Episode of admitted patient care—condition onset flag, code N

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Episode of admitted patient care—condition onset flag, code N

Identifying and definitional attributes

Metadata item type:	Data Element
Short name:	Condition onset flag
Synonymous names:	COF
METEOR identifier:	686100
Registration status:	Health!, Standard 25/01/2018 Tasmanian Health, Standard 06/05/2021
Definition:	A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the admitted patient episode of care, as represented by a code.

Data element concept attributes

Identifying and definitional attributes

Data element concept:	Episode of admitted patient care—condition onset flag
METEOR identifier:	686102
Registration status:	Health!, Standard 25/01/2018 Tasmanian Health, Standard 06/05/2021
Definition:	A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the admitted patient episode of care.
Context:	Health services
Object class:	Episode of admitted patient care
Property:	Condition onset flag

Value domain attributes

Identifying and definitional attributes

Value domain:	Condition onset flag code N
METEOR identifier:	686105
Registration status:	Health!, Standard 25/01/2018 Tasmanian Health, Standard 06/05/2021
Definition:	A code set representing the onset of a diagnosed condition relative to the beginning of the episode of care.

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
	Value	**Meaning**
Permissible values:	1	Condition with onset during the episode of admitted patient care

	2	Condition not noted as arising during the episode of admitted patient care
Supplementary values:	9	Not reported

Collection and usage attributes

Guide for use:

CODE 1 (COF 1) Condition with onset during the episode of admitted patient care

- a condition which arises during the episode of admitted patient care and would not have been present or suspected on admission.

Includes:

- A condition resulting from misadventure during surgical or medical care in the current episode of admitted patient care (e.g. accidental laceration during procedure, foreign body left in cavity, medication infusion error).
- An abnormal reaction to, or later complication of, surgical or medical care arising during the current episode of admitted patient care (e.g. postprocedural shock, disruption of wound, catheter associated urinary tract infection (UTI)).
- A condition newly arising during the episode of admitted patient care (e.g. pneumonia, rash, confusion, UTI, hypotension, electrolyte imbalance).
- A condition impacting on obstetric care arising after admission, including complications or unsuccessful interventions of labour and delivery or prenatal/postpartum management (e.g. labour and delivery complicated by fetal heart rate anomalies, postpartum haemorrhage).
- For neonates, this also includes the condition(s) in the birth episode arising during the birth event (i.e. the labour and delivery process) (e.g. respiratory distress, neonatal aspiration, conditions associated with birth trauma, newborn affected by delivery or intrauterine procedures).
- Disease status or administrative codes arising during the episode of admitted patient care (e.g. cancelled procedure, multi-resistant *Staphylococcus aureus* (MRSA)).

CODE 2 (COF 2) Condition not noted as arising during the episode of admitted patient care

- a condition previously existing or suspected on admission such as the presenting problem, a comorbidity or chronic disease.

Includes:

- A condition that has not been documented at the time of admission, but clearly did not develop after admission (e.g. newly diagnosed diabetes mellitus, malignancy and morphology).
- A previously existing condition that is exacerbated during the current episode of admitted patient care (e.g. atrial fibrillation, unstable angina).
- A condition that is suspected at the time of admission and subsequently confirmed during the current episode of admitted patient care (e.g. pneumonia, acute myocardial infarction (AMI), stroke, unstable angina).
- A condition impacting on obstetric care arising prior to admission (e.g. venous complications, maternal disproportion).
- For neonates, this also includes the condition(s) in the birth episode arising before the labour and delivery process (e.g. prematurity, birth weight, talipes, clicking hip).
- Disease status or administrative codes not arising during the episode of admitted patient care (e.g. history of tobacco use, duration of pregnancy, colostomy status).
- Outcome of delivery (Z37) and place of birth (Z38) codes.

CODE 9 (COF 9) Not reported

The condition onset flag could not be reported due to limitations of the data management system.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Data element attributes

Collection and usage attributes

Guide for use:

Assign the relevant COF value only to ICD-10-AM codes assigned in the principal diagnosis and additional diagnosis fields for the National Hospital Morbidity Database collection.

Sequencing of ICD-10-AM codes must comply with the Australian Coding Standards and therefore codes should not be re-sequenced in an attempt to list codes with the same COF values together.

The principal diagnosis code is always assigned COF 2. The exception to this is neonates in their admitted birth episode in that hospital where codes sequenced as the principal diagnosis may be assigned COF 1 if appropriate.

For neonates, where a condition in the admitted birth episode is determined to have arisen during the birth event (i.e. labour and delivery process), these conditions should be considered as arising during the episode of admitted patient care and assigned COF 1.

When a single ICD-10-AM code describes multiple concepts (i.e. a combination code) and any concept within that code meets the criteria of COF 1, assign COF 1.

When it is difficult to decide if a condition was present at the beginning of the episode of care or if it arose during the episode, assign a COF 2.

Where multiple conditions/sites are classifiable to a single ICD-10-AM code that meets the criteria for different condition onset flag values, assign COF 1; excepting where the condition/site is sequenced as the principal diagnosis and must be assigned COF 2.

Explanatory notes:

The COF value assigned to external cause, place of occurrence and activity codes should match that of the corresponding injury or disease code. Injuries which occur during the admitted episode of care but not on the hospital grounds (e.g. hospital in the home (HITH)) should be assigned COF 1 as 'arising during the episode of admitted patient care'.

The COF value assigned to morphology codes should match that on the corresponding neoplasm code.

The COF value on Z codes related to the outcome of delivery on the mother’s record (Z37), or the place of birth on the baby's record (Z38) should always be assigned COF 2.

The COF value on aetiology and manifestation (dagger and asterisk) codes should be appropriate to each condition and therefore the dagger and asterisk codes may be assigned different COF values.

An episode of admitted patient care includes all periods when the patient remains admitted and under the responsibility of the health care provider, including periods of authorised leave and HITH. Where diagnoses arising during this period meet the criteria for ACS 0002 *Additional diagnoses*, clinical coders should apply the COF Guide for use instructions and assign COF 1 if appropriate. Unauthorised leave does not fall under the responsibility of the health care provider and conditions arising during this time should be assigned COF 2.

Where an admission has multiple admitted patient episode 'care type' changes (e.g. acute to rehabilitation), COF assignment should be relevant to each episode. A condition arising in an episode should be assigned COF 1. If care for that condition continues in subsequent episodes those conditions should be assigned COF 2.

Collection methods:

A condition onset flag should be recorded and coded upon completion of an episode of admitted patient care.

Comments: The condition onset flag is a means of differentiating those conditions which arise during, from those arising before, an admitted patient episode of care. Having this information will provide an insight into the kinds of conditions patients already have when entering hospital and those conditions that arise during the episode of admitted patient care. A better understanding of those conditions arising during the episode of admitted patient care may inform prevention strategies particularly in relation to complications of medical care.

The flag only indicates when the condition had onset, and cannot be used to indicate whether a condition was considered to be preventable.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references: Supersedes Episode of admitted patient care—condition onset flag, code N Health!, Superseded 25/01/2018

Implementation in Data Set Specifications: Admitted patient care clinical related data elements (TDLU) cluster Tasmanian Health, Standard 18/05/2021

Admitted patient care NMDS 2018-19 Health!, Superseded 12/12/2018
Implementation start date: 01/07/2018
Implementation end date: 30/06/2019

Admitted patient care NMDS 2019-20 Health!, Superseded 18/12/2019
Implementation start date: 01/07/2019
Implementation end date: 30/06/2020

Admitted patient care NMDS 2020–21 Health!, Superseded 05/02/2021
Implementation start date: 01/07/2020
Implementation end date: 30/06/2021

Admitted patient care NMDS 2021–22 Health!, Superseded 20/10/2021
Implementation start date: 01/07/2021
Implementation end date: 30/06/2022

Admitted patient care NMDS 2022–23 Health!, Standard 20/10/2021
Implementation start date: 01/07/2022
Implementation end date: 30/06/2023