when a patient self-discharges against clinical advice during an admitted episode of care and does not sign an indemnity before leaving.

**DT Discharge of patient to another healthcare facility**

Event end type DT is used where a patient is discharged/transferred to another healthcare facility that is not listed under event end type DA.

The event end datetime for a discharge/transfer to another healthcare facility is when the patient physically leaves the healthcare facility. There will be a gap between these events, which is the time taken to transfer from one facility to another. It is not expected that these events are contiguous. This also applies to patient retrievals where a retrieval team is sent to another facility to retrieve and transport a patient back to their facility.

Patients transferred to another healthcare facility (ie, public or private) for a sameday procedure do not need to be discharged and readmitted when the patient is returning sameday during an admitted episode of care. For example, a patient in facility A transfers to facility B for a sameday procedure (eg, investigation and/or treatment with or without GA) and transfers back to facility A sameday. Facility A does not need to discharge and readmit the patient.

Where a patient transfers to another facility (ie, public or private) for a sameday procedure and is discharged directly from the other facility, the patient will need to be discharged on the datetime of transfer and the other facility may need to create an admission. For example, a patient in facility A transfers to facility B for a sameday procedure (eg, investigation and/or treatment with or without GA) and is discharged from facility B. Facility A needs to discharge/transfer and facility B may need to admit and discharge as per the NMDS admission rule (ie, event duration is three hours or more or requires a GA).

Where a patient transfers to another facility (ie, public or private) for a procedure (eg, investigation and/or treatment with or without GA) that requires an overnight stay, the patient will need to be discharged/transferred. If the patient is transferred back to the original facility a day or so later this will be a new admission.

Procedures performed at another hospital during an admitted episode of care (transfers).

Same day procedures performed at another hospital during an admitted episode of care (transfers) may be reported to either NNPAC or NMDS but not both national collections, as this would result in duplicate reporting. See Procedure Coding/Reporting Guidelines.

Procedure Coding/Reporting Guidelines

* Each hospital will only report to the national collection the service/treatment they provide to the patient. Do not report the service/treatment provided by another public hospital (they will do their own reporting). For example, patient in public facility A transfers to public facility B for a PET Scan and transfers back to facility A sameday. Facility B will report the PET Scan activity to NNPAC, unless it is performed under GA, a sameday admission/discharge will be required.
* If a patient is transferred (not discharged) from a public hospital during an admitted episode of care to a private outpatient facility for investigations and/or treatment and then transfers back to the public hospital same day, the public hospital should clinically code the procedure(s) performed at the private facility in the public hospital admitted episode of care in accordance with the Australian Coding Standards (ACS).
* If a patient is transferred (not discharged) from a public hospital during an admitted episode of care to a private inpatient facility (eg, Southern Cross) for investigations and/or treatment with or without GA and then transfers back to the public hospital same day, the private hospital should admit/discharge as per the NMDS admission rule (ie, event duration is three hours or more or requires a GA) and report the procedure(s) performed at the private facility.

See also Event end type ‘DA Discharge to an acute facility’.

**DW Discharge to other service within same facility**

DW – introduced 1 July 1995 for services that are required to be identified separately.

Event end type DW is a statistical discharge used to record a change in services provided to a patient during an admitted episode of care (inpatient event).

Event end type DW is to be used where a patient is statistically discharged (internal transfer) from medical, surgical, maternity or the emergency department **to** disability and health of older people (eg, AT&R), disability support services or mental health services, or **from** disability and health of older people (eg, AT&R), disability support services or mental health services to medical, surgical, maternity or the emergency department during an admitted episode of care.

* Disability and health of older people and Disability support service health specialty codes are in the range D00-D84.
* Mental health services health specialty codes are in the range Y00-Y99.

The event end datetime for a patient statistically discharged between disability and health of older people, disability support services or mental health services and medical, surgical, maternity or the emergency department is when the patient transfers into the care of one of these health specialities.

DW event end type is not to be used for internal transfers between surgical, medical and maternity services (with or without a LMC).

Maternity

From 1 July 2009 maternity events became casemix funded for designated secondary maternity facilities. This led to a change in the way facilities reported maternity events to the NMDS. The following examples clarify the reporting requirements.

Where a maternity (obstetric) patient is provided with antenatal, delivery and postnatal services at the same facility there may be internal ward transfers within the hospital, however, only one event is to be reported to the NMDS.

Where a patient is admitted under a maternity specialty and during their stay requires an internal transfer to a medical/surgical specialty within the same facility (or vice versa) this should be reported to the NMDS as one event.

Disability and Health of Older People examples:

A patient is admitted to a healthcare facility with a medical (eg, acute stroke) or surgical (eg, fractured hip) condition. If a clinical decision is made to transfer the patient to an AT&R unit for rehabilitation (ie, HSC D01) within the same healthcare facility there must be a statistical discharge (Event end type of 'DW') from the medical/surgical specialty with a new admission to the AT&R unit.

If a medical/surgical patient who has transferred (statistical discharge DW) to an AT&R unit develops the need for a significant medical or surgical intervention, (which is above and beyond what would be expected to be delivered under an AT&R specialty) and transfers back into the care of a medical/surgical speciality, there should be a statistical discharge (Event end type of 'DW') from the AT&R unit with a new admission to the appropriate medical/surgical health specialty. The patient may then be transferred from medical/surgical back to the AT&R unit sameday or days later for continuing or new AT&R services – this will be another statistical discharge (DW).

If a patient who has transferred (statistical discharged DW) to an AT&R unit requires sameday renal dialysis or attends an outpatient appointment during the AT&R admitted episode of care this does not require a statistical discharge, as the activity (renal dialysis, OP attendance) will be reported to NNPAC.

Please note the use of event end type DW may differ in other national collections (eg, NNPAC).

**Note**: National collections are aware that models of care are changing, as patients may be admitted directly to disability and health of older people or disability support services with procedures performed during the admitted episode of care. Discussions are being had with various groups to determine if changes are needed in reporting requirements to ensure appropriate purchase unit codes are allocated. Therefore, in the meantime please report as per the requirements above.

**Emergency Department Event End Types**

Emergency department event end types were introduced 1 July 2007. These ‘E’ event end types are to be used for emergency department events only, including emergency department adjunct unit/area events.

These E event end types reported to NMDS are used where the event duration is three hours or more as per the NMDS admission rule, except for event end type ED.

**EA Discharge from emergency department acute facility to another acute healthcare facility**

Event end type EA is used where a patient is discharged/transferred from the emergency department (including ED adjunct units) to another acute healthcare facility. Where patients are discharged/transferred to one of the listed facilities, event end type EA should be used.

Facility name and code:

* Auckland City Hospital (3260) – facility code 3260 should be used for ‘transfers to’ and ‘transfers from’ Starship Hospital. Please do not use facility code 3239 for NMDS reporting.
* Christchurch Hospital (4011)
* Dunedin Hospital (4211)
* Gisborne Hospital (3411)
* Grey Base Hospital (5911)
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* Waikato Hospital (5311)
* Wairarapa Hospital (5511)
* Wellington Hospital (5811)
* Whanganui Hospital (5711)
* Whangārei Hospital (4111)

The event end datetime for a discharge/transfer to another acute healthcare facility will be when the patient physically leaves the emergency department.

See also Event end type ‘ET Discharge from Emergency department acute facility to another healthcare facility’.

**ED Died while still in emergency department acute facility**

Event end type ED is used when a patient has died in the emergency department, regardless of event duration. The event end datetime is the datetime of death from the hospital record of the death certificate.

**EI Self-discharge from an emergency department acute facility with indemnity signed**

Event end type EI is used when a patient self-discharges from the emergency department (including ED adjunct units) against clinical advice and signed an indemnity before leaving.

**ER Routine discharge from an emergency department acute facility**

Event end type ER is used where a patient is discharged from the emergency department (including ED adjunct units) to their home or usual place of residence (eg, rest home/aged care facility).

**ES Self-discharge from an emergency department acute facility without indemnity signed**

Event end type ES is used when a patient self-discharges from the emergency department (including ED adjunct units) against clinical advice and does not sign an indemnity before leaving.

**ET Discharge from emergency department acute facility to another healthcare facility**

Event end type ET is used where a patient is discharged/transferred from the emergency department (including ED adjunct units) to another healthcare facility that is not listed under event end type EA.

The event end datetime for a discharge/transfer to another healthcare facility will be when the patient physically leaves the emergency department.

See also Event end type ‘EA Discharge from Emergency department acute facility to another acute healthcare facility’.

**NMDS Event End Types Mapped to Separation (Discharge) Modes**

The NMDS event end types are mapped to separation (discharge) modes, which are required for Australian Refined Diagnosis Related Groups (AR-DRGs).

|  |  |
| --- | --- |
| **Current NMDS Event End Types** | **Separation (Discharge) Modes**  |
| **DA** – Discharge to an acute facility | **01** – Discharge/transfer to an acute hospital |
| **N/A** | **02** – Discharge/transfer to a residential ageing service |
| **DC** – Psychiatric patient discharged to community care | **09** – Home/other |
| **DD** – Died | **08** – Died |
| **DF** – Change of funder | **05** – Statistical separation – type change |
| **DI** – Self-discharge from hospital, indemnity signed | **06** – Left against medical advice |
| **DL** – Committed psychiatric patient discharged to leave for more than 14 days | **09** – Home/other |
| **DN** – Psychiatric remand patient discharged without committal | **09** – Home/other |
| **DO** – Discharge of a patient for organ donation | **08** – Died |
| **DP** – Psychiatric patient transferred for further psychiatric care | **03** – Discharge/transfer to a psychiatric hospital |
| **DR** – Discharge ended routinely | **09** – Home/other |
| **DS** – Self-discharge from hospital, no indemnity signed | **06** – Left against medical advice |
| **DT** – Discharge of patient to another healthcare facility | **04** – Discharge/transfer to other health care accommodation |
| **DW** – Discharge to other service within same facility | **05** – Statistical separation - type change |
| **EA** – Discharge from emergency department acute facility to another acute healthcare facility | **01** – Discharge/transfer to an acute hospital |
| **ED** – Died while still in emergency department acute facility | **08** – Died |
| **EI** – Self-discharge from an emergency department acute facility with indemnity signed | **06** – Left against medical advice |
| **ER** – Routine discharge from an emergency department acute facility | **09** – Home/other |
| **ES** – Self-discharge from an emergency department acute facility without indemnity signed | **06** – Left against medical advice |
| **ET** – Discharge from emergency department acute facility to another healthcare facility | **04** – Discharge/transfer to other health care accommodation |