Coding Notes

Hospital Acquired Diagnosis HADx

Dr. Terri Jackson, Associate Professor, University of Melbourne, has been visiting the ESRI during the month of June working with us and HIQA on a project looking at the Hospital Acquired Diagnosis (HADx) information submitted through HIPE. Dr. Jackson is an international expert in this area and here she gives an overview on this type of information and its development and use internationally.

Recording hospital-acquired diagnoses is new, not just in Ireland, but in most of Australia (where I come from) and in most states in the US. The Canadians seem to have started recording 'diagnosis types' (including their 'Type 2' diagnosis acquired after admission). Victoria picked it up in the mid-1980s with code prefixes that assigned a 'C' (for complication) on diagnoses that weren't apparent on admission, along with 'P's' and 'A's' and 'M's' for other diagnosis types.

The US States of New York and California have been collecting what they call 'present on admission' (POA) flags for at least a decade. This works the other way around, with co-morbidities (conditions the patient already had) flagged, and a 'not present on admission' flag indicating the diagnosis was hospital-acquired. It was research in the early 1990s on using coded data to identify complications of hospital care that demonstrated that a list of diagnosis codes couldn't distinguish between those the patient was admitted with, and those that began after they were admitted to hospital.

Most US hospitals were required to begin recording their POA flag from October 2007, and Australia adopted the 'condition-onset flag' (COF) nationwide in 2008 (with some States still struggling to record what we call the COF). Ireland joined this group in 2011, with

the 2012 HIPE data reflecting the first full year of recording.

Legislators in the US decided that Medicare should stop paying for some kinds of hospital-acquired conditions, and have published a list of diagnosis codes that no longer bump a patient's DRG into a higher-paying category (see http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ HospitalAcqCond/ downloads/hacfactsheet.pdf). Most other countries are using the indicator for research and quality improvement in hospitals.

In Australia, I work in a University Clinical Research Centre based in a hospital. We're using the COF to help us identify where our hospital has higher rates of hospital-acquired diagnoses than the state-wide average. Heads of clinical departments will soon get monthly reports on rates of particular conditions they've chosen as being relevant to their particular clinical specialty. We're also working together to test quality improvement strategies.

Hospital Acquired Diagnosis (HADx) Continued

Our Director of Pharmacy, for example, wants to test different ways of reviewing patient medications on the ward. Because the coded data can tell us how many drug-related HADx there were before he introduced targeted medication reviews on particular wards, we can check patients on those same wards at 2 months, 4 months and 6 months to see if we're getting fewer drug-related complications.

Our Director of Medical Services is concerned about our readmission rate, and we're working together to find out how many readmissions result from a complication of the patient's first admission, compared with those that result from inadequate handover, or poor follow-up care in the community.

We've begun to discuss who are our 'benchmark' hospitals—who has a similar case mix to our hospital, and a similar range of services—so that we can set up data comparisons for different types of surgery, for birth episodes, and for other forms of inpatient care. This way we can begin to learn how low we can get our complication rates by comparing our care patterns with theirs, and adopting those that seem to give the best results.

We also need to know which cases are the ones that happened in this episode, in our hospital. Even clear 'Y' and 'T' codes that indicate complications of surgical and medical care won't distinguish between surgical misadventures at another hospital that were present on admission to our hospital.

So next time you find a note that a patient developed signs of a urinary tract infection when there was no mention of infection on admission records, consider how useful it might be to doctors and nurses in future to develop better guidelines on, say, urinary catheters, if you record that diagnosis as 'hospital acquired'.
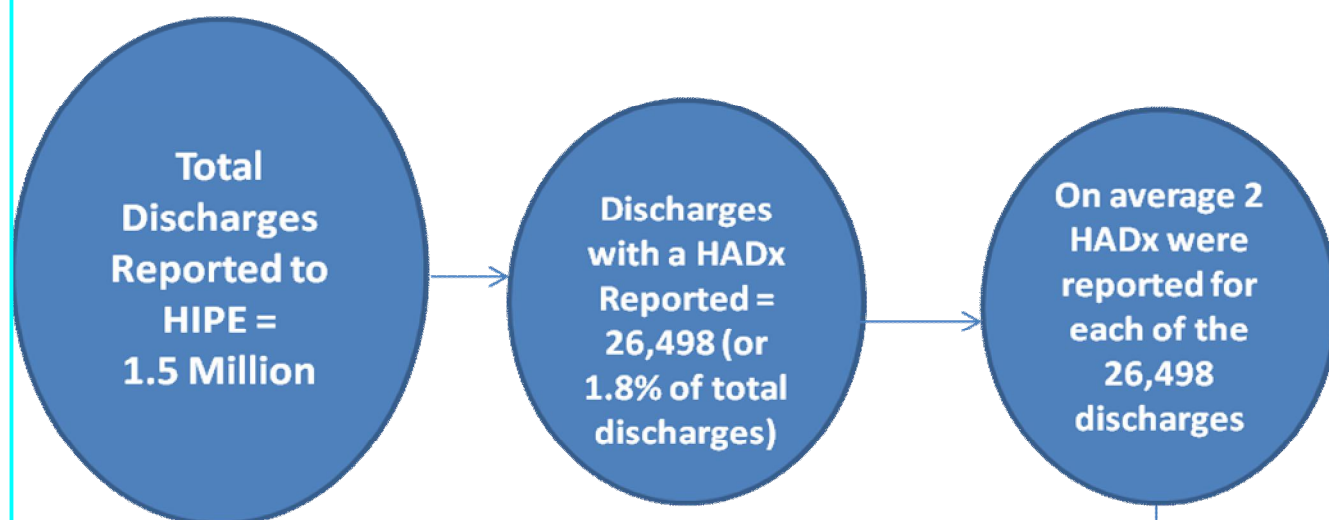
Terri Jackson
Associate Professor, University of Melbourne and
Visiting Scholar, ESRI, June 2013

THANK YOU!

Many thanks to everyone for once again the phenomenal efforts to get the 2012 HIPE data submitted by the deadline. In these challenging times it is fantastic to see the continued dedication and efforts being made throughout HIPE departments across the country. While meeting the deadlines is one challenge, answering coding queries from the ESRI is another job done with equal willingness and diligence. All of us working in HIPE are striving to have timely and accurate data and by meeting deadlines and ensuring data quality through answering queries, running The Checker we can all ensure we achieve this goal. With all the other tasks demanded by the role we really appreciate all the hard work. Take a bow!

Reporting of Hospital Acquired Diagnosis (HADx) Indicator to HIPE. 2012 File

Total Discharges Reported to HIPE = 1.5 Million

→

Discharges with a HADx Reported = 26,498 (or 1.8% of total discharges)

→

On average 2 HADx were reported for each of the 26,498 discharges

↓

Top 10 diagnoses* reported as a HADx			
Rank	**ICD-10-AM 6th Ed Diagnosis Code**	**Description**	**Number reported**
1	Y92.22	Y92.22 Health service area	2,375
2	D64.9	D64.9 Anaemia, unspecified	1,571
3	Z29.2	Z29.2 Other prophylactic pharmacotherapy	822
4	J18.9	J18.9 Pneumonia, unspecified	673
5	Y83.8	Y83.8 Other surgical procedures	624
6	J22	J22 Unspecified acute lower respiratory infection	483
7	N39.0	N39.0 Urinary tract infection, site not specified	480
8	U73.9	U73.9 Unspecified activity	466
9	T81.0	T81.0 Haemorrhage and haematoma complicating a procedure, not elsewhere classified	447
10	I48	I48 Atrial fibrillation and flutter	386

*As diagnoses from Chapter 15 *Pregnancy, Childbirth and the Puerperium* account for over 45% of HADx diagnoses these have been excluded from this table.

Information and Guidance on Hospital Acquired Diagnoses (HADx)

Following on from a review of the data assigned with HADx flag **new edits** will be introduced on the HIPE Portal Data entry system

1. Conditions that are <u>not</u> expected to be assigned the HADx flag:
Edits have been developed for conditions such as Neoplasms (C00 – D48) and congenital anomalies (Q00 – Q99) which by their nature are expected to have been present on admission – even if the diagnosis is first made during the episode of care. The following edit will appear when these codes are entered with a HADx flag:
"Please check HADx flag as this condition is expected to have been present prior to admission".

2. Chronic conditions
The HADx is not expected to be assigned for chronic conditions as due to their nature chronic conditions are generally expected to have been present on admission. Edits are being developed for certain chronic conditions.
The following edit will appear for certain chronic conditions when flagged as HADx:
"Please check that the HADx flag is appropriate in this chronic condition"
If you need clarification on **any** data entry edit please contact us at : HIPEcodingquery@esri.ie.

Note: When more than one code is required to record a condition:
In cases where more than one code is required to code a condition it is possible for each disease code to have a HADx flag assigned or not. Please refer to point 8 and example 10 in ACS 0048 *Condition onset flag*. Please also refer to ICS 0048 *Hospital Acquired Diagnosis (HADx) Indicator* example 4 on page 11 (ICS V5.0 2013)

Example 1
Type 2 Diabetic patient admitted with diabetic foot, during the admission the patient developed acute renal failure.

	HADx
Diabetic foot	**PDX**—HADx not applicable
Diabetes with other specified kidney complication ...	No (not flagged as chronic condition)
Acute kidney failure	Yes

The following examples illustrate when a HADx code is or is not assigned

Example 2
Baby born at 36 weeks (3,200g). Initial check – talipes. Nursing staff felt that there was a slight hip click. Baby was unsettled and fusses at breast. Developed jaundice on the second day which was treated with 15 hours of phototherapy. Rx with biliblanket. Physiotherapy review for talipes. Paediatric review on day 3 "L hip subluxatable". For follow up.

	HADx
Pre term infant	**PDX**—HADx not applicable
Talipes	**No** (not flagged - congenital condition)
Jaundice	**Yes**
Subluxatable hip	**No** (not flagged – congenital condition)
Singleton born in hospital ..	**No** (<u>never flagged</u>)

Information and Guidance on Hospital Acquired Diagnoses (HADx)

Example 3

Patient admitted with bone secondaries (spine and ribs). Left mastectomy 10 years ago – infiltrating duct ca. Patient in pain on admission, has not mobilised for several days. Small red pressure area to sacrum on admission. Day 4 ulcer stage 2, continue pressure care. Day 8 some shortness of breath . Investigations Hb80 which was a significant drop from 115 on admission (patient's normal) Anaemic – transfuse packed cells.

	HADx
Bone metastases †	**PDX**—HADx not applicable
Anaemia in neoplastic disease *..........................	**Yes**
Breast primary	**No** (not flagged as condition is not hospital acquired)
Pressure ulcer (stage 1 progressed to stage 2)......	**No** (not flagged as condition was present on admission)

Please note if a malignancy is diagnosed during the current episode of care it is **not** flagged as HADx

Example 4

A type 2 diabetic admitted with menorrhagia for hysterectomy. Other conditions include hyperthyroidism (controlled with eltroxin), hypertension. On day 2 following the procedure there was oozing from the wound and was positive for MRSA. The patient was isolated and treated. BSLs remained stable throughout the episode of care.

	HADx
Menorrhagia...	**PDX**—HADx not applicable
Wound infection following a procedure	**Yes**
Unspecified staphylococcus as the cause of diseases classified to other chapters ..	**Yes**
Methicillin resistant agent..	**Yes**
Removal of other organ	**Yes**
Place of occurrence	**Yes**
Type 2 diabetes with features of insulin resistance	**No**
Hypertension..	**No**

The diabetes and hypertension were present on admission

Examples where HADx is **not** recorded

Example 5

Patient admitted as a day case for OGD and Colonoscopy to investigate ongoing abdominal pain. A polyp was removed from the ascending colon (this didn't explain the cause of the abdominal pain).

	HADx
Abdominal pain..........	**PDX**—HADx not applicable
Colonic Polyp	**No** (the polyp was present on admission)

Example 6

Patient admitted with acute appendicitis. Appendicectomy was performed. While the patient was in hospital a chest x-ray shows a shadow on the lung. The patient didn't have any related symptoms. Arrangements were made for the patient to return for further investigation.

	HADx
Acute appendicitis......	**PDX**—HADx not applicable
Shadow on lung.........	**No**

In the example above the shadow was found on this episode of care but there is no evidence to suggest that the condition was acquired during the current episode of care.

Example 7

Patient with OA of the right hip was admitted for a hip replacement. While the patient was in hospital they had a grand mal seizure. The last epileptic seizure was 3 years ago. Appointment arranged for MRI of the brain.

	HADx
OA hip......................	**PDX**—HADx not applicable
Grand mal seizure......	**No** (this was not a hospital acquired condition)

Public Private bed days and patient status on discharge

One of the most common download questions relates to the setup of the public/ private/ semi-private beds in the hospital for HIPE and their relationship with the public/private status on discharge of the patient. As questions have been raised about this recently, it is important to ensure that this is defined in a standardised way across all the hospitals.

Definitions

Patient status on discharge
Refers to the public/private status of the patient and not to the type of bed occupied. Either public or private must be specified with 1 for Public or 2 for Private.

Number of days in a Public/Private/Semi-Private/ITU etc. Bed
Refers to the number of days spent in a Public, Private, Semi-Private or ITU bed based on the designation of the bed. Typically, the midnight census is used to determine the daily occupancy of a bed.

Temporary Leave Days
Refers to the number of days where the patient is not in the hospital during the stay and is temporarily sent home.

Issues arising

The main issues that arise regarding the collection of these fields occur when they are confused with each other. The type of bed occupied by a patient is not necessarily the same as the patient status to the consultant. It may be the case that the private patients are always in private beds in your hospital (and similar for public patients) but a private patient can be in a public bed and vice versa. For the purposes of HIPE, if a patient is private, it is not implied that the patient must be in a private bed. Also for the purposes of HIPE, the fact that a patient is in a private bed does not mean that the patient's status on discharge is private.

A second issue which arises surrounds the definition of the ITU bed. The category ITU beds includes a series of high dependency type beds such as ICU/ITU/CCU/HDU/NITU. These beds are not designated public, private or semi-private.

The other issues that arise in this area include:

- The patient is always in some class of a bed when they are in hospital.
- In most cases, the private patients occupy private (or semi-private) beds while public patients occupy public beds.
- In the absence of any standardised method of collecting this bed information, the midnight census is used. Using the midnight census means that even where a patient is moved from bed to bed during the day, it is the type of bed occupied at midnight which is recorded. There is an exception to this regarding the recording of ITU beds – see below.
- The total of the number of public, private, semi-private, ITU and the temporary leave days should equal the length of stay of the patient. The HIPE Portal allows for the total to exceed the length of stay by 1 to allow the recording of the bed the patient occupied prior to discharge. There are checks on this in the HIPE Portal.
- Regarding ITU beds, if a patient spends less than 1 day in an ITU bed, the hospitals can optionally record this as 1 day and make a balancing change to the days in public/private/semi-private or temporary leave to ensure the total continues to add up to the length of stay. (see scenarios 2 and 3 opposite)
- A daycase will always have a patient status. The type of bed occupied, by definition, cannot be based on the midnight census but is determined by the last bed occupied by the patient.

Public Private bed days and patient status on discharge(continued)

Scenario	Description
1	Patient is admitted to a public bed on 01/03/2013 and remains in this bed until they are discharged on 10/03/2013. The patient is public to the consultant. **Patient Status = 1 Public**, Length of stay=9, Public days=9, Private days=0, Semi-Private Days=0, ITU Days=0, Temp Leave Days=0
2	Patient is admitted to a public bed on 01/03/2013 and is moved to ITU on the next day. They remain in ICU for 54 hours and are transferred to semi-private bed on 04/03/2013 before midnight. The patient is discharged 08/03/2013. The patient is private to the consultant. In this case, the hospital allocates the days in ITU strictly using the midnight census. **Patient Status = 2 Private**, Length of stay=7, Public days=1, Private days=0, Semi -Private Days=4, ITU Days=2, Temp Leave Days=0
3	Patient is admitted to a public bed on 01/03/2013 and but is moved to ITU on the next day. They remain in ICU for 54 hours and are transferred to semi-private bed on 04/03/2013 before midnight. The patient is discharged 08/03/2013. The patient is private to the consultant. In this case, the hospital wishes to ensure that all stays in ITU are recorded even when the patient does not spend the night in the bed. **Patient Status = 2 Private,** Length of stay=7, Public days=1, Private days=0, Semi -Private Days=3, ITU Days=3, Temp Leave Days=0
4	Private patient is admitted to a private bed as a daycase on 02/03/2013. **Patient Status = 2 Private,** Length of stay=1, Public days=0, Private days=1, Semi -Private Days=0, ITU Days=0, Temp Leave Days=0
5	Private Patient is admitted to a private bed on the 01/03/2013 and moved to HDU on the 04/03/2013. The patient remains in HDU for 3 days and is moved to public bed on 07/03/2013 as there are no private beds available. When a private bed becomes available the following day, the patient is moved to this bed. The patient is discharged a week later on the 15/03/2013. **Patient Status = 2 Private,** Length of stay=14, Public days=1, Private days=10, Semi-Private Days=0, ITU Days=3, Temp Leave Days=0

All hospitals should examine their PAS/HIS systems and check how the discharge status and the numbers of beds are allocated to ensure that it is correct for HIPE reporting. As with all HIPE data reported this information is subject to review to ensure correct recording of the numbers of beds in conjunction the patient status. Please refer to the HIPE Instruction Manual for more information and contact us if there are any queries.

ITU Days – A Special Case
Particular care needs to be taken when recording the number of ITU days for each patient discharge. If available, coders should compare the statistics for ITU days in the HIPE portal with other intensive care recording systems to check that the ITU days are being calculated correctly.
Note:
- ITU days include time spent in HDU beds, in ICU beds, in CCU beds and in all forms of higher dependency beds.
- When a patient is in an ITU bed, the bed days are not designated as either public, private or semi-private.
- The number of days in the ITU bed must be recorded irrespective of what procedures were performed or what consultant (if any) managed the care.
- Hospitals can optionally record that a patient spent the day in ITU even if they were not there at midnight by increasing the ITU days number and balancing this with a decrease in either the Public / private /Semi-private bed days numbers.

Uploading Your Export File

Following last issue's "Exporting Master Class" all hospitals are encouraged to use the upload export facility to submit their exports each month as this is a more efficient method of exporting. The upload facility has been enhanced to make it easier to use. There may be technical restrictions on the use of this facility in your hospital and if this is the case please continue to email the export directly to export@esri.ie

The following describes the main steps involved in uploading the export file

Step 1) Save your export file

When the export is completed you will be presented with the following steps. Choose the **Save Export File to Desktop** button and ensure to save directly onto the desktop so it can be easily retrieved later when uploading the file. (This is explained in depth in the last issue's "Exporting Master Class").

Step 2) Open Upload Site

Open the Upload website by clicking on the **Upload Export** button.

This will launch the upload website in a new window and your email address and hospital number will be automatically inserted into the relevant text boxes as illustrated next. The email address is derived from your portal username. It is possible to change this to another email address if required.
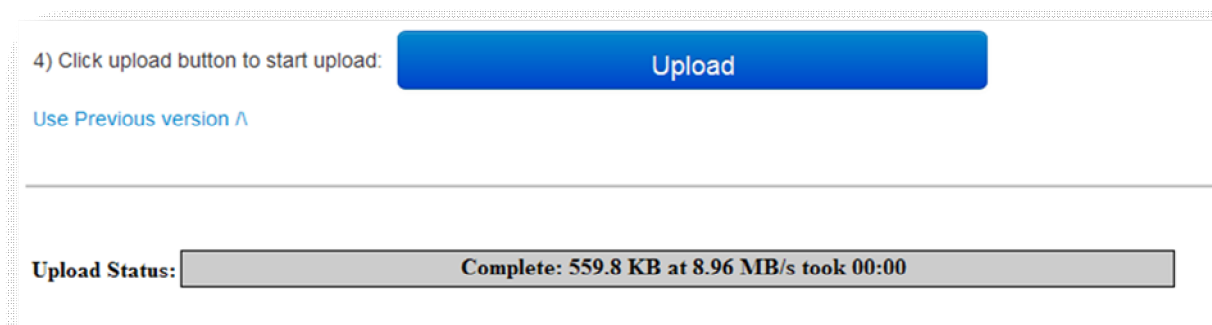
Uploading Your Export File Continued

Step 3) Upload the Export File to ESRI

All that remains to be done is to choose the export file you saved onto the desktop in Step 1 by clicking on the Browse button. Once you have selected the export file from your desktop click on the **Upload** button and the export upload status will be charted underneath as shown.

Step 4) Email Confirmation of Upload
When the file has been successfully uploaded to the ESRI website you will receive an automated email to confirm receipt. Your export is now complete.

Running reports to compare HIPE Vs MDR returns by specialty

Several hospitals have contacted us for guidance on running reports to compare HIPE Vs MDR returns by specialty. This can be done using the hospital's HIPE Portal Reporter and an easy to follow guide has been developed. If you would like a copy of this guide please contact HIPE@esri.ie.

If you have any queries on running reports you can always contact the ESRI at the above email address.

Cracking the Code

HADX Special Edition

Patient readmitted with bleeding from angiography site

Q. Patient was readmitted who had an angiogram (with left heart catheterisation) two days previously with bleeding from the site. Patient also has vomiting and diarrhoea and the chart mentions lower respiratory tract infection (hospital acquired)
Is the PDX also hospital acquired?

A. The PDx will never be flagged as hospital acquired. By definition the PDX is the condition that was responsible for bringing the patient into hospital therefore is present on admission and is not acquired during the admission. Also the HADx is not activated on the Principal Diagnosis field on the HIPE Portal. Additional diagnoses are only flagged as hospital acquired if there is documentation to support that they arose during the current admission.

Assign codes as follows:
T81.0 *Haemorrhage and haematoma complicating a procedure, not elsewhere classified, Haemorrhage at any site resulting from a procedure*
Y84.0 *Cardiac catheterisation*
Y92.22 *Health service area*

Also assign codes for the vomiting and diarrhoea and LRTI if they meet the criteria for collection as additional diagnoses (ACS 0002 Additional Diagnoses). If there is clear documentation that they arose on this episode they can be flagged as hospital acquired (HADx).

Infected Hickman Line.

Q. How is an infected Hickman line coded? There is an MRSA infection of the Hickman line documented and the patient had the line removed. This patient was admitted because of deteriorating Crohn's disease.

A. The principal diagnosis is the Crohn's Disease. Please assign the following codes for the infected Hickman line:
T82.7 *Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts,* together with a code for any specific condition, if known (e.g. cellulitis)
B95.6 *Staphylococcus aureus as the cause of diseases classified to other chapters*
Z06.32 *Methicillin resistant agent*
Y84.8 *Other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure* (if the insertion was not performed as an open surgical procedure)
Y92.22 *Place of occurrence, health service area*
Assign the HADx flag to all codes associated with the infected Hickman line if this infection first arose during this admission.
Assign procedure code 34530-04 [738] *Removal of venous catheter for the removal of the Hickman line.*

Cancer of lung diagnosed during admission

Q. Patient admitted with PR bleeding and an anal fissure, while admitted the patient was diagnosed with cancer of the lung. Will the Ca of the lung be assigned the HADx flag?

A. The HADx flag will not be assigned to the codes for the neoplasm as the neoplasm was present on admission although not diagnosed until during the admission

Postoperative pneumonia

Q. How is postoperative pneumonia coded?

A. The codes to be assigned for Postoperative pneumonia are:
• J95.8 *Other postprocedural respiratory disorders*
• A code for the pneumonia depending on type
• External cause code for the procedure that is linked to the pneumonia
• External cause code for the place of occurrence of the procedure – often Y92.22 *Health Service Area*

The HADx indicator will be assigned to all these codes if the pneumonia is not present on admission and arises during the episode.

The principal diagnosis is coded in accordance with ACS 0001 and will be the reason for admission to the hospital.

Cracking the Code

HADX Special Edition Continued

Patient admitted as an Inpatient from the Day ward with complication of prostate procedure

Q. How do we code a patient admitted from day ward with bleed following TRUS for benign prostatic hypertrophy?

A. The following codes are assigned in this case

- N40 *Hyperplasia of prostate* as this is the reason for admission to the day ward
- T81.0 *Haemorrhage and haematoma complicating a procedure, not elsewhere classified* or other code depending on the cause of bleed. **Also assign HADX indicator**
- Y84.2 *Radiological procedure and radiotherapy.* **Also assign HADX indicator**
- Y92.22 *Health Service Area* as place of occurrence of procedure causing the complication. **Also Assign HADX indicator**

Code any other conditions that meet the criteria for collection in ACS 0002. Assign a code for the TRUS and any other procedures performed.

Please note that the principal diagnosis remains the prostate condition as this was the reason for admission for the day case. The day case admission and the inpatient admission are merged (as the patient was not discharged from the hospital after the day case) and the admission type will be elective to the day ward. Please see note IV on page 6 of the Irish Coding Standards regarding patients admitted into the hospital from the day ward.

HADx when perineal laceration is the principal diagnosis

Q. If first and second degree perineal laceration is the principal diagnosis how do I code the HADx?

A. The HADx is not assigned to the principal diagnosis. So if an obstetrics patient has a tear, or similar condition arising from delivery, as principal diagnosis a HADX flag won't be assigned.

Outcome of Delivery (Z37) and HADx

Q. Do I assign a HADx flag for outcome of delivery codes (Z37 range)?

A. The HADX flag is not assigned for outcome of delivery.

Do you have a coding query? Please email your query to: hipecodingquery@esri.ie
To answer your query we need as much information as possible, please use the Coding Help Sheet as a guide to the amount of detail required, available at: **www.esri.ie/health_information/hipe/**

HIPE Data User Training Course

With the increase in HIPE data users a training day is being held at the ESRI on Thursday, 17th October. This course has been held several times before and feedback from those attending has been very good. It is recommended that anyone using HIPE data in their work attend to ensure understanding of all aspects of these data. This course will be held at the ESRI, Whitaker Square, Sir John Rogerson's Quay, Dublin 2 from 9.45 to 5pm.

The main topics of the course are as follows.

- Introduction to HIPE
- Classification and Guidelines
- Interpretation of HIPE data
- Hands-on training using the HIPE Portal Reporter.

Please contact hipecodingquery@esri.ie for further information.
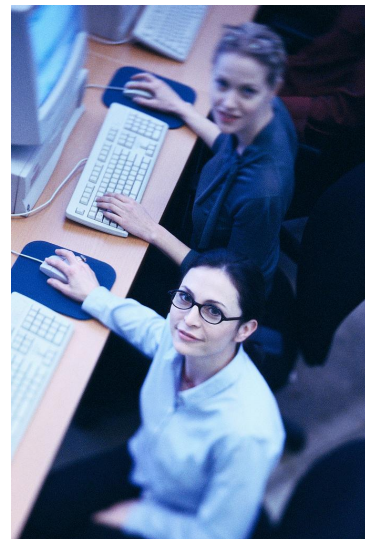
Upcoming Courses

Introduction to HIPE

WebEx Only

This is a general introduction to the variables collected by HIPE for new coders and others working in the HIPE system.

Date: Thursday, 4th July
Time: 10.30am -1pm

Coding Skills I

ESRI Only

This course is for new coders who have participated in the "Introduction to HIPE" course.

Date: Tuesday 23rd - Wednesday 24th July (2 days)

Time: 10am—5pm each day

Coding Skills II

ESRI Only

This course is for those who have previously attended Coding Skills I.

Date: Tuesday 20th August —Thursday 22nd August (3 days)
Time: 10am – 5pm each day.

Coding Skills III

ESRI Only

This course is for coders who have previously attended Coding Skills II. Experienced coders are welcome to attend this course for refresher training.

Date: Tuesday 22nd October—Thursday 24th October (3 days)

Time: 10am – 5pm each day.

Coding Skills IV—Workshops

Topic: Same Day Endoscopy Coding

Date: Tuesday 9th July

Time: 11am – 1pm

Location: WebEx / ESRI

Topic: Z-Code workshop (Part 1)

Date: Wednesday 10th July

Time: 11am – 1pm

Location: WebEx / ESRI

Topic: Z-Code workshop (Part 2)

Date: Thursday 11th July

Time: 11am – 1pm

Location: WebEx / ESRI

Topic: Vascular Access Devices, Venous Catheters & Drug Delivery Devices
Date: Tuesday, 16th July

Time: 11am – 1pm

Location: WebEx / ESRI

HIPE Portal Reporter Beginner Course

Date: 30th July 2013
Time: 10am to 12:30pm
Location: WebEx only

The course will cover the following topics:

- Navigation
- Selections
- Reports

What would you like to see in Coding Notes?

If you have any ideas for future topics, please let us know.
Thanks and keep in touch: hipe@esri.ie

See the 'Find it Fast' section of the ESRI website for easy access.

www.esri.ie/health_information/find_it_fast/

Thought for this issue

"Action without vision is only passing time, vision without action is merely day dreaming, but vision with action can change the world."

Nelson Mandela, Former President of South Africa