Discharge date

Important note: This is an archived metadata standard from the AIHW Knowledgebase. For current metadata standards and related information please access METeOR, the AIHW's Metadata Online Registry at http://meteor.aihw.gov.au

Identifying and Definitional Attributes

Data Dictionary:	NHDD		
Knowledgebase ID:	000043	Version number:	1
Metadata type:	DATA ELEMENT		
Registration Authority:	NHIMG	Admin status:	SUPERSEDED
		Effective date:	30-JUN-93

Definition: Date on which patient was formally separated from the establishment or on which status transfer occurred (see below).

Separation includes:

- discharge from the establishment (if recognised and stated as such);

- statistical separation, defined as leaves of absence (any type including leave for special care and unauthorised leave) which exceed seven days for in-patients of acute hospitals and private psychiatric hospitals and ten days for in-patients of public psychiatric hospitals;

- death;

- transfer to another in-patient institution, if the patient does not return to the original institution within seven days (acute hospitals and private psychiatric hospitals) or ten days (public psychiatric hospitals);

- actual or statistical separation and readmission on status transfer between any of the following categories:

Acute hospitals and private psychiatric hospitals

1. nursing home type (acute hospitals)
2. rehabilitation (acute hospitals)
3. other.

Context: Institutional health care: required to identify the period in which an admitted patient hospital stay or episode occurred and for derivation of length of stay.

Relational and Representational Attributes

Datatype: Numeric

Representational form: DATE

Representation layout: DDMMYY

Minimum Size: 6

Maximum Size: 6

Data Domain: NOVAL Valid dates

Related metadata: is used in the calculation of Length of stay version 1
has been superseded by Discharge date version 2
is used in the derivation of Diagnosis related group version 1
is used in the derivation of Separations version 2

Administrative Attributes

Source Document:

Source Organisation: National Health Data Committee

Comments: The effects of definition and recording of leave periods on discharge policy is discussed in relation to data element Leave periods.

Acute hospitals and private psychiatric hospitals

The Morbidity Working Party recommended that change of status (as measured by Type of episode of care) be ideally accompanied by discharge and readmission. This would result in separate records for acute episodes and non-acute episodes (nursing home type or rehabilitation). For further discussion, refer to comment on data element Type of episode of care.

Hindle (1988a) has examined the changes required to hospital morbidity systems to support the use of Diagnosis Related Group casemix information systems and costing systems. The Diagnosis Related Group system was designed to deal with in-patients who undergo a complete episode of acute care at a single hospital.

Patients who remain in hospital for non-acute nursing care or rehabilitation following their acute care should not have the non-acute portion of their stay classified into a Diagnosis Related Group.

Similarly, Hindle (1988b) argues that Diagnosis Related Group information and costing systems must exclude patients who

required no acute care during the entire episode. The typical case is the Nursing Home Type Patient, who is accommodated in a hospital because there is no alternative facility. Many country hospitals are, in effect, both acute care hospitals and nursing homes. There are also some metropolitan hospitals which have non-acute care facilities on site, such as rehabilitation or psychiatric units, because it is convenient to link acute and non-acute activities. For whatever reason, non-acute episodes have quite different cost structures, and must be separated from Diagnosis Related Groups. Hindle argued that:
'It makes no sense to assign non-acute in-patients to Diagnosis Related Groups. Take for example, the elderly patient who was admitted for a fracture, and then subsequently remains indefinitely for nursing care. In some States, this type of patient could be assigned to a surgical Diagnosis Related Group; even though his or her length of stay might be 1000 days, and the average length of stay for that Diagnosis Related Group will only be a few days. Most of the days of stay and resultant costs have no connection with the original in-patient episodes: the Diagnosis Related Group, lasting only a few days; and a prolonged period of non-acute care for which the Diagnosis Related Group classification is not suitable.

'In future, it will be necessary to split this kind of episode into acute and non-acute parts. This is, in fact, already done in a few circumstances; such as when a patient is admitted to hospital X for non-acute care, and subsequently transferred to hospital Y for acute care. Moreover, if the patient were then transferred back to hospital X after the acute episode at hospital Y, another discharge and admission would be counted. Why should the workload be measured in a completely different way if the patient remains in hospital X for the acute episode'

'It follows that discharge abstracting systems must not only allow the acute part of the episode to be counted as a Diagnosis Related Group, but also ensure that the non-acute days are separately counted. The latter are products of the hospital, like the Diagnosis Related Group; but they are additional to the Diagnosis Related Group.'

Hindle recommended that acute and non-acute phases of the episode should be treated as separate episodes. The Morbidity Working Party agreed that this was the preferred approach (see comment on item P21) and recommended that those States and Territories which did not discharge and readmit upon status transfer should make provision for recording at least two status

changes (according to the categories specified for item P21 'Type of episode of care') and the dates on which those status changes occurred.

A minimum of two change-of-status fields would be necessary to cope with patients who go from acute care to rehabilitation to nursing home type care. In this approach, the principal diagnosis relates to the acute episode. The major drawback of this approach is that there may be considerable time lags (many months or even years) before the acute episode enters the morbidity collection.

Public psychiatric hospitals

Discharge policies for public psychiatric hospitals vary between the States in relation to the treatment of leave periods (discussed under item P27) and of legal status change. Victoria discharges patients of psychiatric hospitals and readmits them on change of status under the Mental Health Act 1986 (Vic) (but record this under a data item for discharge status). Other States do not do this. For psychiatric units in acute public hospitals, Victoria currently discharges and readmits patients who take weekend leave.

For the purposes of the National Minimum Data Set, change of status under the Mental Health Act is not considered to result in discharge and readmission for in-patients of public psychiatric hospitals.

For the purposes of the data set, Victoria will statistically link patient episodes generated by acute hospital psychiatric patients who are discharged and readmitted for weekend leave, and patient episodes resulting from change of status under the Mental Health Act 1986 (Vic). (See item P27 'Leave periods' for further comments.)

Nursing homes

Nursing home patients are not discharged and readmitted on change of Resident Classification Instrument level.

Statistical discharge at year end

Hindle (1988) proposed that a discharge form be completed for each continuing non-acute in-patient at the end of the year (or other reporting period) so that the occupied bed-days for that patient are included in each reporting year.

This proposal is unnecessary for Victorian and South Australian acute hospitals, as each admission is transmitted to the central database after that event. Any admission unmatched by a discharge is therefore a remaining in-patient at year end.

The Morbidity Working Party considered Hindle's proposal and rejected it.

Hindle's proposal is unnecessary for public psychiatric hospitals as all States apart from New South Wales have an admission and discharge reporting system. The annual year-end census recommended for New South Wales by the Psychiatric Working Party will count bed-days for continuing patients at the end of the year.

This proposal is also unnecessary for nursing homes and hostels, as in the Commonwealth Department of Community Services and Health database each admission is transmitted to the central database after that event. Any admission unmatched by a discharge is therefore a remaining in-patient at the end of the year.

Data Element Links

Information Model Entities linked to this Data Element

NHIM — Exit / leave from service event

Data Agreements which include this Data Element

NMDS - Admitted patient care — From 01-Jul-89 to 30-Jun-93