National Health Data Dictionary

Version 10

National Health Data Committee

2001

Australian Institute of Health and Welfare
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Foreword

The Australian Institute of Health and Welfare is pleased to produce this tenth version of the *National Health Data Dictionary*, which is a vital tool for use in ensuring the quality of Australian health data.

The Dictionary is now ten years old. A decade of growth has seen it become a useful tool for the collection of health information across the nation. The next decade will see greater growth, and perhaps a shift in emphasis away from its base for standardised hospital data collections to a more all-encompassing set of data standards for the entire health sector.

Much of the drive for standardisation arises from Australia's various Health Care Agreements. With the growing cost of health care provision, there is a proportionately greater emphasis being placed on performance measurement. This requires national monitoring and reporting of standardised information to be effective. It is also becoming increasingly important to monitor the health and 'wellness' of the Australian population and there are many initiatives under way. The National Electronic Health Records Taskforce has proposed the concept of a national health information network (Health*Connect*) that would allow personal health information to be collected, safely stored and exchanged—but only with the individual health consumer's permission. Under Health*Connect*, health-related information about an individual would be collected in a standard, electronic format at the point of care (such as at a hospital or a general practitioner's clinic).

With initiatives such as these, it is important that the health care community maintains its ability to standardise the terminology used in the analysis of health information. It is only through the cooperation and consensus of Australia's health sector that it is possible to produce, in the Dictionary, a set of core definitions and data items for use in all Australian health data collections. The future will see this base broadened to incorporate the many other aspects of health information such as those included in the electronic health record mentioned above.

All Australian health departments, the Australian Bureau of Statistics, the Australian Institute of Health and Welfare, the National Centre for Classification in Health, the Department of Veterans' Affairs, the Australian Private Hospitals Association, representatives of the private health insurance industry and the Health Insurance Commission cooperate in this endeavour.

Data elements in this edition continue to be presented in a format based on the ISO/IEC Standard 11179 *Specification and Standardization of Data Elements*—the international standard for defining data elements issued by the International Organization for Standardization and the International Electrotechnical Commission. As in Version 9, data elements are also presented according to their alignment to entities in the National Health Information Model.

Use of the Dictionary will help ensure that data elements are collected uniformly from all services and jurisdictions throughout Australia, and thereby improve the quality of information for community discussion and public policy debate on health issues in Australia.

Thanks are due to Joe Christensen and David Neilsen of the Institute staff who have prepared the material for this tenth edition, and to all members of the National Health Data Committee who have overseen its preparation.

I urge all collectors of health-related data in Australia to use the Dictionary and so improve the comparability and quality of Australian health data. The Dictionary content is expanding beyond institutional health care, and many of the new data elements relate to other sectors of health care.

The National Health Data Committee and the Institute continue to welcome comment on the Dictionary. Readers are encouraged to complete and return the lift-out feedback sheet included at the back of the Dictionary. In addition, should readers have any views on future improvements to the Dictionary, please contact the Institute so that the issues can be addressed.

Richard Madden
Director,
Australian Institute of Health and Welfare

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Introduction

The *National Health Data Dictionary* was first published as the *National Minimum Data Set – Institutional Health Care* in September 1989. In March 1993 the *National Health Data Dictionary – Institutional Health Care (Version 2.0)* was published. Since the establishment of the first National Health Information Agreement in June 1993, there have been many changes in the development and management of national health information, resulting in the expansion of both the scope and content of the seven subsequent versions of the *National Health Data Dictionary*. The National Health Information Agreement was renewed in 1998 for a further five-year term.

Under the National Health Information Agreement, the *National Health Data Dictionary* is the authoritative source of health data definitions used in Australia where national consistency is required. The Dictionary is designed to improve the comparability of data across the health field. It is also designed to make data collection activities more efficient, by reducing duplication of effort in the field, and more effective, by ensuring that information to be collected is appropriate to its purpose.

The objectives of the *National Health Data Dictionary* are to:

- establish a core set of uniform definitions relating to the full range of health services and a range of population parameters (including health status and determinants);
- promote uniformity, availability, reliability, validity, consistency and completeness in the data;
- accord with nationally and internationally agreed protocols and standards, wherever possible; and
- promote the national standard definitions by being readily available to all individuals and organisations involved in the generation, use and/or development of health and health services information.

The National Health Data Committee

The National Health Data Committee is a standing committee of the National Health Information Management Group—a body established under the National Health Information Agreement to oversee implementation of the Agreement. All data element definitions to be included in the *National Health Data Dictionary* require endorsement by the National Health Information Management Group.

The primary role of the National Health Data Committee is to assess data definitions proposed for inclusion in the *National Health Data Dictionary* and to make recommendations to the National Health Information Management Group on revisions and additions to each successive version of the Dictionary. In particular, the Committee's role is to ensure that the *National Health Data Dictionary* definitions comply with endorsed standards for the definition of data elements, and that all data definitions being considered for the Dictionary have undergone sufficient national consultation with recognised experts and stakeholders in the relevant field.

The rules applied to each data element definition are designed to ensure that each definition is clear, concise, comprehensive and provides sufficient information to ensure that all those who collect, provide, analyse and use the data understand its meaning.

All definitions in the *National Health Data Dictionary* are presented in a format that is described in more detail at Appendix B.

The National Health Data Committee comprises representatives of:

- the Commonwealth Department of Health and Aged Care
- each State and Territory government health authority
- the Australian Institute of Health and Welfare
- the Australian Bureau of Statistics
- the Australian Private Hospitals' Association
- the private health insurance industry (through Lysaght's Hospital and Medical Club)
- the Department of Veterans' Affairs
- the National Centre for Classification in Health
- the Health Insurance Commission
- other members designated by the National Health Information Management Group.

The National Health Information Management Group appoints the Chair of the National Health Data Committee, currently Geoff Sims of the Australian Institute of Health and Welfare.

A list of Committee members and their contact details (as at February 2001) is provided at Appendix A.

The National Health Data Committee does not normally develop data definitions directly. Rather, it provides a channel through which standards emerging from nationally focused data development work are documented and endorsed by the National Health Information Management Group for implementation in national data collections and made more widely available to stakeholders in the national health information arena. The range and relevance of the data definitions included in the *National Health Data Dictionary* are dependent, to a significant extent, on the material submitted to the National Health Data Committee by the expert working groups that are actively developing data in the health field.

More information about the National Health Data Committee and its processes is available from the Secretariat (see address at end of this section).

The Knowledgebase—Australia's health, community services and housing metadata registry

The Knowledgebase—Australia's health, community services and housing metadata registry (formerly known as the National Health Information Knowledgebase or NHIK) is an electronically accessible registry of national data definitions. The organisation authorised to register *National Health Data Dictionary* data definitions in the Knowledgebase (that is, the Registration Authority) is the National Health Information Management Group. The Knowledgebase is also a registry for other Registration Authorities approved by the relevant national information management groups. The Knowledgebase integrates and presents information about:

- the *National Health Data Dictionary*
- National Minimum Data Set agreements
- National Health Performance Indicators
- the National Health Information Model
- the National Community Services Information Model
- the *National Community Services Data Dictionary*
- proposed data sets under development
- related data dictionaries from other organisations.

The integrating features of the Knowledgebase enable information managers and policy developers to query and view information in ways not possible with traditional paper-based records, repositories, dictionaries or manuals. It is envisaged that, over time, access to the *National Health Data Dictionary* will be primarily electronic—via the Knowledgebase.

All data definitions that are included in Version 10 of the *National Health Data Dictionary*, as well as all previous versions of those data definitions, are available on the Knowledgebase. Draft data definitions under development by the National Health Data Committee are also available on the Knowledgebase under the National Health Data Committee as Registration Authority, but are not available in print form.

The Knowledgebase has been designed and created by the Australian Institute of Health and Welfare on behalf of the National Health Information Management Group. The Knowledgebase is an Internet application, accessible through any browser compatible with HTML version 3.2 or later. It has been written using Oracle's Webserver technology.

In line with advances in technology and the general move to on-line documentation and accessibility, this site may be extensively redesigned in the coming years

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The Internet address for the Knowledgebase—Australia's health, community services and housing metadata registry is http://www.aihw.gov.au

Version 10

This version of the Dictionary contains 286 data definitions, including 15 new data elements and the retirement of six data elements that have been agreed by the members of the National Health Data Committee, and endorsed by the National Health Information Management Group. As for Version 9, a full alphabetical listing of all data elements in this version of the Dictionary is provided at the front of this publication. In addition, a subject/key word index to this version of the Dictionary is provided at Appendix K.

This hard copy publication of Version 10 only includes data elements that are CURRENT as at 1 July 2001. However, all data elements including those that have been superseded or rendered obsolete by new data elements or new versions of data elements in Version 10 are available on the Knowledgebase.

As in Version 9, data definitions are presented in a format based on the standard ISO/IEC 11179 *Specification and Standardization of Data Elements*—the international standard for defining data elements issued by the International Organization for Standardization and the International Electrotechnical Commission. This format is explained in detail at Appendix B.

Version 10 continues the format of Version 9 in that all data elements are organised and presented according to their alignment with entities in the National Health Information Model (Version 2.0, Draft). The mapping of data elements to the Model is being progressively refined following consultation with stakeholders in the national health information field. This presentation format is designed to enhance the integration of the Model with the data elements—thus providing a more complete framework for understanding and implementing existing definitions and for identifying areas for further data development activity. A copy of the full National Health Information Model (Version 2.0, Draft) is included following this introductory section.

To assist with understanding the relationship between the data elements and their associated model entities, definitions of all entities in the National Health Information Model (Version 2.0, Draft) are provided at Appendix C.

Feedback

Readers are invited to comment on any aspect of the *National Health Data Dictionary* by completing and returning the lift-out feedback form included at the back of this publication.

Comments and suggestions can also be provided electronically via the Feedback area on the Knowledgebase.

Secretariat contact details

Further information about the *National Health Data Dictionary* and the National Health Data Committee can be obtained through the National Health Data Committee Secretariat at the Australian Institute of Health and Welfare.

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National Health Information Model

Draft Version 2.0

Prepared by the National Information Development Unit
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PARTY CHARACTERISTICS

PERSON CHARACTERISTIC
- DEMOGRAPHIC CHARACTERISTIC
- PHYSICAL CHARACTERISTIC
- LABOUR CHARACTERISTIC
- LIFESTYLE CHARACTERISTIC
- SOCIAL CHARACTERISTIC
- EDUCATION CHARACTERISTIC
- PARENTING CHARACTERISTIC
- ACCOMMODATION CHARACTERISTIC
- CULTURAL CHARACTERISTIC
- INSURANCE / BENEFIT CHARACTERISTIC
- LEGAL CHARACTERISTIC
- OTHER PERSON CHARACTERISTIC

STATE OF HEALTH AND WELLBEING
- AGGREGATE HEALTH AND WELLBEING
- COMPONENT HEALTH AND WELLBEING
  - HEALTH STATUS
    - PHYSICAL WELLBEING
    - MENTAL WELLBEING
    - FUNCTIONAL WELLBEING
  - SOCIAL WELLBEING
  - ECONOMIC WELLBEING
  - CULTURAL WELLBEING
  - SPIRITUAL WELLBEING

PERSON VIEW
- ATTITUDE
- BELIEF
- EXPECTATION
- VALUE

PARTY GROUP CHARACTERISTIC

ORGANISATION CHARACTERISTIC

PARTY
- PERSON
- PARTY GROUP

ORGANISATION
- LEGALLY CONSTITUTED ORGANISATION
- ORGANISATION SUB-UNIT

PARTY ROLE

PARTY RELATIONSHIP ROLE

PERSON ROLE
- CITIZEN ROLE
- FAMILY MEMBER ROLE
- CARER ROLE
- ADVOCATE ROLE
- RESOURCE ROLE
- OTHER PERSON ROLE

PARTY GROUP ROLE

ORGANISATION ROLE
- SERVICE FUNDER ROLE
- SERVICE PURCHASER ROLE
- OTHER ORGANISATION ROLE

RECIPIENT ROLE

SERVICE PROVIDER ROLE

RESEARCH ROLE

OTHER ROLE

BUSINESS FACTORS

BUSINESS STATEMENT
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- OTHER POLICY / PLAN ELEMENT

HEALTH AND WELFARE POLICY / PLAN ELEMENT
- VISION / MISSION
- GOAL / OBJECTIVE
- PRIORITY
- PERFORMANCE INDICATOR

BUSINESS PROGRAM
- HEALTH AND WELFARE PROGRAM

HEALTH AND WELFARE PROGRAM ELEMENT
- PROGRAM STRATEGY
- PROGRAM ACTIVITY
- PROGRAM EVALUATION

BUSINESS AGREEMENT
- FUNDING AGREEMENT
- EMPLOYMENT AGREEMENT
- OTHER AGREEMENT

PERFORMANCE GOAL
- BENCHMARK
- STANDARD

ENABLING FACTORS

RESOURCE
- AGGREGATE RESOURCE ITEM
- SPECIFIC RESOURCE ITEM
  - MATERIAL RESOURCE ITEM
  - FINANCIAL RESOURCE ITEM
  - HUMAN RESOURCE ITEM
  - INFORMATION RESOURCE ITEM

OTHER ENABLING FACTOR
- KNOWLEDGE FACTOR
- ACCESSIBILITY FACTOR
- AVAILABILITY FACTOR

ENVIRONMENTAL FACTORS

PHYSICAL ENVIRONMENT
- NATURAL ENVIRONMENT
- BUILT ENVIRONMENT

SOCIAL ENVIRONMENT
- JUDICIAL SYSTEM
- EDUCATIONAL SYSTEM
- COMMUNITY ORGANISATION
- OTHER SOCIAL ENVIRONMENT

LOCATION
- ADDRESS

SETTING
- ORGANISATIONAL SETTING
- SERVICE DELIVERY SETTING
- OTHER SETTING

EXPENDITURE
- CAPITAL EXPENDITURE
- RECURRENT EXPENDITURE

OUTCOME
- STATED OUTCOME
- EXPECTED OUTCOME

NEED / ISSUE

CARE PLAN

EVENT

PERSON EVENT
- BIRTH EVENT
- LIFE EVENT
  - SELF HELP EVENT
  - CRISIS EVENT
    - ILLNESS EVENT
      - ACUTE EVENT
      - NON-ACUTE EVENT
    - INJURY EVENT
    - OTHER CRISIS EVENT
  - OTHER LIFE EVENT
- DEATH EVENT

HEALTH AND WELFARE SERVICE EVENT
- REQUEST FOR / ENTRY INTO SERVICE EVENT
- SERVICE PROVISION EVENT
- EXIT / LEAVE FROM SERVICE EVENT
- ASSESSMENT EVENT
- SCREENING EVENT
- EDUCATION EVENT
- ADVOCACY EVENT
- PLANNING EVENT
- SURVEILLANCE / MONITORING EVENT
- PAYMENT / CONTRIBUTION EVENT
- OTHER HEALTH AND WELFARE SERVICE EVENT

LEGAL STATUS EVENT

COMMUNITY EVENT

ENVIRONMENTAL EVENT

RESEARCH EVENT

OTHER EVENT

National Minimum Data Sets

A National Minimum Data Set (NMDS) is a core set of data elements agreed by the National Health Information Management Group for mandatory collection and reporting at a national level. One National Minimum Data Set may include data elements that are also included in another National Minimum Data Set. A National Minimum Data Set is contingent upon a national agreement to collect uniform data and to supply it as part of the national collection, but does not preclude agencies and service providers from collecting additional data to meet their own specific needs.

The *National Health Data Dictionary* contains definitions of data elements that are included in National Minimum Data Set collections in the health sector, including data elements used to derive some of the performance indicators required under Australian Health Care Agreements (bilateral agreements between the Commonwealth and State/Territory governments about funding and delivery of health services). The Dictionary also contains some data elements that are not currently included in any agreed National Minimum Data Set collection but have been developed and endorsed as appropriate national standards. That is, all data elements used in National Minimum Data Sets are included in the Dictionary, but not all data elements in the Dictionary are included in National Minimum Data Sets.

The National Health Data Dictionary, Version 10, identifies data elements from the following national minimum data sets:

1 **Admitted patient care NMDS**
(formerly part of ***Institutional health care NMDS***)

2 **Admitted patient mental health care NMDS**
(formerly named ***Institutional mental health care NMDS***)

3 **Admitted patient palliative care NMDS**
(formerly named ***Palliative care NMDS***)

4 **Alcohol and other drug treatment services NMDS**

5 **Community mental health care NMDS**
(now contains only patient level data)

6 **Community mental health establishments NMDS**
(split from ***Community mental health care NMDS*** and now contains only establishment level data)

7 **Elective surgery waiting times NMDS**

8 **Emergency Department waiting times NMDS**

9 **Health labourforce NMDS**

10 **Injury surveillance NMDS**

11 **Perinatal NMDS**

12 **Public hospital establishments NMDS**
(formerly part of ***Institutional health care NMDS*** and now contains only establishment level data)

Descriptions of these National Minimum Data Sets follow.

Admitted patient care NMDS

Admin. status: CURRENT 1/07/2001 Version number: 2

Identifying and definitional attributes

Data record type: NATIONAL MINIMUM DATA SET

Start date: 1 July 1989

Scope: Episodes of care for admitted patients in all public and private acute and psychiatric hospitals, free standing day hospital facilities and alcohol and drug treatment centres in Australia. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore Territories may also be included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.

Statistical units: Episodes of care for admitted patients

Collection methodology: Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant State or Territory health authority on a regular basis (for example, monthly).

National reporting arrangements: State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year

Data elements included:

♦ new in NMDS this version ∇ modified this version

Data elements included (continued):

Supporting data element concepts:

Data elements in common with other NMDSs:

See Appendix J

Scope links with other NMDSs:

Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals:

- Admitted patient mental health care NMDS, version 2

Episodes of care for admitted patients where care type is palliative care:

- Admitted patient palliative care NMDS, version 2

Source organisation: National Health Information Management Group

Comments:

Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.

Number of days of hospital in the home care data will be collected from all states and territories except Western Australia from 1 July 2001. Western Australia will begin to collect data from a later date.

♦ new in NMDS this version ∇ modified this version

Admitted patient mental health care NMDS

Admin. status: CURRENT 1/07/2001 Version number: 2

Identifying and definitional attributes

Data record type: NATIONAL MINIMUM DATA SET

Start date: 1 July 1997

Scope: The scope of this minimum data set is restricted to admitted patients receiving care in psychiatric hospitals or in designated psychiatric units in acute hospitals. The scope does not currently include patients who may be receiving treatment for psychiatric conditions in acute hospitals who are not in psychiatric units.

Statistical units: Episodes of care for admitted patients

Collection methodology: Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant State or Territory health authority on a regular basis (for example, monthly).

National reporting arrangements: State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year

Data elements included:

♦ new in NMDS this version ∇ modified this version

Data elements included (continued):	Previous specialised treatment, version 3 ..... page 305 Principal diagnosis, version 3 ..... page 168 Referral to further care (psychiatric patients), version 1 ..... page 386 Separation date, version 5 ..... page 388 Sex, version 2 ..... page 30 Source of referral to public psychiatric hospital, version 3 ..... page 310 Total leave days, version 3 ..... page 390 Total psychiatric care days, version 2 ..... page 428 Type of accommodation, version 2 .....page 113 Type of usual accommodation, version 1 .....page 115
Supporting data element concepts:	Admission, version 3 ..... page 284 Admitted patient, version 3 ..... page 248 Episode of care, version 1 ..... page 337 Hospital, version 1 ..... page 206 Patient, version 1 ..... page 257 Separation, version 3 ..... page 387
Data elements in common with other NMDSs:	See Appendix J
Scope links with other NMDSs:	Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals: • Admitted patient care NMDS, version 2 • Admitted patient palliative care NMDS, version 2
Source organisation:	National Health Information Management Group
Comments:	Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published. Number of days of hospital in the home care data will be collected from all states and territories except Western Australia from 1 July 2001. Western Australia will begin to collect data from a later date.

♦ new in NMDS this version ∇ modified this version

Admitted patient palliative care NMDS

Admin. status: CURRENT 1/07/2001 Version number: 2

Identifying and definitional attributes

Data record type: NATIONAL MINIMUM DATA SET

Start date: 1 July 2000

Scope: The scope of this data set is admitted patients receiving palliative care in all public and private acute hospitals, and free standing day hospital facilities. Hospitals operated by the Australian Defence Force, correctional authorities and Australia's external Territories are not currently included.

Palliative care patients are identified by the data element 'Care type'.

Statistical units: Episodes of care for admitted patients

National reporting arrangements: State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year

Data elements included:

Supporting data element concepts:

♦ new in NMDS this version ∇ modified this version

Data elements in common with other NMDSs:	See Appendix J
Scope links with other NMDSs:	Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals: • Admitted patient care NMDS, version 2 • Admitted patient mental health care NMDS, version 2
Source organisation:	National Health Information Management Group
Comments:	Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published. Number of days of hospital in the home care data will be collected from all states and territories except Western Australia from 1 July 2001. Western Australia will begin to collect data from a later date.

Alcohol and other drug treatment services NMDS

Admin. status: CURRENT 1/07/2001 Version number: 2

Identifying and definitional attributes

Data record type: NATIONAL MINIMUM DATA SET

Start date: 1 July 2000

Scope: Publicly funded government and non-government agencies providing alcohol and/or drug treatment services. Including community-based ambulatory services and outpatient services.

Services in prisons and other correctional institutions will be excluded from the coverage of the collection at this stage. Methadone treatment services are also excluded. 'Sobering-up' shelters will be excluded from the coverage where they are primarily concerned with overnight stays. 'Half-way houses' will be excluded if they are primarily accommodation services. Admitted patients in psychiatric hospitals or general hospital wards are excluded. Information required about patients in hospitals will be extracted from currently available morbidity data.

Statistical units: Completed treatment episodes for clients with alcohol and drug problems.

Collection methodology: Data to be reported in each agency on completed treatment episode and then forwarded to State/Territory authorities for collation.

National reporting arrangements: State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year

Data elements included:

♦ new in NMDS this version ∇ modified this version

Data elements included (continued):	Other treatment type for alcohol and other drugs, version 1♦ .... page 382 Person identifier, version 1 ..... page 258 Preferred language, version 2 ..... page 107 Principal drug of concern, version 1 ..... page 170 Reason for cessation of treatment episode for alcohol and other drugs, version 2♦ ..... page 384 Sex, version 2 ..... page 30 Source of referral to alcohol and other drug treatment service, version 1 ..... page 308 Treatment delivery setting for alcohol and other drugs, version 1♦ ..... page 209
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Data elements in common with other NMDSs:	See Appendix J
Source organisation:	National Health Information Management Group
Comments:	Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.

♦ new in NMDS this version ∇ modified this version

Community mental health care NMDS

Admin. status: CURRENT 1/07/2001 Version number: 2

Identifying and definitional attributes

Data record type: NATIONAL MINIMUM DATA SET

Start date: 1 July 2000

Scope: Patient level data: Data required for reporting by specialised psychiatric services that deliver ambulatory services, in both institutional and community settings. It does not extend to services provided to patients who are in general (non-specialised) care who may be receiving treatment or rehabilitation for psychiatric conditions.

The data provided through the Community mental health care NMDS supplements that reported for psychiatric and acute care hospitals through the Admitted patient mental health care NMDS.

Statistical units: Service contact dates

National reporting arrangements: State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year

Data elements included:

Supporting data element concepts

Data elements in common with other NMDSs See Appendix J

Source organisation: National Health Information Management Group

Comments: Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.

♦ new in NMDS this version ∇ modified this version

Community mental health establishments NMDS

Admin. status CURRENT 1/07/2000 Version number: 1

Identifying and definitional attributes

Data record type: NATIONAL MINIMUM DATA SET

Start date: 1 July 1998

Scope: Data required for reporting by specialised psychiatric services that deliver ambulatory services, in both institutional and community settings and/or community-based residential care. It does not extend to services provided to patients who are in general (non-specialised) care who may be receiving treatment or rehabilitation for psychiatric conditions.

The data provided through the NMDS—Community Mental Health Establishments supplements that reported for psychiatric and acute care hospitals through the NMDS—Admitted Patient Mental Health Care.

Statistical units: Establishment level data.

National reporting arrangements: State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year

Data elements included:

Supporting data element concepts:

Data elements in common with other NMDSs: See Appendix J

Source organisation: National Health Information Management Group

Comments: Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.

♦ new in NMDS this version ∇ modified this version

Elective surgery waiting times NMDS

Admin. status: CURRENT 1/07/2001 Version number: 2

Identifying and definitional attributes

Data record type: NATIONAL MINIMUM DATA SET

Start date: 1 July 1994

Scope: The scope of this minimum data set is patients on waiting lists for elective surgery (as defined in the Waiting list category data element) in public acute hospitals. Hospitals may also collect information for other care (as defined in the Waiting list category data element), but these are not part of the NMDS for elective surgery waiting times.

Hospitals operated by the Australian Defence Force, corrections authorities and Australia's external Territories are not currently included.

To monitor waiting times for patients who are yet to be admitted to hospital, the scope is patients on elective surgery waiting lists at the census date.

To monitor waiting times for patients who have been admitted for elective surgery, the scope is patients who are admitted to hospital from elective surgery waiting lists, and who undergo the procedure for which they were waiting on an elective basis.

Data are also collected on the number of patients who have been removed from an elective surgery waiting list for reasons other than admission on an elective basis for the elective surgery for which they were waiting.

Statistical units: Patients on waiting lists on census dates; patients removed from waiting lists (for admission or other reason) during each financial year.

National reporting arrangements: State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year

Census dates are 30 September, 31 December, 31 March and 30 June

Data elements included:

♦ new in NMDS this version ∇ modified this version

Data elements included (continued):	Region code, version 2♦ ..... page 191 Surgical specialty, version 1 ..... page 80 Waiting list category, version 3 ..... page 315 Waiting time at a census date, version 1 ..... page 439 Waiting time at admission, version 1 ..... page 441
Supporting data element concepts:	Clinical review, version 1 ..... page 393 Elective care, version 1 ..... page 335 Elective surgery, version 1 ..... page 336 Hospital census, version 1 ..... page 369 Hospital waiting list, version 1 ..... page 299 Non-elective care, version 1 ..... page 354
Data elements in common with other NMDSs:	Nil
Source organisation:	National Health Information Management Group
Comments:	Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.

♦ new in NMDS this version ∇ modified this version

Emergency Department waiting times NMDS

Admin. status: CURRENT 1/07/2000 Version number: 1

Identifying and definitional attributes

Data record type: NATIONAL MINIMUM DATA SET

Start date: 1 July 1999

Scope: The scope of this data set is to be negotiated between Commonwealth and State/Territory Government health authorities. It is likely that data will only be required for reporting by metropolitan hospitals and larger rural/regional hospitals.

National reporting arrangements: State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year

Data elements included:

Supporting data element concepts:

Data elements in common with other NMDSs: See Appendix J

Source organisation: National Health Information Management Group

Comments: Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.

♦ new in NMDS this version ∇ modified this version

Health labour force NMDS

Admin. status: CURRENT 1/07/2000 Version number: 1

Identifying and definitional attributes

Data record type: NATIONAL MINIMUM DATA SET

Start date: 1 July 1989

Scope: The scope of this set of data elements is all health occupations. National collections using this data set have been undertaken for the professions of medicine, nursing, dentistry, pharmacy, physiotherapy and podiatry, using labour force questionnaires in the annual renewal of registration to practice.

National reporting arrangements: State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year

Data elements included:

Supporting data element concepts:

Data elements in common with other NMDSs: See Appendix J

Source organisation: National Health Information Management Group

Comments: Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.

♦ new in NMDS this version ∇ modified this version

Injury surveillance NMDS

Admin. status: CURRENT 1/07/2000 Version number: 1

Identifying and definitional attributes

Data record type:	NATIONAL MINIMUM DATA SET
Start date:	1 July 1989
Scope:	The scope of this minimum data set is patient level data from selected Emergency Departments of hospitals and other settings.
National reporting arrangements:	State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.
Periods for which data are collected and nationally collated:	Financial years ending 30 June each year
Data elements included:	Activity when injured, version 2 .....page 272 Bodily location of main injury, version 1 .....page 137 External cause—admitted patient, version 4 .....page 274 External cause—human intent, version 4 .....page 276 Narrative description of injury event, version 1 .....page 280 Nature of main injury—non-admitted patient, version 1 .....page 156 Place of occurrence of external cause of injury, version 5 .....page 212
Supporting data element concepts:	Nil
Data elements in common with other NMDSs:	See Appendix J
Source organisation:	National Health Information Management Group
Comments:	Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published

♦ new in NMDS this version ∇ modified this version

Perinatal NMDS

Admin. status: CURRENT 1/07/2000 Version number: 1

Identifying and definitional attributes

Data record type: NATIONAL MINIMUM DATA SET

Start date: 1 July 1997

Scope: The scope of this minimum data set is all births in Australia in hospitals, birth centres and the community. The data set includes information on all births, both live and stillborn, of at least 20 weeks gestation or 400g birth weight.

National reporting arrangements: State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year

Data elements included:

Supporting data element concepts:

♦ new in NMDS this version ∇ modified this version

Data elements in common with other NMDSs:	See Appendix J
Source organisation:	National Health Information Management Group
Comments:	Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.

Public hospital establishments NMDS

Admin. status: CURRENT 1/07/2000 Version number: 1

Identifying and definitional attributes

Data record type: NATIONAL MINIMUM DATA SET

Start date: 1 July 1989

Scope: The scope of this dataset is establishment level data for public acute and psychiatric hospitals, including hospitals operated for or by the Department of Veterans' Affairs, and alcohol and drug treatment centres.

From version 9 Patient level data remains in the new NMDS called Admitted patient care. These new NMDS replace the version 8 NMDS called Institutional health care.

Similar data for private hospitals and free standing day hospital facilities is collected by the Australian Bureau of Statistics in the Private Health Establishments Collection.

Hospitals operated by the Australian Defence Force, corrections authorities and Australia's external Territories are not currently included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.

Statistical units: Public hospital establishments

Collection methodology: Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant State or Territory health authority on a regular basis (for example, monthly.

National reporting arrangements: State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year

Data elements included:

♦ new in NMDS this version ∇ modified this version

Data elements included (continued):

Supporting data element concepts:

Data elements in common with other NMDSs:

See Appendix J

Scope links with other NMDSs:

Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals:

- Admitted patient care NMDS, version 1
- Admitted patient mental health care NMDS, version 1
- Admitted patient palliative care NMDS, version 1

Source organisation:

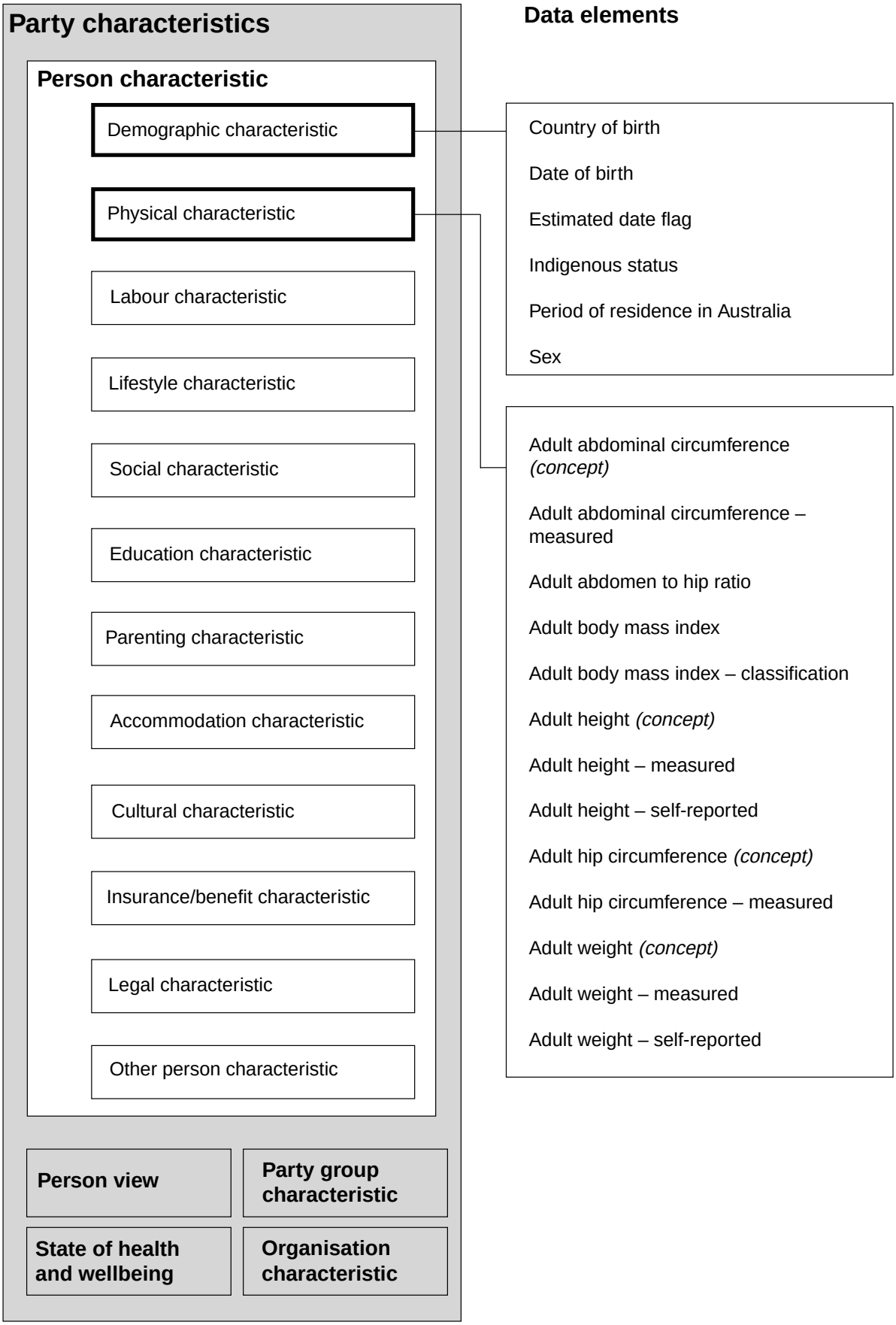
National Health Information Management Group

Comments:

Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.

♦ new in NMDS this version ∇ modified this version

National Health Information Model entity



Country of birth

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

NHIK identifier: 000035 Version number: 3

Data element type: DATA ELEMENT

Definition: The country in which the person was born.

Context: Country of birth is important in the study of access to services by different population sub-groups. Country of birth is the most easily collected and consistently reported of possible data items. The item provides a link between the Census of Population and Housing, other ABS statistical collections and regional data collections. Country of birth may be used in conjunction with other data elements such as period of residence in Australia, etc., to derive more sophisticated measures of access to services by different population sub-groups.

Relational and representational attributes

Datatype: Numeric Field size: Min. 4 Max. 4 Layout: NNNN

Data domain: Standard Australian Classification of Countries (SACC) 4-digit (individual country) level. ABS catalogue no. 1269.0 (1998).

Guide for use: A country, even if it comprises other discrete political entities such as states, is treated as a single unit for all data domain purposes. Parts of a political entity are not included in different groups. Thus, Hawaii is included in Northern America (as part of the identified country United States of America), despite being geographically close to and having similar social and cultural characteristics as the units classified to Polynesia.

Related data: supersedes previous data element Country of birth, version 2

Administrative attributes

Source document: ABS Catalogue No. 1269.0 (1998)

Source organisation: Australian Bureau of Statistics

National minimum data sets:

Admitted patient care	from 1/07/1989 to
Admitted patient mental health care	from 1/07/1997 to
Admitted patient palliative care	from 1/07/2000 to
Alcohol and other drug treatment services	from 1/07/2000 to
Community mental health care	from 1/07/2001 to
Perinatal	from 1/07/1997 to

Comments: The *Standard Australian Classification of Countries* (ABS 1269.0 1998) supersedes the *Australian Standard Classification of Countries for Social Statistics* (ASCCSS) which was reported in version 9 of the NHDD.

Date of birth

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

NHIK identifier: 000036 Version number: 3

Data element type: DATA ELEMENT

Definition: The date of birth of the person.

Context: Required to derive age for demographic analyses, for analysis by age at a point of time and for use to derive a Diagnosis Related Group (admitted patients).

Perinatal: data collections require the collection of the date of birth for the mother and the baby(s).

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid dates

Guide for use: If date of birth is not known, provision should be made to collect age (in years) and a date of birth derived from age.

Verification rules: For the provision of State and Territory hospital data to Commonwealth agencies this field must:

- be ≤ Admission date, otherwise resulting in a fatal error
- not be null
- be consistent with diagnoses and procedure codes, for records to be grouped, otherwise resulting in a fatal error.

Collection methods: It is recommended that in cases where all components of the date of birth are not known or where an estimate is arrived at from age, a valid date be used together with a flag to indicate that it is an estimate.

Data collection systems must be able to differentiate between the date of birth of the mother and the baby(s). This is important in the Perinatal data collection as the date of birth of the baby is used to determine the antenatal length of stay and the postnatal length of stay.

Related data: supersedes previous data element Date of birth, version 2

is used in the derivation of Diagnosis related group, version 1

is used in the calculation of Length of stay (postnatal), version 1

is used in the calculation of Length of stay (antenatal), version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient care	from 1/07/1989 to
Health labourforce	from 1/07/1989 to
Admitted patient mental health care	from 1/07/2000 to
Perinatal	from 1/07/1997 to
Community mental health care	from 1/07/2000 to
Admitted patient palliative care	from 1/07/2000 to
Alcohol and other drug treatment services	from 1/07/2000 to

Estimated date flag

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000431 Version number: 1

Data element type: DATA ELEMENT

Definition: An indication of whether any component of a reported date was estimated.

Context: Provision of a date is often a mandatory requirement in data collections. However, at times, the actual date or part thereof is not known (e.g. date of birth or date of injury).

This data element is designed to flag the part or parts of a date that have been estimated when a date provided is based on an approximation of the date in question rather than reporting of the actual date. This data element may assist with record linkage processes (for example when the date of birth is a component of the linkage key).

Relational and representational attributes

Datatype: Alphabetic Field size: Min. 0 Max. 3 Layout: AAA

Data domain: Null date not estimated

A	date estimated from reported age
D	day value in date was estimated
DM	day and month values in date were estimated
DMY	all values (day, month, year) in date were estimated
M	month value (only) in date was estimated
MY	month and year values in date were estimated
Y	year value (only) in date was estimated
DY	day and year values in date were estimated

Guide for use: May be used to record an estimated date for date of birth or data elements for other dates such as date of death.

Collection methods: This data element should be reported in conjunction with a reported date when any part of the date represents an estimate rather than the actual or known date.

Related data: used in conjunction with the data element Date of birth, version 3

Indigenous status

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000001 Version number: 3

Data element type: DATA ELEMENT

Definition: An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives.

Context: Given the gross inequalities in health status between indigenous and non-indigenous peoples in Australia, the size of the Aboriginal and Torres Strait Islander populations and their historical and political context, there is a strong case for ensuring that information on indigenous status is collected for planning and service delivery purposes and for monitoring Aboriginal and Torres Strait Islander health.

Relational and representational attributes

Datatype: Numeric Field size: Min 1 Max 1 Layout: N

Data domain:

1 Aboriginal but not Torres Strait Islander origin

2 Torres Strait Islander but not Aboriginal origin

3 Aboriginal and Torres Strait Islander origin

4 Neither Aboriginal nor Torres Strait Islander origin

9 Not stated

Guide for use: There are three components to the Definition:

- descent;
- self-identification; and
- community acceptance.

The classification for 'Indigenous Status' has a hierarchical structure comprising two levels. There are four categories at the detailed level of the classification which are grouped into two categories at the broad level. There is one supplementary category for 'not stated' responses. The classification is as follows:

- Indigenous
  - Aboriginal but not Torres Strait Islander Origin
  - Torres Strait Islander but not Aboriginal Origin
  - Both Aboriginal and Torres Strait Islander Origin
- Non-indigenous
  - Neither Aboriginal nor Torres Strait Islander Origin
- Not Stated

Guide for use (continued):

This category is not to be available as a valid answer to the questions but is intended for use:

- primarily when importing data from other data collections that do not contain mappable data;
- where an answer was refused; or
- where the question was not able to be asked prior to discharge because the patient was unable to communicate (e.g. patient unconscious) or a person who knows the patient was not available.

Only in the last two situations may the tick boxes on the questionnaire be left blank

Collection methods:

The standard question for Indigenous Status is as follows:

[Are you] [Is the person] [Is (name)] of Aboriginal or Torres Strait Islander origin?

(For persons of both Aboriginal and Torres Strait Islander origin, mark both 'Yes' boxes.)

No . . . . . .

Yes, Aboriginal . . . . . .

Yes, Torres Strait Islander . . . . . .

This question is recommended for self-enumerated or interview-based collections. It can also be used in circumstances where a close relative, friend, or another member of the household is answering on behalf of the subject.

When someone is not present, the person answering for them should be in a position to do so, i.e. this person must know the person about whom the question is being asked well and feel confident to provide accurate information about them. However, it is strongly recommended that this question be asked directly wherever possible.

In circumstances where it is impossible to ask the person directly, such as in the case of death, the question should be asked of a close relative or friend, and only if a relative or friend is not available should the undertaker or other such person answer.

This question should always be asked even if the person does not 'look' Aboriginal or Torres Strait Islander.

The Indigenous Status question allows for more than one response. The procedure for coding multiple responses is as follows:

If the respondent marks 'No' and either 'Aboriginal' or 'Torres Strait Islander', then the response should be coded to either Aboriginal or Torres Strait Islander as indicated (i.e. disregard the 'No' response).

If the respondent marks both the 'Aboriginal' and 'Torres Strait Islander' boxes, then their response should be coded to 'Both Aboriginal and Torres Strait Islander Origin'.

If the respondent marks all three boxes ('No', 'Aboriginal' and 'Torres Strait Islander'), then the response should be coded to 'Both Aboriginal and Torres Strait Islander Origin' (i.e. disregard the 'No' response).

Administrative attributes

Source document: Standards for Statistics on Cultural and Language Diversity, ABS Catalogue Number. 1289.0, November 1999.

Source organisation: Australian Bureau of Statistics

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Admitted patient mental health care	from 1/07/2000 to
Perinatal	from 1/07/1997 to
Community mental health care	from 1/07/2000 to
Admitted patient palliative care	from 1/07/2000 to
Alcohol and other drug treatment services	from 1/07/2000 to

Period of residence in Australia

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

NHIK identifier: 000126 Version number: 1

Data element type: DATA ELEMENT

Definition: Length of time in years.

Context: This data item was included in the recommended second-level data set by the National Committee on Health and Vital Statistics (1979) to allow analyses relating to changes in morbidity patterns of ethnic subpopulations related to length of stay in host country; for example, cardiovascular disease among Greek immigrants in Australia.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain: 00 Under one year residence in Australia

01–97 One to 97 years residence in Australia

98 Born in Australia

99 Unknown

Collection methods: This information may be obtained either from:

- a direct question with response values as specified in the data domain; or
- derived from other questions about date of birth, birthplace and year of arrival in Australia.

Related data: used in conjunction with Country of birth, version 3

Administrative attributes

Source organisation: National minimum data set working parties

Comments: This item was not considered a high priority by the Office of Multicultural Affairs (1988) and to date only 'Country of birth' and 'Indigenous status' are considered by the National Health Data Committee to be justified for inclusion in the National Minimum Data Set—Admitted patient care.

A group of items to enable collection of non-English speaking background is under development by the Australian Bureau of Statistics during 1997.

Sex

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

NHIK identifier: 000149 Version number: 2

Data element type: DATA ELEMENT

Definition: The sex of the person.

Context: Required for analyses of service utilisation, needs for services and epidemiological studies.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Male

2 Female

3 Indeterminate

9 Not stated/inadequately described

Guide for use: An indeterminate sex category may be necessary for situations such as the classification of perinatal statistics when it is not possible for the sex to be determined.

Verification rules: For the provision of State and Territory hospital data to Commonwealth agencies this field must be consistent with diagnosis and procedure codes, for records grouped in Major Diagnostic Categories 12, 13 and 14, for valid grouping, otherwise resulting in a fatal error for sex conflicts. For other Major Diagnostic Categories, sex conflicts result in a warning error.

Collection methods: It is suggested that the following format be used for data collection:

What is your (the person's) sex?

___ Male

___ Female

The term 'sex' refers to the biological differences between males and females, while the term 'gender' refers to the socially expected/perceived dimensions of behaviour associated with males and females—masculinity and femininity. The ABS advises that the correct terminology for this data element is sex.

Information collection for transsexuals and people with transgender issues should be treated in the same manner. To avoid problems with edits, transsexuals undergoing a sex change operation should have their sex at time of hospital admission recorded.

Related data: supersedes previous data element Sex, version 1

is used in the derivation of Diagnosis related group, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Admitted patient mental health care	from 1/07/2000 to
Perinatal	from 1/07/1997 to
Community mental health care	from 1/07/2000 to
Admitted patient palliative care	from 1/07/2000 to
Alcohol and other drug treatment services	from 1/07/2000 to

Comments: This item has been altered to enable standardisation of the collection of information relating to sex (to include indeterminate), gender, people with transgender issues and transsexuals.

Adult abdominal circumference

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

NHIK identifier: 000371 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A person's abdominal circumference

Relational and representational attributes

Related data: relates to Adult abdominal circumference—measured, version 1

Adult abdominal circumference—measured

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000372 Version number: 1

Data element type: DATA ELEMENT

Definition: A person's abdominal circumference measured half way between the inferior margin of the last rib and the crest of the ilium in the mid-axillary plane. The measurement is taken at the end of normal expiration.

The measurement of abdominal circumference is not the same as that of waist circumference where the minimum girth is measured.

Adult abdominal circumference: measured is a continuous variable measured to the nearest 0.1 cm.

In order to ensure consistency in measurement, the measurement protocol described under Data Collection Methods should be used.

Context: Public health and health care:

Its main use is to enable the calculation of Adult abdomen to hip ratio which requires the measurement of hip circumference and abdominal circumference.

There is evidence that abdominal circumference alone might be used to identify people at health risk both from being overweight and from having a central fat distribution (Lean et al. 1995; Han et al. 1995; Pouliot et al. 1994; Seidell et al. 1992).

Relational and representational attributes

Datatype: Numeric Field size: Min. 3 Max. 4 Layout: NNN.N

Data domain: Distance in centimetres

Guide for use: If measured abdominal circumference is not able to be collected, code 999.9

Collection methods: Measurement protocol:

The measurement of abdominal circumference requires a narrow (< 7 mm wide), flexible, inelastic tape measure. The kind of tape used should be described and reported. The graduations on the tape measure should be at 0.1 cm intervals and the tape should have the capacity to measure up to 200 cm. Measurement intervals and labels should be clearly readable under all conditions of use of the tape measure.

The subject should remove any belts and heavy outer clothing. Measurement of abdominal circumference should be taken over at most one layer of light clothing. Ideally the measure is made directly over the skin.

The subject stands comfortably with weight evenly distributed on both feet, and the feet separated about 25–30 cm. The arms should hang loosely at the sides. Posture can affect abdominal circumference.

The measurement is taken midway between the inferior margin of the last rib and the crest of the ilium, in the mid axillary plane. Each landmark should be palpated and marked, and the midpoint determined with a tape measure and marked.

Collection methods (continued): The circumference is measured with an inelastic tape maintained in a horizontal plane, at the end of normal expiration. The tape is snug, but does not compress underlying soft tissues. The measurer is positioned by the side of the subject to read the tape. To ensure contiguity of the two parts of the tape from which the circumference is to be determined, the cross-handed technique of measurement, as described by Norton et al. (1996), should be used. Ideally an assistant will check the position of the tape on the opposite side of the subject's body.

The measurement is recorded at the end of a normal expiration to the nearest 0.1 cm. Take a repeat measurement and record it to the nearest 0.1 cm. If the two measurements disagree by more than 1 cm, then take a third measurement. All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured abdominal circumference is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over reporting (Armitage and Berry 1994). For example, a mean value of 72.25 cm would be rounded to 72.2 cm, while a mean value of 72.35 cm would be rounded to 72.4 cm.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health data elements currently exist for sex, date of birth, country of birth and Indigenous Status. Data elements are being developed for physical activity and smoking.

Validation and quality control measures:

Steel tapes should be checked against a 1 metre engineer's rule every 12 months. If tapes other than steel are used they should be checked daily against a steel rule.

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996)) between observers should not exceed 2% and be less than 1.5% within observers.

Extreme values at the lower and upper end of the distribution of measured abdominal circumference should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference.

Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

Related data: is used in the calculation of Adult abdomen to hip ratio, version 1

Administrative attributes

Source document: The measurement protocol described below is that recommended by the World Health Organization (WHO Expert Committee 1995).

Source organisation: World Health Organization (see also Comments)

Comments:

Submitting organisation: The Expert Working Group on Data Standards for Indicators of Body Fatness in Australian Adults through the National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare.

Responsible organisations: National Health Data Committee (NHDC)/National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare.

This data element applies to persons aged 18 years or older. It is recommended for use in population surveys and health care settings.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For reporting purposes, it may be desirable to present abdominal circumference in categories. It is recommended that 5 cm groupings are used for this purpose. Abdominal circumference should not be rounded before categorisation. The following categories may be appropriate for describing the abdominal circumferences of Australian men and women, although the range will depend on the population.

Abdom < 60 cm

60 cm = Abdom < 65 cm

65 cm = Abdom < 70 cm

... in 5 cm categories

105 cm = Abdom < 110 cm

Abdom = 110 cm

Adult abdomen to hip ratio

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000373 Version number: 1

Data element type: DATA ELEMENT

Definition: A person's abdomen to hip ratio.

Adult abdomen to hip ratio is a continuous variable. Adult abdomen to hip ratio is calculated by: abdominal circumference (cm) divided by hip circumference (cm).

Context: Public health and health care:

Body fat distribution has emerged as an important predictor of obesity-related morbidity and mortality. Abdominal obesity, which is more common in men than women, has, in epidemiological studies, been closely associated with conditions such as coronary heart disease, stroke, non-insulin dependent diabetes mellitus and high blood pressure.

Abdomen to hip ratio (AHR) can be used:

- to indicate the prevalence of abdominal obesity and its sociodemographic distribution (problem identification);
- to evaluate health promotion and disease prevention programs (assessment of interventions);
- to monitor progress towards National Health Goals and Targets;
- to ascertain determinants and consequences of abdominal obesity; and
- in nutritional surveillance and long-term planning.

Cutoff points for abdomen to hip ratio that may define increased risk of cardiovascular disease and all cause mortality range from 0.9 to 1.0 for men and 0.8 to 0.9 for women (Croft et al. 1995; Bray 1987; Bjorntorp 1985). These values are based primarily on evidence of increased risk of death in European populations, and may not be appropriate for all age and ethnic groups.

In Australia and New Zealand, the cutoffs of > 0.9 for males and > 0.8 for females were used in the Australian Bureau of Statistics' 1995 National Nutrition Survey.

Relational and representational attributes

Datatype: Numeric Field size: Min. 3 Max. 3 Layout: N.NN

Guide for use: Adult abdomen to hip ratio cannot be calculated if either component necessary for its calculation (i.e. abdominal circumference or hip circumference) has not been collected (i.e. is coded to 999.9).

Collection methods: AHR should be derived after the data entry of abdominal circumference and hip circumference. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

Related data: is calculated using Adult hip circumference—measured, version 1

is calculated using Adult abdominal circumference—measured, version 1

Administrative attributes

Source organisation: Responsible organisations: National Health Data Committee (NHDC)/National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare. (See also Comments)

Comments: Submitting organisation: The Expert Working Group on Data Standards for Indicators of Body Fatness in Australian Adults through the National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare. Date of submission: October 1997

This data element applies to persons aged 18 years or older. It is recommended for use in population surveys and health care settings.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles a sample size of at least 200 is recommended for each group for which the centiles are being specified.

Adult body mass index

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000367 Version number: 1

Data element type: DATA ELEMENT

Definition: A person's weight (body mass) relative to height. It is a measure of body mass corrected for height which is used to assess the extent of weight deficit or excess. In sedentary populations, body mass index (BMI) also provides an imprecise but practical indicator of the level of body fat.

Adult body mass index is a continuous variable.

Adult body mass index is calculated by: weight (kg) divided by (height (m) squared)

Context: Public health and health care:

BMI is used as an indicator of both underweight and, overweight and obesity, in sedentary Western adults. On a population basis there is a strong association between BMI and health risk.

In population based surveys, BMI may be used:

- to indicate the prevalence of thinness and overweight and their sociodemographic distribution (problem identification);
- to evaluate health promotion and disease prevention programs (assessment of interventions);
- to monitor progress towards National Health Goals and Targets;
- to ascertain determinants and consequences of thinness and overweight; and
- in nutritional surveillance and long-term planning.

Relational and representational attributes

Datatype: Numeric Field size: Min. 3 Max. 4 Layout: NN.NN*/NN.N**

Guide for use: Adult body mass index cannot be calculated if either component necessary for its calculation (i.e. weight or height) is unknown or has not been collected (i.e. is coded to 888.8 or 999.9)

Collection methods: *NN.NN for BMI calculated from measured height and weight.

**NN.N for BMI calculated from self-reported height and/or self-reported weight

BMI calculated from measured height and weight should be distinguished from BMI calculated from self-reported height and/or weight. When either self-reported height or self-reported weight is used in the calculation, BMI should be recorded as self-reported BMI.

BMI should be derived after the data entry of weight and height. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

Collection methods (continued): National health data elements currently exist for sex, date of birth, country of birth and Indigenous Status. Data elements are being developed for physical activity and smoking.

Related data: is calculated using Adult height—measured, version 1

is calculated using Adult height—self-reported, version 1

is calculated using Adult weight—measured, version 1

is calculated using Adult weight—self-reported, version 1

is used in the derivation of Adult body mass index—classification, version 1

Administrative attributes

Source organisation: Responsible organisations: National Health Data Committee (NHDC)/National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare. (See also Comments)

Comments: Submitting organisation: The Expert Working Group on Data Standards for Indicators of Body Fatness in Australian Adults through the National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare. Date of submission: October 1997.

This data element applies to persons aged 18 years or older. It is recommended for use in population surveys and health care settings.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles a sample size of at least 200 is recommended for each group for which the centiles are being specified.

Body mass index can be calculated from measured height and weight, or self-reported height and weight.

Body mass index tends to be underestimated when based on self-reported, rather than measured, height and weight. This is due to the fact that, on average, height tends to be overestimated and weight tends to be underestimated when self-reported by respondents.

There are many individuals for whom BMI is an inappropriate measure of body fatness. These are individuals whose high body mass is due to excess muscle rather than fat (e.g. body builders or others in whom the level of physical activity promotes an increase in muscle mass); or in those with osteoporosis who will have a lower than usual BMI; or those who have a different body build (e.g. individuals with unusually long or short legs or a different body fat distribution) (WHO Expert Committee 1995). This is particularly important when assessing individuals but should also be taken into account in interpreting data from populations in which there are sub-groups with genetic or environmental differences in body build, composition, skeletal proportions or body fat distribution.

Epidemiological research shows that there is a strong association between BMI and health risk. Excess adipose tissue in adults is associated with excess morbidity and mortality from conditions such as hypertension, unfavourable blood lipid concentrations, diabetes mellitus, coronary heart disease, some cancers, gall bladder disease, and osteoarthritis. It may also lead to social and economic disadvantage as well as psychosocial problems. It is a major public health issue in most industrialised societies.

Comments (continued): Thinness (low BMI) is also an indicator of health risk, often being associated with general illness, anorexia, cigarette smoking, drug addiction and alcoholism. Low BMI is consistently associated with increased risk of osteoporosis and fractures in the elderly.

Adult body mass index—classification

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000368 Version number: 1

Data element type: DATA ELEMENT

Definition: The category of weight deficit or excess.

Context: Public health and health care:

BMI is used as an indicator of both underweight and, overweight and obesity, in sedentary Western adults. On a population basis there is a strong association between BMI and health risk.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Grade 3 thinness (BMI < 16.00)

2 Grade 2 thinness (BMI 16.00–16.99)

3 Grade 1 thinness (BMI 17.00–18.49)

4 Normal range (BMI 18.50–19.99)

5 (BMI 20.00–24.99)

6 Grade 1 overweight (BMI 25.00–29.99)

7 Grade 2 overweight (BMI 30.00–39.99)

8 Grade 3 overweight (BMI > or = 40.00)

(WHO Expert Committee 1995; NHMRC 1984, 1985

Collection methods: This data element applies to persons aged 18 years or older. It is recommended for use in population surveys and health care settings.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health data elements currently exist for sex, date of birth, country of birth and Indigenous Status. Data elements are being developed for physical activity and smoking.

Standard definitions of overweight and obesity in terms of BMI are used to derive age-specific and age-adjusted indicators of overweight and obesity for reporting progress towards National Health Goals and Targets.

Related data: used in conjunction with Adult body mass index, version 1

Administrative attributes

Source document: 'Physical status: the use and interpretation of anthropometry' (WHO Expert Committee 1995)

Source organisation: World Health Organization (see also Comments)

Comments:

Submitting organisation: The Expert Working Group on Data Standards for Indicators of Body Fatness in Australian Adults through the National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare.

Responsible organisation: National Health Data Committee (NHDC)/National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare.

There are, however, many individuals for whom BMI is an inappropriate measure of body fatness. These are individuals whose high body mass is due to excess muscle rather than fat (e.g. body builders or others in whom the level of physical activity promotes an increase in muscle mass); or in those with osteoporosis who will have a lower than usual BMI; or those who have a different body build (e.g. individuals with unusually long or short legs or a different body fat distribution) (WHO Expert Committee 1995). This is particularly important when assessing individuals but should also be taken into account in interpreting data from populations in which there are sub-groups with genetic or environmental differences in body build, composition, skeletal proportions or body fat distribution.

Epidemiological research shows that there is a strong association between BMI and health risk. Excess adipose tissue in adults is associated with excess morbidity and mortality from conditions such as hypertension, unfavourable blood lipid concentrations, diabetes mellitus, coronary heart disease, some cancers, gall bladder disease, and osteoarthritis. It may also lead to social and economic disadvantage as well as psychosocial problems. It is a major public health issue in most industrialised societies.

Overweight and obesity, as defined by NHMRC guidelines for the interpretation of BMI (NHMRC 1984, 1985), are exceedingly common in Australia and their prevalence is increasing. The direct economic cost of obesity (BMI = 30) to Australia was estimated to be over $500 million in 1992–93 (NHMRC 1997).

Thinness (low BMI) is also an indicator of health risk, often being associated with general illness, anorexia, cigarette smoking, drug addiction and alcoholism. Low BMI is consistently associated with increased risk of osteoporosis and fractures in the elderly.

The WHO may revise this classification to:

1 Grade 3 thinness (BMI < 16.00)

2 Grade 2 thinness (BMI 16.00–16.99)

3 Grade 1 thinness (BMI 17.00–18.49)

4 Normal range (BMI 18.50–24.99)

5 Overweight (BMI 25.00–29.99)

6 Obesity Grade 1(BMI 30.00–34.99)

7 Obesity Grade 2 (BMI 35.00–44.99)

8 Obesity Grade 3 (BMI ≥ 45.00)

Presentation of data:

Methods used to establish cut-off points for overweight have been arbitrary and, as a result, cut-off points vary between countries. The data are derived mainly from studies of mortality and morbidity risk performed in people living in western Europe or the United States of America, and cut-off points for BMI as an indicator of adiposity and risk in populations who differ in body build and genetic disposition are likely to vary. Caution is required in relation to BMI cut-off points when used for different ethnic groups because of limited outcome data for some ethnic groups, e.g. Aboriginal and Torres Strait Islander peoples. Further, the cut-off points for adults should not be used for children.

Comments (continued): There are no recognised reference standards for the lower limit of the 'normal' range. The classification below is that recommended by the World Health Organization. This is regarded as an interim classification. As with overweight the cut-off points for a given level of risk are likely to vary with body build, genetic background and physical activity.

The classification above is different to ones that have been used in the past and it is important that in any trend analysis consistent definitions are used.

BMI should not be rounded before categorisation to the classification below.

Adult height

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000361 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: ***A person's height.***

Relational and representational attributes

Related data: relates to Adult height—measured, version 1
relates to Adult height—self-reported, version 1

Adult height—measured

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000362 Version number: 1

Data element type: DATA ELEMENT

Definition: A person's measured height.

Adult height: measured is a continuous variable measured to the nearest 0.1 cm.

In order to ensure consistency in measurement, the measurement protocol described under Data Collection Methods should be used.

Context: Public health and health care:

Stature is a major indicator of general body size and of bone length. It is important in screening for disease or malnutrition, and in the interpretation of weight (Lohman et al. 1988). Shortness is known to be a predictor of all cause mortality, coronary heart disease mortality in middle aged men, and of less favourable gestational outcomes in women (Marmot et al. 1984, Kramer 1988).

Its main use is to enable the calculation of Adult body mass index which requires the measurement of height and weight.

Relational and representational attributes

Datatype: Numeric Field size: Min. 3 Max. 4 Layout: NNN.N

Guide for use: If measured height is not able to be collected, code 999.9.

Collection methods: Measurement protocol:

The measurement of height requires a vertical metric rule, a horizontal headboard, and a non-compressible flat even surface on which the subject stands. The equipment may be fixed or portable, and should be described and reported.

The graduations on the metric rule should be at 0.1 cm intervals, and the metric rule should have the capacity to measure up to at least 210 cm. Measurement intervals and labels should be clearly readable under all conditions of use of the instrument.

Apparatus that allows height to be measured while the subject stands on a platform scale is not recommended.

The subject should be measured without shoes (i.e. is barefoot or wears thin socks) and wears little clothing so that the positioning of the body can be seen. Anything that may affect or interfere with the measurement should be noted on the data collection form (e.g. hairstyles and accessories, or physical problems).

The subject stands with weight distributed evenly on both feet, heels together, and the head positioned so that the line of vision is at right angles to the body. The correct position for the head is in the Frankfort horizontal plan (Norton et al. 1996). The arms hang freely by the sides. The head, back, buttocks and heels are positioned vertically so that the buttocks and the heels are in contact with the vertical board.

To obtain a consistent measure, the subject is asked to inhale deeply and stretch to their fullest height. The measurer applies gentle upward pressure through the mastoid processes to maintain a fully erect position when the measurement is taken. Ensure that the head remains positioned so that the line of vision is at right angles to the body, and the heels remain in contact with the base board.

Collection methods (continued): The movable headboard is brought onto the top of the head with sufficient pressure to compress the hair.

The measurement is recorded to the nearest 0.1 cm. Take a repeat measurement. If the two measurements disagree by more than 0.5 cm, then take a third measurement. All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured height is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over reporting (Armitage and Berry 1994). For example, a mean value of 172.25 cm would be rounded to 172.2 cm, while a mean value of 172.35 cm would be rounded to 172.4 cm.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health data elements currently exist for sex, date of birth, country of birth and Indigenous Status. Data elements are being developed for physical activity and smoking.

Validation and quality control measures:

All equipment, whether fixed or portable should be checked prior to each measurement session to ensure that both the headboard and floor (or footboard) are at 90 degrees to the vertical rule. With some types of portable anthropometer it is necessary to check the correct alignment of the headboard, during each measurement, by means of a spirit level.

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement of height, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996)) between observers should not exceed 5 mm and be less than 5 mm within observers.

Extreme values at the lower and upper end of the distribution of measured height should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference. Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

Related data: is used in the calculation of Adult body mass index, version 1

Administrative attributes

Source document: The measurement protocol described below is those recommended by the International Society for the Advancement of Kinanthropometry as described by Norton et al. (1996), and the World Health Organization (WHO Expert Committee 1995), which was adapted from Lohman et al. (1988).

Source organisation: International Society for the Advancement of Kinanthropometry and the World Health Organization. (See also Comments)

Comments:

Submitting organisation: The Expert Working Group on Data Standards for Indicators of Body Fatness in Australian Adults through the National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare. Date of submission: October 1997.

Responsible organisation: National Health Data Committee (NHDC)/National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare.

This data element applies to persons aged 18 years or older. It is recommended for use in population surveys and health care settings.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present height data in categories. It is recommended that 5 cm groupings are used for this purpose. Height data should not be rounded before categorisation. The following categories may be appropriate for describing the heights of Australian men and women, although the range will depend on the population. The World Health Organization's range for height is 140–190 cm.

Ht <140 cm

140 cm = Ht < 145 cm

145 cm = Ht < 150 cm

... in 5 cm categories

185 cm = Ht < 190 cm

Ht = 190 cm

Adult height—self-reported

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000363 Version number: 1

Data element type: DATA ELEMENT

Definition: A person's self-reported height.

Context: Public health and health care:

Stature is a major indicator of general body size and of bone length. It is important in screening for disease or malnutrition, and in the interpretation of weight (Lohman et al. 1988). Shortness is known to be a predictor of all cause mortality and coronary heart disease mortality in middle aged men (Marmot et al. 1984) and of less favourable gestational outcomes in women (Kramer 1988).

Its main use is to enable the calculation of body mass index which requires the measurement of height and body mass (weight).

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 3 Layout: NNN

Guide for use: If self-reported height is unknown, code 888

If self-reported height is not responded to, code 999

Collection methods: The method of data collection, e.g. face to face interview, telephone interview or self-completion questionnaire, can affect survey estimates and should be reported.

The data collection form should include a question asking the respondent what their height is. For example, the ABS National Health Survey 1995 included the question 'How tall are you without shoes'?. The data collection form should allow for both metric (to the nearest 1 cm) and imperial (to the nearest 0.5 inch) units to be recorded.

If practical, it is preferable to enter the raw data into the database before conversion of measures in imperial units to metric. However if this is not possible, height reported in imperial units can be converted to metric prior to data entry using a conversion factor of 2.54 cm to the inch.

Rounding to the nearest 1 cm will be required for measures converted to metric prior to data entry, and may be required for data reported in metric units to a greater level of precision than the nearest 1 cm. The following rounding conventions are desirable to reduce systematic over reporting (Armitage and Berry 1994):

nnn.x where x < 5—round down, e.g. 172.2 cm would be rounded to 172 cm.

nnn.x where x > 5—round up, e.g. 172.7 cm would be rounded to 173 cm.

nnn.x where x = 5—round to the nearest even number, e.g. 172.5 cm would be rounded to 172 cm, while 173.5 cm would be rounded to 174 cm.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health data elements currently exist for sex, date of birth, country of birth and Indigenous Status. Data elements are being developed for physical activity and smoking.

Related data: is used in the calculation of Adult body mass index, version 1

Source organisation: Responsible organisations: National Health Data Committee (NHDC)/National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare. (See also Comments)

Comments:

Submitting organisation: The Expert Working Group on Data Standards for Indicators of Body Fatness in Australian Adults through the National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare. Date of submission: October 1997.

This data element applies to persons aged 18 years or older. It is recommended for use in population surveys when it is not possible to measure height.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present height data in categories. It is recommended that 5 cm groupings are used for this purpose. Height data should not be rounded before categorisation. The following categories may be appropriate for describing the heights of Australian men and women, although the range will depend on the population. The World Health Organization's range for height is 140–190 cm.

Ht <140 cm

140 cm = Ht < 145 cm

145 cm = Ht < 150 cm

... in 5 cm categories

185 cm = Ht < 190 cm

Ht = 190 cm

On average, height tends to be overestimated when self-reported by respondents. Data for Australian men and women aged 20–69 years in 1989 indicated that men overestimated by an average of 1.1 cm (sem of 0.04 cm) and women by an average of 0.5 cm (sem of 0.05 cm) (Waters 1993). The extent of overestimation varied with age.

Adult hip circumference

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000369 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A person's hip circumference

Relational and representational attributes

Related data: relates to Adult hip circumference—measured, version 1

Adult hip circumference—measured

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000370 Version number: 1

Data element type: DATA ELEMENT

Definition: A person's hip circumference measured at the level of maximum posterior extension of the buttocks.

Adult hip circumference: measured is a continuous variable measured to the nearest 0.1 cm.

In order to ensure consistency in measurement, the measurement protocol described under Data Collection Methods should be used.

Context: Public health and health care:

Its main use is to enable the calculation of Adult abdomen to hip ratio which requires the measurement of hip circumference and abdominal circumference.

Relational and representational attributes

Datatype: Numeric Field size: Min. 3 Max. 4 Layout: NNN.N

Guide for use: If measured hip circumference is not able to be collected, code 999.9

Collection methods: Measurement protocol:

The data collection form should allow for up to three measurements of hip circumference to be recorded in centimetres to 1 decimal place. The data collection form should also have the capacity to record any reasons for the non-collection of hip circumference data.

The measurement of hip circumference requires a narrow (< 7 mm wide), flexible, inelastic tape measure. The kind of tape used should be described and reported. The graduations on the tape measure should be at 0.1 cm intervals and the tape should have the capacity to measure up to 200 cm. Measurement intervals and labels should be clearly readable under all conditions of use of the tape measure.

The subject should wear only non-restrictive briefs or underwear, a light smock over underwear or light clothing. Belts and heavy outer clothing should be removed. Hip measurement should be taken over one layer of light clothing only.

The subject stands erect with arms at the sides, feet together and the gluteal muscles relaxed. The measurer sits at the side of the subject so that the level of maximum posterior extension of the buttocks can be seen. An inelastic tape is placed around the buttocks in a horizontal plane. To ensure contiguity of the two parts of the tape from which the circumference is to be determined, the cross-handed technique of measurement, as described by Norton et al. (1996), should be used. Ideally an assistant will check the position of the tape on the opposite side of the subject's body. The tape is in contact with the skin but does not compress the soft tissues. Fatty aprons should be excluded from the hip circumference measurement.

The measurement is recorded to the nearest 0.1 cm. Take a repeat measurement and record it to the nearest 0.1 cm. If the two measurements disagree by more than 1 cm, then take a third measurement.

Collection methods (continued): All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the data base as this enables intra-observer and, where relevant, inter-observer errors to be assessed.The subject's measured hip circumference is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over reporting. For example, a mean value of 102.25 cm would be rounded to 102.2 cm, while a mean value of 102.35 cm would be rounded to 102.4 cm.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

Validation and quality control measures:

Steel tapes should be checked against a 1 metre engineer's rule every 12 months. If tapes other than steel are used they should be checked daily against a steel rule.

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996)) between observers should not exceed 2% and be less than 1.5% within observers.

Extreme values at the lower and upper end of the distribution of measured hip circumference should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference.

Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

Related data: is used in the calculation of Adult abdomen to hip ratio, version 1

Administrative attributes

Source document: The measurement protocol described below is that recommended by the World Health Organization (WHO Expert Committee 1995).

Source organisation: World Health Organization (see also Comments)

Comments: Submitting organisation: The Expert Working Group on Data Standards for Indicators of Body Fatness in Australian Adults through the National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare. Date of submission: October 1997.

Responsible organisation: National Health Data Committee (NHDC)/National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare.

This data element applies to persons aged 18 years or older. It is recommended for use in population surveys and health care settings.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

Comments (continued): For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present hip circumference data in categories. It is recommended that 5cm groupings be used for this purpose. Hip circumference data should not be rounded before categorisation.

Adult weight

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000364 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A person's weight (body mass).

Relational and representational attributes

Related data: relates to Adult weight—measured, version 1
relates to Adult weight—self-reported, version 1

Adult weight—measured

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000365 Version number: 1

Data element type: DATA ELEMENT

Definition: A person's measured weight (body mass) without any clothing or in light indoor clothes.

Adult weight: measured is a continuous variable measured to the nearest 0.1 kg.

In order to ensure consistency in measurement, the measurement protocol described under Data Collection Methods should be used.

Context: Public health and health care:

Weight is an overall measure of body size that does not distinguish between fat and muscle. Weight is an indicator of nutrition status and health status. Low pre-pregnancy weight is an indicator of poorer gestational outcome in women (Kramer 1988). Low weight is also associated with osteoporosis. In general, change in weight in adults is of interest because it is an indicator of changing health status.

It is used to enable the calculation of Adult body mass index which requires the measurement of height and weight.

Relational and representational attributes

Datatype: Numeric Field size: Min. 3 Max. 4 Layout: NNN.N

Guide for use: If measured weight is not able to be collected, code 999.9

Collection methods: Measurement protocol:

Equipment used should be described and reported. Scales should have a resolution of at least 0.1kg and should have the capacity to weigh up to at least 200 kg. Measurement intervals and labels should be clearly readable under all conditions of use of the instrument.

The subject stands over the centre of the weighing instrument, with the body weight evenly distributed between both feet.

Heavy jewellery should be removed and pockets emptied. Light indoor clothing can be worn, excluding shoes, belts, and sweater. Any variations from light indoor clothing (e.g. heavy clothing, such as kaftans or coats worn because of cultural practices) should be noted on the data collection form.

Adjustments for non-standard clothing (i.e. other than light indoor clothing) should only be made in the data checking/cleaning stage prior to data analysis.

If the subject has had one or more limbs amputated, record this on the data collection form and weigh them as they are.

If they are wearing an artificial limb, record this on the data collection form but do not ask them to remove it. Similarly, if they are not wearing the limb, record this but do not ask them to put it on.

Collection methods (continued): The measurement is recorded to the nearest 0.1 kg. If the scales do not have a digital readout, take a repeat measurement. If the two measurements disagree by more than 0.5 kg, then take a third measurement. All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured weight is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 kg. If so, rounding should be to the nearest even digit to reduce systematic over reporting (Armitage and Berry 1994). For example, a mean value of 72.25 kg would be rounded to 72.2 kg, while a mean value of 72.35 kg would be rounded to 72.4 kg.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health data elements currently exist for sex, date of birth, country of birth and Indigenous Status.

Validation and quality control measures:

If practical, equipment should be checked daily using one or more objects of known weight in the range to be measured.

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement of weight, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement) between observers should not exceed 0.5 kg and be less than 0.5 kg within observers.

Extreme values at the lower and upper end of the distribution of measured height should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference.

Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

Related data: is used in the calculation of Adult body mass index, version 1

Administrative attributes

Source document: The measurement protocol described below is that recommended by the World Health Organization (WHO Expert Committee 1995).

Source organisation: World Health Organization (see also Comments)

Comments: Submitting organisation: The Expert Working Group on Data Standards for Indicators of Body Fatness in Australian Adults through the National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare. Date of submission: October 1997.

Responsible organisation: National Health Data Committee (NHDC)/National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare.

This data element applies to persons aged 18 years or older. It is recommended for use in population surveys and health care settings.

Comments (continued): Presentation of data:

Means and 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present weight data in categories. It is recommended that 5 kg groupings are used for this purpose. Weight data should not be rounded before categorisation.

Adult weight—self-reported

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000366 Version number: 1

Data element type: DATA ELEMENT

Definition: A person's self-reported weight (body mass) without any clothing or in light indoor clothes.

Context: Public health and health care:

Weight is an overall measure of body size that does not distinguish between fat and muscle. Weight is an indicator of nutrition status and health status. Low pre-pregnancy weight is an indicator of poorer gestational outcome in women (Kramer 1988). Low weight is also associated with osteoporosis. In general, change in weight is of interest in adults because it is an indicator of changing health status.

It is used to enable the calculation of body mass index which requires the measurement of height and weight.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 3 Layout: NNN

Guide for use: If self-reported body mass (weight) is unknown, code 888

If self-reported body mass (weight) is not responded to, code 999

Collection methods: The method of data collection, e.g. face to face interview, telephone interview or self-completion questionnaire, can affect survey estimates and should be reported.

The data collection form should include a question asking the respondent what their weight is. For example, the ABS National Health Survey 1989-90 included the question 'How much do you weigh without clothes and shoes'?. The data collection form should allow for both metric (to the nearest 1 kg) and imperial (to the nearest 1 lb) units to be recorded.

If practical, it is preferable to enter the raw data into the data base before conversion of measures in imperial units to metric. However, if this is not possible, weight reported in imperial units can be converted to metric prior to data entry using a conversion factor of 0.454 kg to the lb.

Rounding to the nearest 1 kg will be required for measures converted to metric prior to data entry, and may be required for data reported in metric units to a greater level of precision than the nearest 1 kg. The following rounding conventions are desirable to reduce systematic over reporting (Armitage and Berry 1994):

nnn.x where x < 5—round down, e.g. 72.2 kg would be rounded to 72 kg.

nnn.x where x > 5—round up, e.g. 72.7 kg would be rounded to 73 kg.

nnn.x where x = 5—round to the nearest even number, e.g. 72.5 kg would be rounded to 72 kg, while 73.5 kg would be rounded to 74 kg.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

Collection methods (continued): National health data elements currently exist for sex, date of birth, country of birth and Indigenous Status. Data elements are being developed for physical activity and smoking.

Related data: is used in the calculation of Adult body mass index, version 1

Administrative attributes

Source organisation: Responsible organisations: National Health Data Committee (NHDC)/National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare. (See also Comments)

Comments: Submitting organisation: The Expert Working Group on Data Standards for Indicators of Body Fatness in Australian Adults through the National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare. Date of submission: October 1997.

This data element applies to persons aged 18 years or older. It is recommended for use in population surveys when it is not possible to measure weight.

Presentation of data:

Means and 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present weight data in categories. It is recommended that 5 kg groupings are used for this purpose. Weight data should not be rounded before categorisation. The following categories may be appropriate for describing the weights of Australian men and women, although the range will depend on the population. The World Health Organization's range for weight is 30–140 kg.

Wt< 30 kg

30 kg = Wt <35 kg

35 kg = Wt < 40 kg

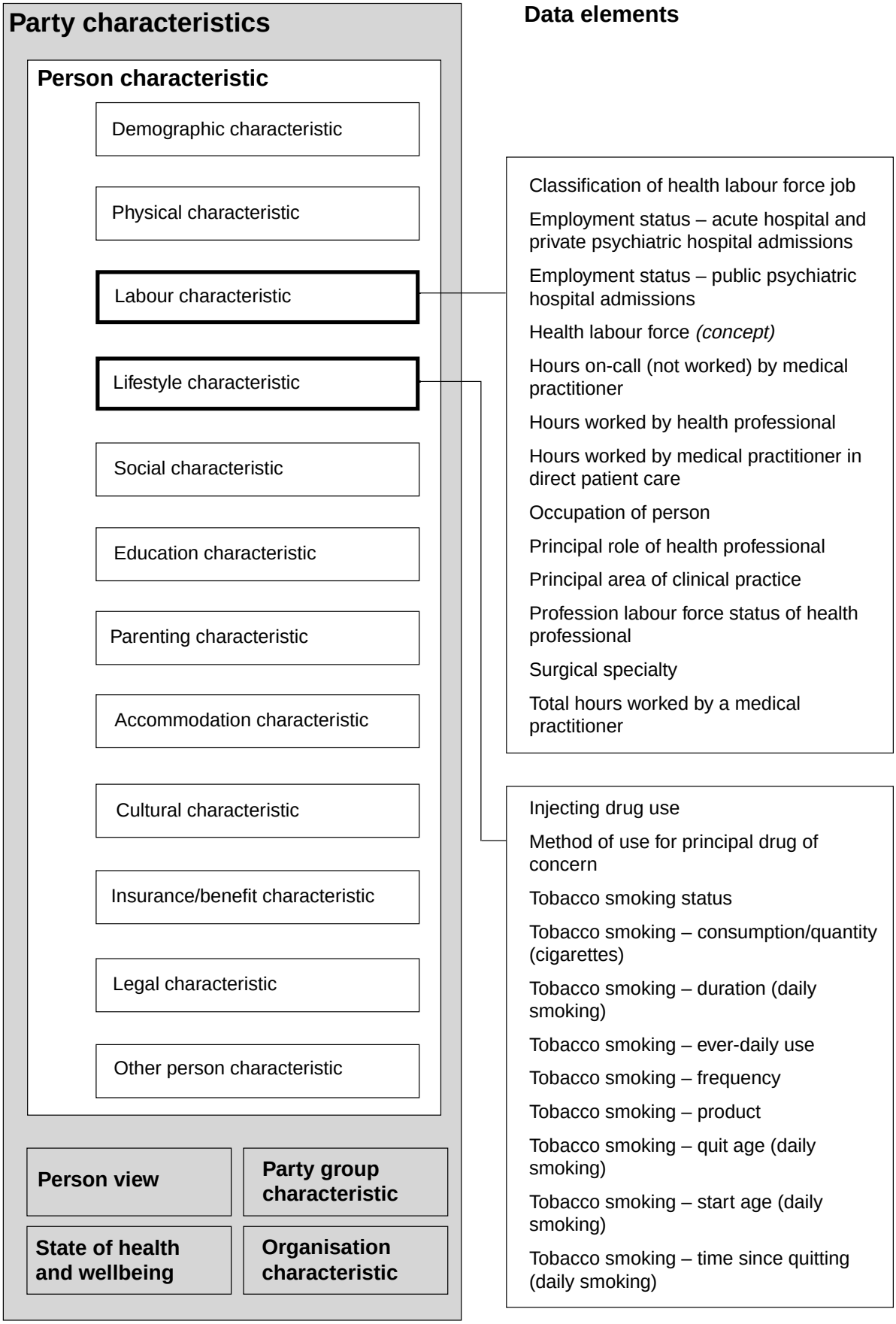
... in 5 kg categories

135 kg = Wt < 140 kg

Wt = 140 kg

On average, body mass (weight) tends to be underestimated when self-reported by respondents. Data for men and women aged 20–69 years in 1989 indicated that men underestimated by an average of 0.2 kg (sem of 0.05 kg) and women by an average of 0.4 kg (sem of 0.04 kg) (Waters 1993). The extent of underestimation varied with age.

National Health Information Model entity



Classification of health labour force job

Admin. status: CURRENT 1/07/1995

Identifying and definitional attributes

Knowledgebase ID: 000023 Version number: 1

Data element type: DATA ELEMENT

Definition: Position or job classification is a broad description of the roles and levels within a general organisational or industrial structure for health professions, and classifications vary among the professions according to organisational arrangements.

Context: Health labour force: distribution of a professional labour force across job classification categories cross classified with other variables allows analysis of:

- career progression
- age and gender distribution
- imputed salary/wage distribution

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 3 Max. 3 Layout: ANN

Data domain:

A01	Medicine—General practitioner working mainly in general practice
A02	Medicine—General practitioner working mainly in a special interest area
A03	Medicine—Salaried non-specialist hospital practitioner: RMO or intern
A04	Medicine—Salaried non-specialist hospital practitioner: other hospital career medical officer
A05	Medicine—Specialist
A06	Medicine—Specialist in training (e.g. registrar)
B01	Dentistry (private practice only)—Solo practitioner
B02	Dentistry (private practice only)—Solo principal with assistant(s)
B03	Dentistry (private practice only)—Partnership
B04	Dentistry (private practice only)—Associateship
B05	Dentistry (private practice only)—Assistant
B06	Dentistry (private practice only)—Locum
C01	Nursing—Enrolled nurse
C02	Nursing—Registered nurse
C03	Nursing—Clinical nurse
C04	Nursing—Clinical nurse consultant/supervisor
C05	Nursing—Nurse manager
C06	Nursing—Nurse educator
C07	Nursing—Nurse researcher
C08	Nursing—Assistant director of nursing
C09	Nursing—Deputy director of nursing
C10	Nursing—Director of nursing
C11	Nursing—Tutor/lecturer/senior lecturer in nursing (tertiary institution)

Data domain (continued):

C12	Nursing—Associate professor/professor in nursing (tertiary institution)
C98	Nursing—Other (specify)
C99	Nursing—Unknown/inadequately described/not stated
D01	Pharmacy (community pharmacist)—Sole proprietor
D02	Pharmacy (community pharmacist)—Partner-proprietor
D03	Pharmacy (community pharmacist)—Pharmacist-in-charge
D04	Pharmacy (community pharmacist)—Permanent assistant
D05	Pharmacy (community pharmacist)—Reliever, regular location
D06	Pharmacy (community pharmacist)—Reliever, various locations
E01	Pharmacy (Hospital/clinic pharmacist)—Director/deputy director
E02	Pharmacy (Hospital/clinic pharmacist)—Grade III pharmacist
E03	Pharmacy (Hospital/clinic pharmacist)—Grade II pharmacist
E04	Pharmacy (Hospital/clinic pharmacist)—Grade I pharmacist
E05	Pharmacy (Hospital/clinic pharmacist)—Sole pharmacist
F01	Podiatry—Own practice (or partnership)
F02	Podiatry—Own practice and sessional appointments elsewhere
F03	Podiatry—Own practice and fee-for-service elsewhere
F04	Podiatry—Own practice, sessional and fee-for-service appointments elsewhere
F05	Podiatry—Salaried podiatrist
F06	Podiatry—Locum, regular location
F07	Podiatry—Locum, various locations
F08	Podiatry—Other (specify)
G01	Physiotherapy—Own practice (or partnership)
G02	Physiotherapy—Own practice and sessional appointments elsewhere
G03	Physiotherapy—Own practice and fee-for-service elsewhere
G04	Physiotherapy—Own practice, sessional and fee-for-service appointments elsewhere
G05	Physiotherapy—Salaried physiotherapist
G06	Physiotherapy—Locum, regular location
G07	Physiotherapy—Locum, various locations

Administrative attributes

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/1989 to

Comments Position or job classifications are specific to each profession and may differ by State or Territory. The classifications above are simplified so that comparable data presentation is possible and possible confounding effects of enterprise specific structures are avoided.For example, for medicine, the job classification collected in the national health labour force collection is very broad. State/Territory health authorities have more detailed classifications for salaried medical practitioners in hospitals. These classifications separate interns, the Resident Medical Officer levels, Registrar levels, Career Medical Officer positions, and supervisory positions including clinical and medical superintendents. Space restrictions do not at present permit these classes to be included in the National Health Labour Force Collection questionnaire.

Employment status—acute hospital and private psychiatric hospital admissions

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000395 Version number: 2

Data element type: DATA ELEMENT

Definition: Self-reported employment status of a person, immediately prior to admission to an acute or private psychiatric hospital.

Context: The Australian Health Ministers' Advisory Council Health Targets and Implementation Committee (1988) identified socioeconomic status as the most important factor explaining health differentials in the Australian population. The committee recommended that national health statistics routinely identify the various groups of concern. This requires routine recording in all collections of indicators of socioeconomic status. In order of priority, these would be: employment status, income, occupation and education.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Unemployed/pensioner

2 Other

Collection methods: For national reporting purposes it is preferable to distinguish these two data items logically, however, in practice, this data item and current or last occupation could probably be collected with a single question, as is done in Western Australia:

Occupation?

For example:

- housewife or home duties
- pensioner miner
- tree feller
- retired electrician
- unemployed trades assistant
- child
- student
- accountant

Related data: relates to Employment status—public psychiatric hospital admissions, version 2

supersedes previous data element Employment status, version 1

Administrative attributes

Source organisation: National minimum data set working parties

National minimum data sets:

Admitted patient mental health care from 1/07/2000 to

Employment status—public psychiatric hospital admissions

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000317 Version number: 2

Data element type: DATA ELEMENT

Definition: Self-reported employment status of a person, immediately prior to admission to a public psychiatric hospital.

Context: The Australian Health Ministers' Advisory Council Health Targets and Implementation Committee (1988) identified socioeconomic status as the most important factor explaining health differentials in the Australian population. The committee recommended that national health statistics routinely identify the various groups of concern. This requires routine recording in all collections of indicators of socioeconomic status. In order of priority, these would be: employment status, income, occupation and education.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Child not at school
2	Student
3	Employed
4	Unemployed
5	Home duties
6	Other

Collection methods: For national reporting purposes it is preferable to distinguish these two data items logically, however, in practice, this data item and current or last occupation could probably be collected with a single question, as is done in Western Australia:

Occupation?

For example:

- housewife or home duties
- pensioner miner
- tree feller
- retired electrician
- unemployed trades assistant
- child
- student
- accountant

Related data: relates to Employment status—acute hospital and private psychiatric hospital admissions, version 2

supersedes previous Employment status, version 1

Administrative attributes

Source organisation: National minimum data set working parties

National minimum data sets:

Admitted patient mental health care from 1/07/2000 to

Health labour force

Admin. status: CURRENT 1/07/1995

Identifying and definitional attributes

Knowledgebase ID: 000061 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: All those in paid employment, unpaid contributing family workers, and unpaid volunteers:

- whose primary employment role is to achieve a health outcome for either individuals or the population as a whole, whether this is in clinical, research, education, administrative or public health capacities;
- employed in the health industry defined by the Australian Bureau of Statistics (ABS) using the Australian and New Zealand Standard Industrial Classification, other than those already included.

The health labour force consists of all those persons included in the health work force plus all those persons not currently employed in the health work force who are seeking employment therein. Health professionals registered in Australia but working overseas are excluded from the national health labour force. Health professionals registered in a particular State or Territory but working solely in another State or Territory or overseas are excluded from the health labour force for that State or Territory.

Context: Health labour force statistics and public hospital establishments.

Relational and representational attributes

Related data: relates to Profession labour force status of health professional, version 1

Administrative attributes

Source organisation: National Health Labour Force Data Working Group

Hours on-call (not worked) by medical practitioner

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000393 Version number: 2

Data element type: DATA ELEMENT

Definition: The number of hours in a week that a medical practitioner is required to be available to provide advice, respond to any emergencies etc.

Context: Health labour force: used in relation to issues of economic activity, productivity, wage rates, working conditions etc. Used to develop capacity measures relating to total time available. Assists in analysis of human resource requirements and labour force modelling. Used to determine full-time and part-time work status and to compute full-time equivalents (FTE) (see entry for FTE).

Often the definition for full-time or FTE differs (35, 37.5 and 40 hours) and knowing total hours and numbers of individuals allows for variance in FTE.

Relational and representational attributes

Datatype: Numeric Field size: Min. 3 Max. 3 Layout: NNN

Data domain: Total hours, expressed as 000, 001 etc.

Guide for use: Code 999 for not stated/inadequately described

Data element relates to each position (job) held by a medical practitioner.

Verification rules: Value must be less than 169 (except for 999).

Collection methods: There are inherent problems in asking for information on number of hours on-call not worked per week, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours on-call not worked are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.

Related data: relates to Hours worked by medical practitioner in direct patient care, version 2

relates to Total hours worked by a medical practitioner, version 2

supersedes previous data element Hours worked, version 1

Administrative attributes

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/1989 to

Hours worked by health professional

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000313 Version number: 2

Data element type: DATA ELEMENT

Definition: Hours worked is the amount of time a person spends at work in a week in employment/self-employment. It may apply to hours actually worked in a week or hours usually worked per week, and the National Health Labour Force Collection collects hours usually worked. It includes all paid and unpaid overtime less any time off. It also

- includes travel to home visits or calls out;
- excludes other time travelling between work locations;
- excludes unpaid professional and/or voluntary activities.

Total hours worked is the amount of time spent at work in all jobs.

As well as total hours worked, for some professions the National Health Labour Force Collection asks for hours worked in each of the main job, second job and third job. Hours worked for each of these is the amount of time spent at work in each job.

Context: Health labour force: important variable in relation to issues of economic activity, productivity, wage rates, working conditions etc. Used to develop capacity measures relating to total time available. Assists in analysis of human resource requirements and labour force modelling. Used to determine full-time and part-time work status and to compute full-time equivalents (FTE) (see entry for FTE).

Often the definition for full-time or FTE differs (35, 37.5 and 40 hours) and knowing total hours and numbers of individuals allows for variance in FTE.

Relational and representational attributes

Datatype: Numeric Field size: Min. 3 Max. 3 Layout: NNN

Data domain: Total hours, expressed as 000, 001 etc.

Guide for use: Code 999 for not stated/inadequately described

Verification rules: Value must be less than 127 (except for 999).

Collection methods: There are inherent problems in asking for information on number of hours usually worked per week, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours worked are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.

Related data: supersedes previous data element Hours worked, version 1

Administrative attributes

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/1989 to

Comments: It is often argued that health professionals contribute a considerable amount of time to voluntary professional work and that this component needs to be identified. This should be considered as an additional item, and kept segregated from data on paid hours worked.

Hours worked by medical practitioner in direct patient care

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000392 Version number: 2

Data element type: DATA ELEMENT

Definition: The number of hours worked in a week by a medical practitioner on service provision to patients including direct contact with patients, providing care, instructions and counselling, and providing other related services such as writing referrals, prescriptions and phone calls.

Context: Health labour force: used in relation to issues of economic activity, productivity, wage rates, working conditions etc. Used to develop capacity measures relating to total time available. Assists in analysis of human resource requirements and labour force modelling.

Relational and representational attributes

Datatype: Numeric Field size: Min. 3 Max. 3 Layout: NNN

Data domain: Total hours, expressed as 000, 001 etc.

Guide for use: Code 999 for not stated/inadequately described.

Data element relates to each position (job) held by a medical practitioner, not the aggregate of hours worked for all jobs.

Verification rules: Value must be less than 127 (except for 999).

Collection methods: There are inherent problems in asking for information on number of hours usually worked per week in direct patient care, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours worked in direct patient care are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.

Related data: relates to Hours on-call (not worked) by medical practitioner, version 2

relates to Total hours worked by a medical practitioner, version 2

supersedes previous data element Hours worked, version 1

Administrative attributes

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/1989 to

Comments: It is often argued that health professionals contribute a considerable amount of time to voluntary professional work and that this component needs to be identified. This should be considered as an additional item, and kept segregated from data on paid hours worked.

Occupation of person

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000230 Version number: 2

Data element type: DATA ELEMENT

Definition: The current job or duties in which the person is principally engaged.

Context: Injury surveillance: there is considerable user demand for data on occupation-related injury and illness, including from Worksafe Australia and from industry, where unnecessary production costs are known in some areas and suspected to be related to others in work-related illness, injury and disability.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain: Australian Standard Classification of Occupations, Second edition (ABS 1997, Catalogue No. 1220.0 2 digit code level (sub major group)

Related data: supersedes previous data element Occupation of person, version 1

Administrative attributes

Source document: Australian Standard Classification of Occupations, Second Edition, 1997, Catalogue No. 1220.0

Source organisation: Australian Bureau of Statistics

Comments: The structure of the Australian Standard Classification of Occupations has five levels:

9	Major groups	1-digit codes
35	Sub-major groups	2-digit codes
81	Minor groups	3-digit codes
340	Unit groups	4-digit codes
986	Occupations	5-digit codes

For example:

Level	Code	Title
Major group	2	Professionals
Sub-major group	23	Health Professionals
Minor group	231	Medical Practitioners
Unit group	2311	Generalist Medical Practitioners
Occupation	2311–11	General Medical Practitioner

A Computer Assisted Coding system is available from the Australian Bureau of Statistics to assist in coding occupational data to Australian Standard Classification of Occupations codes.

Principal area of clinical practice

Admin. status: CURRENT 1/07/1995

Identifying and definitional attributes

Knowledgebase ID: 000135 Version number: 1

Data element type: DATA ELEMENT

Definition: Principal area of clinical practice is defined as either the field of principal professional clinical activity or the primary area of responsibility, depending on the profession. It may be described in terms of the particular discipline, skills or knowledge field of the profession, whether general or specialised; or described in terms of the principal client group; or described by the principal activity of an institution, or section of an institution, where clinical practice takes place.

Context: Health labour force: to analyse distribution of clinical service providers by the area of their principal clinical practice. Cross-classified with other data, this item allows analysis of geographic distribution and profiles of population subsets. Required for health labour force modelling.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 3 Max. 3 Layout: ANN

Data domain:

A11	GP/primary medical care practitioner—general practice
A12	GP/primary medical care practitioner—a special interest area (specified)
A21	GP/primary medical care practitioner—vocationally registered
A22	GP/primary medical care practitioner—holder of fellowship of RACGP
A23	GP/primary medical care practitioner—RACGP trainee
A24	GP/primary medical care practitioner—other
B31	Non-specialist hospital (salaried)—RMO/intern
B32	Non-specialist hospital (salaried)—other hospital career
B41	Non-specialist hospital (salaried)—holder of Certificate of Satisfactory Completion of Training
B42	Non-specialist hospital (salaried)—RACGP trainee
B44	Non-specialist hospital (salaried)—other
B51	Non-specialist hospital (salaried)—specialist (includes private and hospital)
B52	Non-specialist hospital (salaried)—specialist in training (e.g. registrar)
B90	Non-specialist hospital (salaried)—not applicable
C	The following nursing codes are subject to revision because of changes in the profession and should be read in the context of the comments below:
C01	Nurse labour force—mixed medical/surgical nursing
C02	Nurse labour force—medical nursing
C03	Nurse labour force—surgical nursing
C04	Nurse labour force—operating theatre nursing
C05	Nurse labour force—intensive care nursing
C06	Nurse labour force—paediatric nursing
C07	Nurse labour force—maternity and obstetric nursing
C08	Nurse labour force—psychiatric/mental health nursing

Data domain (continued):

C09	Nurse labour force—developmental disability nursing
C10	Nurse labour force—gerontology/geriatric nursing
C11	Nurse labour force—accident and emergency nursing
C12	Nurse labour force—community health nursing
C13	Nurse labour force—child health nursing
C14	Nurse labour force—school nursing
C15	Nurse labour force—district/domiciliary nursing
C16	Nurse labour force—occupational health nursing
C17	Nurse labour force—private medical practice nursing
C18	Nurse labour force—independent practice
C19	Nurse labour force—independent midwifery practice
C20	Nurse labour force—no one principal area of practice
C98	Nurse labour force—other (specify)
C99	Nurse labour force—unknown/inadequately described/not stated

Guide for use: Specifics will vary for each profession as appropriate and will be reflected in the classification/coding that is applied. Classification within the National Health Labour Force Collection is profession-specific.

Administrative attributes

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/1989 to

Comments: The comments that follow apply to the nurse labour force specifically.

It is strongly recommended that, in the case of the nurse labour force, further disaggregation be avoided as much as possible. The reason for this recommendation is that any expansion of the classification to include specific specialty areas (e.g. cardiology, otorhinolaryngology, gynaecology etc.) will only capture data from hospitals with dedicated wards or units; persons whose clinical practice includes a mix of cases within a single ward setting (as in the majority of country and minor metropolitan hospitals) will not be included in any single specialty count, leading to a risk of the data being misinterpreted. The data would show a far lower number of practitioners involved in providing services to patients with some of the listed specialty conditions than is the case.

Principal role of health professional

Admin. status: CURRENT 1/07/1995

Identifying and definitional attributes

Knowledgebase ID: 000138 Version number: 1

Data element type: DATA ELEMENT

Definition: The principal role of a health professional is that in which the person usually works the most hours each week.

Context: Health labour force: this data element provides information on the principal professional role of respondents who currently work within the broad context/discipline field of their profession (as determined by data element Professional labour force status). Identification of clinicians provides comparability with other labour force collections that just include clinicians.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Clinician
2	Administrator
3	Teacher/educator
4	Researcher
5	Public health/health promotion
6	Occupational health
7	Environmental health
8	Other (specify)
9	Unknown/inadequately described/not stated

Guide for use: Code 1. A clinician is a person mainly involved in the area of clinical practice, i.e. diagnosis, care and treatment, including recommended preventative action, to patients or clients. Clinical practice may involve direct client contact or may be practised indirectly through individual case material (as in radiology and laboratory medicine).

Code 2. An administrator in a health profession is a person whose main job is in an administrative capacity in the profession, e.g. directors of nursing, medical superintendents, medical advisors in government health authorities, health profession union administrators (e.g. Australian Medical Association, Australian Nurses Federation).

Code 3. A teacher/educator in a health profession is a person whose main job is employment by tertiary institutions or health institutions to provide education and training in the profession.

Code 4. A researcher in a health profession is a person whose main job is to conduct research in the field of the profession, especially in the area of clinical activity. Researchers are employed by tertiary institutions, medical research bodies, health institutions, health authorities, drug companies and other bodies.

Codes 5, 6 and 7. Public health/health promotion, occupational health and environmental health are specialties in medicine, and fields of practice for some other health professions. They are public health rather than clinical practice, and hence are excluded from clinical practice.

Collection methods: For respondents indicating that their principal professional role is in clinical practice, a more detailed identification of that role is established according to profession-specific categories.

Administrative attributes

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/1989 to

Profession labour force status of health professional

Admin. status: CURRENT 1/07/1995

Identifying and definitional attributes

Knowledgebase ID: 000140 Version number: 1

Data element type: DATA ELEMENT

Definition: For the national health labour force collections, profession labour force status of a health professional in a particular profession is defined by employment status according to the classification/coding frame below at the time of renewal of registration.

Employment in a particular health profession is defined by practice of that profession or work that is principally concerned with the discipline of the profession (for example, research in the field of the profession, administration of the profession, teaching of the profession or health promotion through public dissemination of the professional knowledge of the profession).

Context: Health labour force: this data element provides essential data for estimating the size and distribution of the health labour force, monitoring growth, forecasting future supply, and addressing work force planning issues. It was developed by the National Committee for Health and Vital Statistics during the 1980s and endorsed by the Australian Health Ministers Advisory Council in 1990 as a national minimum data set item for development of the national health labour force collections.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 3 Layout: N or N.N

Data domain:

1	Employed in the profession: working in/practising the reference profession—in reference State
2	Employed in the profession: working in/practising the reference profession—mainly in other State(s) but also in reference State
3	Employed in the profession: working in/practising the reference profession—mainly in reference State but also in other State(s)
4	Employed in the profession: working in/practising the reference profession—only in State(s) other than reference State
5.1	Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice in the profession—seeking either full-time or part-time work
5.2	Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice in the profession—seeking full-time work
5.3	Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice in the profession—seeking part-time work
5.9	Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice in the profession—seeking work (not stated)
6.1	Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession—seeking either full-time or part-time work

Data domain (continued):

6.2 Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession—seeking full-time work

6.3 Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession—seeking part-time work

6.9 Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession—seeking work (not stated)

7 Not in the labour force for the profession: not in work/practice in the profession and not looking for work/practice in the profession

8 Not in the labour force for the profession: working overseas

9 Unknown/not stated

Guide for use:

The term 'employed in the profession' equates to persons who have a job in Australia in the field of the reference profession.

A person who is normally employed in the profession but is on leave at the time of the annual survey is defined as being employed.

A health professional who is not employed but is eligible to work in, and is seeking employment in the profession, is defined as unemployed in the profession.

A health professional looking for work in the profession, and not currently employed in the profession, may be either unemployed or employed in an occupation other than the profession.

A registered health professional who is not employed in the profession, nor is looking for work in the profession, is defined as not in the labour force for the profession.

Registered health professionals not in the labour force for the profession may be either not employed and not looking for work, or employed in another occupation and not looking for work in the profession.

Collection methods:

For the national health labour force collection survey questionnaire, this is the key filter question. It excludes from further survey questions at this point:

- persons working overseas although working/practising in the reference profession
- respondents working only in States other than the reference state
- respondents not working in the reference profession and not looking for work in the reference profession

It also directs respondents working in the reference State and other States to respond to subsequent questions only in respect of work in the reference State.

These distinctions are necessary in order to eliminate multiple counting for respondents renewing licenses to practise in more than one State.

The definitions of employed and unemployed in this data item differ from ABS definitions for these categories defined in LFA2 'Employed persons', LFA8 'Labour force status', LFA9 'Looking for full-time work', LFA10 'Looking for part-time work', LFA12 'Not in the labour force', LFA13 'Status in employment', and LFA14 'Unemployed persons'.

The definitions of employed and unemployed in this data item differ from ABS definitions for these categories defined in LFA2 'Employed persons', LFA8 'Labour force status', LFA9 'Looking for full-time work', LFA10 'Looking for part-time work', LFA12 'Not in the labour force', LFA13 'Status in employment', and LFA14 'Unemployed persons'.

Collection methods (continued): The main differences are:

- The National Health Labour Force Collection includes persons other than clinicians working in the profession as persons employed in the profession. ABS uses the Australian Standard Classification of Occupations where, in general, classes for health occupations do not cover non-clinicians. The main exception to this is nursing where, because of the size of the profession, there are classes for nursing administrators and educators.
- The labour force collection includes health professionals working in the Defence Forces; ABS does not, with the exception of the population census.
- ABS uses a tightly defined reference period for employment and unemployment; the labour force collection reference period is self-defined by the respondent as his/her usual status at the time of completion of the survey questionnaire.
- The labour force collection includes, among persons looking for work in the profession, those persons who are registered health professionals but employed in another occupation and looking for work in the profession; ABS does not.
- The labour force collection includes in the category not in the labour force health professionals registered in Australia but working overseas; such persons are excluded from the scope of ABS censuses and surveys.

Related data: relates to concept Health labour force, version 1

relates to concept Occupation, version 1

Administrative attributes

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/1989 to

Surgical specialty

Admin. status: CURRENT 1/01/1995

Identifying and definitional attributes

Knowledgebase ID: 000161 Version number: 1

Data element type: DATA ELEMENT

Definition: The area of clinical expertise held by the doctor who will perform the elective surgery.

Context: Elective surgery: many hospitals manage their waiting lists on a specialty basis. Current data show that the total ready for care times waited and numbers of long wait patients vary significantly between specialities. Furthermore, the hospital capacity to handle the demand for elective surgery varies with specialty.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain:

01	Cardio-thoracic surgery
02	Ear, nose and throat surgery
03	General surgery
04	Gynaecology
05	Neurosurgery
06	Ophthalmology
07	Orthopaedic surgery
08	Plastic surgery
09	Urology
10	Vascular surgery
11	Other

Administrative attributes

Source organisation: Hospital Access Program Waiting Lists Working Group/National Health Data Committee/Waiting Times Working Group

National minimum data sets:

Elective surgery waiting times from 1/07/1994 to

Comments: The above classifications are consistent with the Recommended Medical Specialties and Qualifications agreed by the National Specialist Qualification Advisory Committee of Australia, September 1993. Vascular surgery is a subspecialty of general surgery. The Royal Australian College of Surgeons has a training program for vascular surgeons. The specialties listed above refer to the surgical component of these specialties—ear, nose and throat surgery refers to the surgical component of the specialty otolaryngology; gynaecology refers to the gynaecological surgical component of obstetrics and gynaecology; ophthalmology refers to the surgical component of the specialty (patients awaiting argon laser phototherapy are not included).

Total hours worked by a medical practitioner

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000394 Version number: 2

Data element type: DATA ELEMENT

Definition: The total hours worked in a week in a job by a medical practitioner, including any on-call hours actually worked (includes patient care and administration)

Context: Health labour force: used in relation to issues of economic activity, productivity, wage rates, working conditions etc. Used to develop capacity measures relating to total time available. Assists in analysis of human resource requirements and labour force modelling. Used to determine full-time and part-time work status and to compute full-time equivalents (FTE) (see entry for FTE).

Often the definition for full-time or FTE differs (35, 37.5 and 40 hours) and knowing total hours and numbers of individuals allows for variance in FTE.

Relational and representational attributes

Datatype: Numeric Field size: Min. 3 Max. 3 Layout: NNN

Data domain: Total hours, expressed as 000, 001 etc.

Guide for use: Code 999 for not stated/inadequately described

Data element relates to each position (job) held by a medical practitioner, not the aggregate of hours worked in all.

Verification rules: Value must be less than 169 (except for 999).

Collection methods: There are inherent problems in asking for information on number of hours usually worked per week, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours worked are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.

Related data: relates to Hours worked by medical practitioner in direct patient care, version 2

relates to Hours on-call (not worked) by medical practitioner, version 2

supersedes previous data element Hours worked, version 1

Administrative attributes

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/1989 to

Comments: It is often argued that health professionals contribute a considerable amount of time to voluntary professional work and that this component needs to be identified. This should be considered as an additional item, and kept segregated from data on paid hours worked.

Injecting drug use

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000432 Version number: 1

Data element type: DATA ELEMENT

Definition: The client's use of injection as a method of administering drugs. Includes intravenous, intramuscular and subcutaneous forms of injection.

Context: Alcohol and other drug treatment services: The data element is important for identifying patterns of drug use and harms associated with injecting drug use.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Current injecting drug use (last injected within the previous three months)
2	Injecting drug use more than three months ago but less than twelve months ago
3	Injecting drug use more than twelve months ago (and not in last twelve months)
4	Never injected
9	Not stated/inadequately described

Collection methods: To be collected on commencement of treatment with a service.

Related data: relates to Principal drug of concern, version 1

relates to Method of use for principal drug of concern, version 1

relates to Other drugs of concern, version 1

Administrative attributes

Source organisation: Intergovernmental Committee on Drugs NMDS-WG

National minimum data sets:

Alcohol and other drug treatment services from 01/07/2000 to

Comments: This data element used in conjunction with Commencement of treatment for reporting the NMDS—alcohol and other drug treatment services, and has been developed for use in clinical settings. A code that refers to a three month period to define 'current' injecting drug use, is required as a clinically relevant period of time.

The data element may also be used in population surveys that require a longer timeframe, for example to generate 12-month prevalence rates, by aggregating codes 1 and 2. However, caution must be exercised when comparing clinical samples with population samples.

Method of use for principal drug of concern

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000433 Version number: 1

Data element type: DATA ELEMENT

Definition: The client's usual method of administering the 'Principal drug of concern' as stated by the client.

Context: Alcohol and other drug treatment services: Identification of drug use methods is important for minimising specific harms associated with drug use, and is consequently of value for informing treatment approaches.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Ingests
2	Smokes
3	Injects
4	Sniffs (powder)
5	Inhales (vapour)
6	Other
9	Not stated/inadequately described

Guide for use: Code 1 Refers to eating or drinking as the method of administering the 'Principal drug of concern'.

Collection methods: Collect only for Principal drug of concern.

To be collected on commencement of treatment with a service.

Related data: relates to Principal drug of concern, version 1,

relates to Injecting drug use, version 1

Administrative attributes

Source organisation: Intergovernmental Committee on Drugs NMDS-WG

National minimum data sets:

Alcohol and other drug treatment services from 01/07/2000 to

Tobacco smoking status

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000410 Version number: 1

Data element type: DATA ELEMENT

Definition: A person's current and past smoking behaviour.

Context: Public health and health care: Smoker type is used to define sub-populations of adults (age 18+ years) based on their smoking behaviour.

Smoking has long been known as a health risk factor. Population studies indicate a relationship between smoking and increased mortality/morbidity.

This data element can be used to estimate smoking prevalence. Other uses are:

- To evaluate health promotion and disease prevention programs (assessment of interventions)
- To monitor health risk factors and progress towards National Health Goals and Targets

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Daily smoker
2	Weekly smoker
3	Irregular smoker
4	Ex-smoker
5	Never smoked

Guide for use: The above grouping subdivides a population into five mutually exclusive categories.

Daily smoker—A person who smokes daily

Weekly smoker—A person who smokes at least weekly but not daily

Irregular smoker—A person who smokes less than weekly

Ex-smoker—A person who does not smoke at all now, but has smoked at least 100 cigarettes or a similar amount of other tobacco products in his/her lifetime.

Never-smoker—A person who does not smoke now and has smoked fewer than 100 cigarettes or similar amount of other tobacco products in his/her lifetime.

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults—interviewer administered (Questions 1 and 4) and self-administered (Questions 1 and 1a) versions. The questionnaires are designed to cover persons aged 18+.

Related data: is qualified by Date of birth, version 3

Administrative attributes

Source document: Standard Questions on the Use of Tobacco Among Adults (1998)

Source organisation: Australian Institute of Health and Welfare (AIHW)

Comments:

There are two other ways of categorising this information:

- Regular and irregular smokers where a regular smoker includes someone who is a daily smoker or a weekly smoker. 'Regular' smokers is the preferred category to be reported in prevalence estimates.
- Daily and occasional smokers where an occasional smoker includes someone who is a weekly or irregular smoker. The category of 'occasional' smoker can be used when the aim of the study is to draw contrast between daily smokers and other smokers.

Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected.

It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults (self- and interviewer-administered versions) can be obtained from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.

Tobacco smoking—consumption/quantity (cigarettes)

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000403 Version number: 1

Data element type: DATA ELEMENT

Definition: The number of cigarettes (manufactured or roll-your-own) smoked per day by a person.

Context: Public health and health care: The number of cigarettes smoked is an important measure of the magnitude of the tobacco problem for an individual.

Research shows that of Australians who smoke, the overwhelming majority smoke cigarettes (manufactured or roll-your-own) rather than other tobacco products.

From a public health point of view, consumption level is relevant only for regular smokers (those who smoke daily or at least weekly).

Data on quantity smoked can be used:

- To evaluate health promotion and disease prevention programs (assessment of interventions);
- To monitor health risk factors and progress towards National Health Goals and Targets;
- To ascertain determinants and consequences of smoking;
- To assess a person's exposure to tobacco smoke.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 2 Layout: NN

Data domain: Two digits representing the number of cigarettes smoked daily or 99 for 'not stated'.

Guide for use: This data element is relevant only for persons who currently smoke cigarettes daily or at least weekly.

Daily consumption should be reported, rather than weekly consumption. Weekly consumption is converted to daily consumption by dividing by 7 and rounding to the nearest whole number.

Quantities greater than 98 (extremely rare) should be coded 98.

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults—interviewer administered (Questions 3a and 3b) and self-administered (Questions 2a and 2b) versions. The questions cover persons aged 18+.

Related data: is qualified by Date of birth, version 3

is qualified by Tobacco smoking—frequency, version 1

is qualified by Tobacco smoking—product, version 1

Administrative attributes

Source document: Standard Questions on the Use of Tobacco Among Adults (1998)

Source organisation: Australian Institute of Health and Welfare (AIHW)

Comments:

Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected.

It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults (self- and interviewer-administered versions) can be obtained from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.

Tobacco smoking—duration (daily smoking)

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000404 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: Duration (in years) of daily smoking for a person who is now a daily smoker or has been a daily smoker in the past.

Context: Public health and health care: Duration of daily smoking is an indicator of exposure to increased risk to health. In this data element, duration is measured as the years elapsed from the time the person first started smoking daily and when they most recently quit smoking daily (or the present for those persons who still smoke daily). There may have been intervening periods when the person did not smoke daily. However, as the negative health effects of smoking accumulate over time, the information on duration of daily smoking, as measured in this data element, remains useful, despite any intervening periods of non-daily smoking.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 2 Layout: NN

Data domain: Number of completed years or 99 for 'not stated'

Guide for use: In order to estimate duration of smoking the person's date of birth or current age should also be collected. If a person reports that they smoke daily now then duration is the difference between the start-age and the person's current age.

If a person reports that they smoked daily in the past but do not smoke daily now then duration is the difference between the quit age and the start age.

Record duration of less than one year as 0.

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults—interviewer administered (Question 1,5,6,7) and self-administered (Question 1,3,3a,4) versions. The questions cover persons aged 18+.

Related data: is qualified by Date of birth, version 3

is qualified by Tobacco smoking—ever daily use, version 1

is derived from Tobacco smoking—quit age (daily smoking), version 1

is derived from Tobacco smoking—start age (daily smoking), version 1

Administrative attributes

Source document: Standard Questions on the Use of Tobacco Among Adults (1998)

Source organisation: Australian Institute of Health and Welfare (AIHW)

Comments:

Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected.

It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The standard questions on the use of tobacco (self- and interviewer-administered versions) can be obtained from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.

Tobacco smoking—ever daily use

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000405 Version number: 1

Data element type: DATA ELEMENT

Definition: Whether a person has ever smoked tobacco in any form daily in his or her lifetime.

Context: Public health and health care:

Whether a person has ever smoked on a daily basis can be used to assess an individual's health risk from smoking and to monitor population trends in smoking behaviour.

It can also be used:

- To evaluate health promotion and disease prevention programs (assessment of interventions);
- To monitor health risk factors;
- To ascertain determinants and consequences of smoking.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Ever—daily

2 Never—daily

Guide for use: If a person reports that they now smoke cigarettes, cigars, pipes or any other tobacco products daily OR if they report that in the past they have been a daily smoker, they are coded to 1 (ever—daily)

If a person reports that they have never smoked cigarettes, cigars, pipes or any other tobacco products daily AND they have never in the past been a daily smoker then they are coded to 2 (never—daily)

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults—interviewer administered (Question 1 and 5) and self-administered (Question 1 and 3) versions. The questions cover persons aged 18+.

Related data: is qualified by Date of birth, version 3

is qualified by Tobacco smoking—frequency, version 1

Administrative attributes

Source document: Standard Questions on the Use of Tobacco Among Adults (1998)

Source organisation: Australian Institute of Health and Welfare (AIHW)

Comments:

Where the information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected.

It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults (self- and interviewer-administered versions) can be obtained from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.

Tobacco smoking—frequency

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000406 Version number: 1

Data element type: DATA ELEMENT

Definition: How often a person now smokes a tobacco product.

Context: Public health and health care: The frequency of smoking helps to assess a person's exposure to tobacco smoke which is a known risk factor for cardiovascular disease and cancer. From a public health point of view, the level of consumption of tobacco as measured by frequency of smoking tobacco products is only relevant for regular smokers (persons who smoke daily or at least weekly).

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Smokes daily
2	Smokes at least weekly, but not daily
3	Smokes less often than weekly
4	Does not smoke at all

Guide for use: To record multiple use data, repeat the data field as many times as necessary, viz: product1, product2 etc. In most instances, data on both product and frequency are needed. In such situations, repeat both fields as many times as necessary, viz: product1, frequency1, product2, frequency2 etc.

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults—interviewer administered (Question 1) and self-administered (Question 1) versions. The questions relate to smoking of manufactured cigarettes, roll-your-own cigarettes, cigars, pipes and other tobacco products and are designed to cover persons aged 18+.

Related data:

is qualified by Date of birth, version 3

is a qualifier of Tobacco smoking—consumption/quantity (cigarettes), version 1

relates to Tobacco smoking—duration (daily smoking), version 1

relates to Tobacco smoking—ever daily use, version 1

used in conjunction with Tobacco smoking—product, version 1

relates to Tobacco smoking—start age (daily smoking), version 1

Administrative attributes

Source document: Standard Questions on the Use of Tobacco Among Adults (1998)

Source organisation: Australian Institute of Health and Welfare (AIHW)

Comments:

Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected.

It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults (self- and interviewer-administered versions) can be obtained from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.

Tobacco smoking—product

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000407 Version number: 1

Data element type: DATA ELEMENT

Definition: The type of tobacco product smoked by a person.

Context: Public health and health care: Tobacco smoking is a known risk factor for cardiovascular disease and cancer. The type of tobacco product smoked by a person in conjunction with information about the frequency of smoking assists with establishing a profile of smoking behaviour at the individual or population level and with monitoring shifts from cigarette smoking to other types of tobacco products and vice versa.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Cigarettes—manufactured
2	Cigarettes—roll-your-own
3	Cigars
4	Pipes
5	Other tobacco product
6	None

Guide for use: To record multiple use data, repeat the data field as many times as necessary, viz: product1, product2 etc. In most instances, data on both product and frequency are needed.

In such situations, repeat both fields as many times as necessary, viz: product1, frequency1, product2, frequency2 etc.

Collection methods: The recommended standard for collecting information about smoking the above tobacco products is the Standard Questions on the Use of Tobacco Among Adults—interviewer or self-administered versions.

The questions cover persons aged 18+.

Related data: is qualified by Date of birth, version 3

is a qualifier of Tobacco smoking—consumption/quantity (cigarettes), version 1

used in conjunction with Tobacco smoking—frequency, version 1

Administrative attributes

Source document: Standard Questions on the Use of Tobacco Among Adults (1998)

Source organisation: Australian Institute of Health and Welfare (AIHW)

Comments:

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected.

It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults (self- and interviewer-administered versions) can be obtained from the National Centre for Monitoring Cardiovascular Disease at the Australian Institute of Health and Welfare, telephone (02) 6244 1000.

Tobacco smoking—start age (daily smoking)

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000409 Version number: 1

Data element type: DATA ELEMENT

Definition: Age (in years) at which a person who has ever been a daily smoker first started to smoke daily.

Context: Public health and health care: Start-age may be used to derive duration of smoking, which is a much stronger predictor of the risks associated with smoking than is the total amount of tobacco smoked over time.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain: Age in completed years or 99 for 'not stated'

Guide for use: This information is relevant only if a person currently smokes daily or has smoked daily in the past.

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults—interviewer administered (Question 7) and self-administered (Question 4) versions. The questions cover persons aged 18+.

Related data: is qualified by Date of birth, version 3

is used in the derivation of Tobacco smoking—duration (daily smoking), version 1

is qualified by Tobacco smoking—ever daily use, version 1

used in conjunction with Tobacco smoking—quit age (daily smoking), version 1

Administrative attributes

Source document: Standard Questions on the Use of Tobacco Among Adults (1998)

Source organisation: Australian Institute of Health and Welfare (AIHW)

Comments: Where the information is collected by survey and the sample permits, population estimates should be presented by sex and age groups. The recommended age groups are: <10, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20–24, 25–29 and 30. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected.

It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults (self- and interviewer-administered versions) can be obtained from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.

Tobacco smoking—quit age (daily smoking)

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000408 Version number: 1

Data element type: DATA ELEMENT

Definition: Age (in years) at which a person who has smoked daily in the past and is no longer a daily smoker most recently stopped smoking daily.

Context: Public health and health care: Quit-age and start-age provide information on the duration of daily smoking and exposure to increased risk to health.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain: Age in completed years or 99 for 'not stated'

Guide for use: In order to estimate quit-age, the person's date of birth or current age should also be collected. Quit-age may be directly reported, or derived from the date the person quit smoking or the length of time since quitting, once the person's date of birth (or current age) is known.

Quit-age is relevant only to persons who have been daily smokers in the past and are not current daily smokers.

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults—interviewer administered (Question 6) and self-administered (Question 3a) versions. The questions cover persons aged 18+.

The relevant question in each version of the questionnaires refers to when the person finally stopped smoking daily, whereas the definition for this data element refers to when the person most recently stopped smoking daily. However, in order to provide information on when the person most recently stopped smoking daily, the most appropriate question to ask at the time of collecting the information is when the person finally stopped smoking daily.

Related data: is qualified by Date of birth, version 3

is used in the derivation of Tobacco smoking—duration (daily smoking), version 1

used in conjunction with Tobacco smoking—start age (daily smoking), version 1

is qualified by Tobacco smoking status, version 1

is used in the derivation of Tobacco smoking—time since quitting (daily smoking), version 1

Administrative attributes

Source document: Standard Questions on the Use of Tobacco Among Adults (1998)

Source organisation: Australian Institute of Health and Welfare (AIHW)

Comments:

Where the information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults (self- and interviewer-administered versions) can be obtained from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.

Tobacco smoking—time since quitting (daily smoking)

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000411 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: Time since a person most recently quit daily smoking.

Context: Public health and health care: Time since quitting daily smoking may give an indication of improvement in the health risk profile of a person.

It is also useful in evaluating health promotion campaigns.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain:

01	12 months (1 year)
02	2 years etc. to 78
79	79+ years
80	Less than 1 month
81	1 month
82	2 months
83	3 months
84	4 months
85	5 months
86	6 months
87	7 months
88	8 months
89	9 months
90	10 months
91	11 months
92	months, not specified
93	years, not specified
99	not stated

Guide for use: In order to estimate time since quitting for all respondents, the person's date of birth or current age should also be collected.

For optimal flexibility of use, the time since quitting is coded as months or years. However, people may report the time that they quit smoking in various ways (e.g. age, a date, or a number of days or weeks ago). When the information is reported in weeks and is less than 4, or in days and is less than 28, then code 80.

When the person reports the time since quitting as weeks ago, convert into months by dividing by 4 (rounded down to the nearest month).

If days reported are between 28 and 59 code to 81.

Where the information is about age only, time since quitting (daily use) is the difference between quit-age and age at survey.

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults—interviewer administered (Question 6) and self-administered (Question 3) versions.

Related data: is qualified by Date of birth, version 3

is qualified by Tobacco smoking—ever daily use, version 1

is derived from Tobacco smoking—quit age (daily smoking), version 1

Administrative attributes

Source document: Standard Questions on the Use of Tobacco Among Adults (1998)

Source organisation: Australian Institute of Health and Welfare (AIHW)

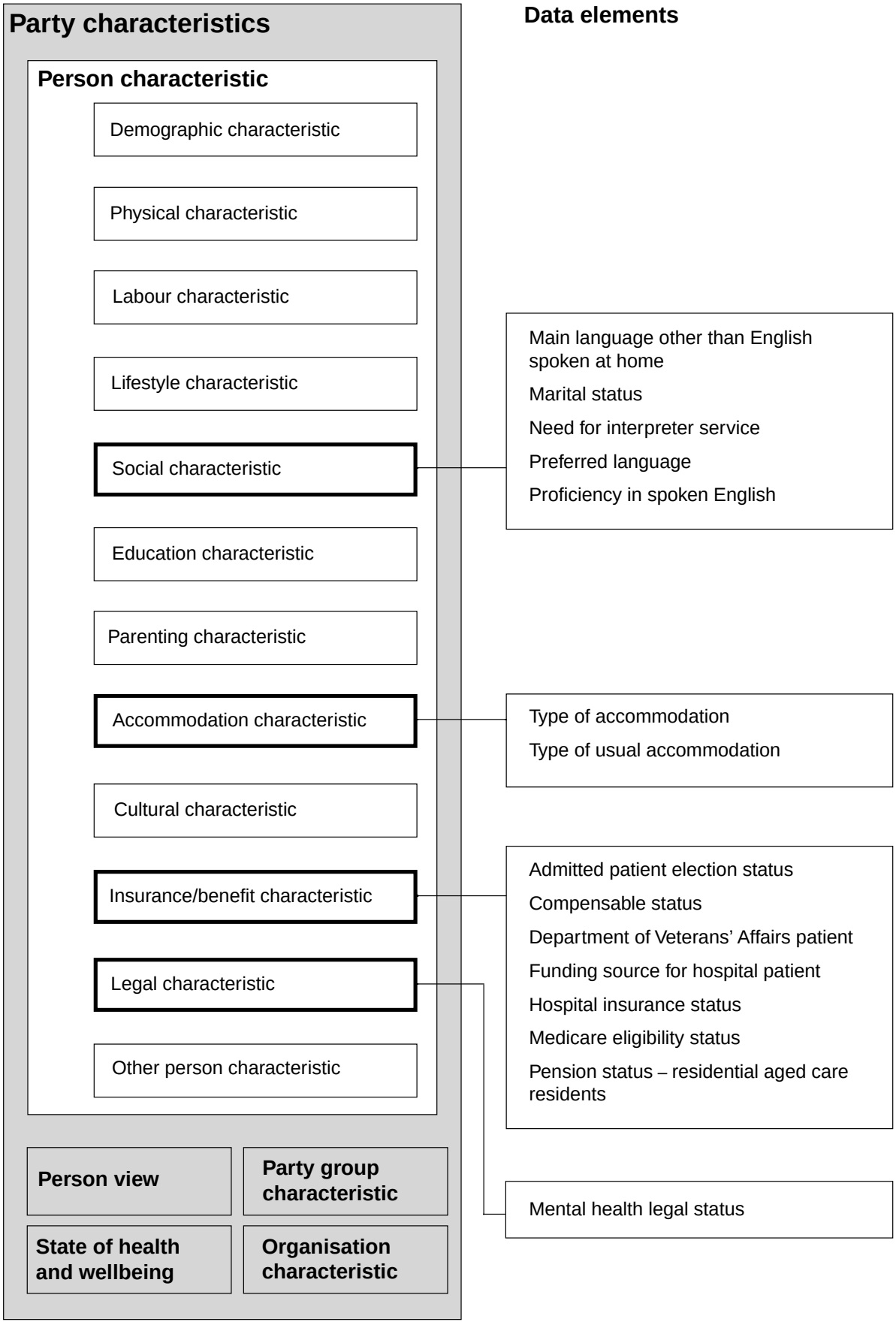
Comments: Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected.

It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults (self- and interviewer-administered versions) can be obtained from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.

National Health Information Model entity



Main language other than English spoken at home

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000638 Version number: 1

Data element type: DATA ELEMENT

Definition: The language reported by a person as the main language other than English spoken by a person in his/her home (or most recent private residential setting occupied by the person) on a regular basis, to communicate with other residents of the home or setting and regular visitors.

Context: This data element is important in identifying those people most likely to suffer disadvantage in terms of their ability to access services due to language and/or cultural difficulties.

In conjunction with Indigenous status, Main language other than English spoken at home and Country of birth, this data element forms the minimum core set of cultural and language indicators recommended by the Australian Bureau of Statistics.

Data on main language spoken at home are regarded as an indicator of 'active' ethnicity and also as useful for the study of inter-generational language retention. The availability of such data may help providers of health and community services to effectively target the geographic areas or population groups that need those services. It may be used for the investigation and development of language services such as interpreter/translation services.

Relational and representational attributes

Datatype: Numeric Field size: Min. 4 Max. 4 Layout: NNNN

Data domain: Refer to the ABS Standards for Statistics on Cultural and Language Diversity, 1999, Cat No. 1289.0 for details.

Guide for use: At the most detailed level the ABS Classification comprises four-digit codes based on a hierarchical structure. It includes codes for Indigenous Australian languages and sign language. Generally for output purposes, four-digit language codes are grouped into language regions, either at two-digit or one-digit level.

Example 1 The Lithuanian language has a code of 3102 where:

3 denotes that it is an Eastern European language;

1 denotes that it is a Baltic language; and

02 denotes the specific language.

Example 2 The Pintupi Aboriginal language has a code of 8217 where:

8 denotes that it is an Australian Indigenous language;

2 denotes that the language is Central Aboriginal; and

17 denotes the specific language.

Note that the code 9900 should be used where language is Not stated/ inadequately described.

Guide for use (continued): Persons not in private residential settings should respond for 'at home' as the most recent private residential setting in which that person has resided.

The reference in the title to 'at home' may cause offence to homeless persons and should be shortened to 'Main language other than English spoken' where applicable.

Collection methods: It is recommended that data be collected at the 2 or 4 digit level. Data collected at the 4 digit level will obviously provide more detailed information than that collected at the 2 digit level, but may be more difficult to collect.

Recommended question:

Do you speak a language other than English at home?

- No, (English only) ☐
- Yes, Italian ☐
- Yes, Greek ☐
- Yes, Cantonese ☐
- Yes, Mandarin ☐
- Yes, Arabic ☐
- Yes, Vietnamese ☐
- Yes, German ☐
- Yes, Tagalog (Filipino) ☐
- Yes, Other (please specify) _____

Related data: Is related to Country of birth, version 3

Is related to Proficiency in spoken English, version 1

Administrative attributes

Source document: *Standards for Statistics on Cultural and Language Diversity*, 1999, Australian Bureau of Statistics Cat No. 1289.0

Source organisation: Australian Bureau of Statistics

Comments: Data may be collected at any level but is most accurate at the 4 digit level.

Marital status

Admin. status: CURRENT 1/07/1994

Identifying and definitional attributes

Knowledgebase ID: 000089 Version number: 3

Data element type: DATA ELEMENT

Definition: Current marital status of the person.

Context: Marital status is a core data element in a wide range of social, labour and demographic statistics. Its main purpose is to establish the living arrangements of individuals, to facilitate analysis of the association of marital status with the need for and use of services and for epidemiological analysis.

The ABS has defined registered marital status based on a legal concept and social marital status, a social, marriage-like arrangement (i.e. de facto marriage). The ABS standards working party recommended that the ABS registered marital status be accepted (ABS 1993).

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Never married
2	Widowed
3	Divorced
4	Separated
5	Married (including de facto)
6	Not stated/inadequately described

Guide for use: The category Married (registered and de facto) should be generally accepted as applicable to all de facto couples, including of the same sex.

Collection methods: While marital status is an important factor in assessing the type and extent of support needs, such as for the elderly living in the home environment, marital status does not adequately address the need for information about social support and living arrangements and other data elements need to be formulated to capture this information.

Related data: supersedes previous data element Marital status, version 1

Administrative attributes

Source organisation: Australian Bureau of Statistics

National minimum data sets:

Admitted patient mental health care	from 1/07/2000 to
Community mental health care	from 1/07/2001 to

Comments:

ABS standards (see ABS: Directory of Concepts and Standards for Social, Labour and Demographic statistics) identify two concepts of marital status:

- registered marital status-defined as whether a person has, or has had, a legally registered marriage;
- social marital status-based on a persons living arrangements (including de-facto marriages), as reported by the person.

ABS recommends that the social marital status concept be collected when information on marital status is sought, whereas the registered marital status concept need only be collected where it is specifically required for the purposes of the collection and only in areas of consent if necessary. Most community services data collections ask clients to self-report their marital status. Hence, the operative concept is one of social marital status.

Need for interpreter service

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000100 Version number: 1

Data element type: DATA ELEMENT

Definition: Need for interpreter services (yes/no) as perceived by the person.

Context: To assist in planning for provision of interpreter services.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain: 0 Interpreter not needed

1 Interpreter needed

Related data: used in conjunction with Preferred language, version 2

Administrative attributes

Source organisation: National Health Data Committee

Comments: This data element has not been included in the National minimum data set – admitted patient care because of reservations about its utility in assessing demand for interpreter services and concerns that a question of this nature might raise expectations of service provision which could not always be fulfilled.

Preferred language

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000132 Version number: 2

Data element type: DATA ELEMENT

Definition: The language (including sign language) most preferred by the person for communication. This may be a language other than English even where the person can speak fluent English.

Context: Health and welfare services: An important indicator of ethnicity, especially for persons born in non-English-speaking countries. Its collection will assist in the planning and provision of multilingual services and facilitate program and service delivery for migrants and other non-English speakers.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain:

00	Afrikaans
01	Albanian
02	Alyawarr (Alyawarra)
03	Arabic (including Lebanese)
04	Armenian
05	Arrernte (Aranda)
06	Assyrian (including Aramaic)
07	Australian Indigenous languages, not elsewhere classified
08	Bengali
09	Bisaya
10	Bosnian
11	Bulgarian
12	Burarra
13	Burmese
14	Cantonese
15	Cebuano
16	Croatian
17	Czech
18	Danish
19	English
20	Estonian
21	Fijian
22	Finnish
23	French
24	German
25	Gilbertese

Data domain (continued):

26	Greek
27	Gujarati
28	Hakka
29	Hebrew
30	Hindi
31	Hmong
32	Hokkien
33	Hungarian
34	Indonesian
35	Irish
36	Italian
37	Japanese
38	Kannada
39	Khmer
40	Korean
41	Kriol
42	Kuurinji (Gurindji)
43	Lao
44	Latvian
45	Lithuanian
46	Macedonian
47	Malay
48	Maltese
49	Mandarin
50	Mauritian Creole
51	Netherlandic
52	Norwegian
53	Persian
54	Pintupi
55	Pitjantjatjara
56	Polish
57	Portuguese
58	Punjabi
59	Romanian
60	Russian
61	Samoan
62	Serbian
63	Sinhalese
64	Slovak
65	Slovene
66	Somali
67	Spanish
68	Swahili
69	Swedish

Data domain (continued):	70	Tagalog (Filipino)
	71	Tamil
	72	Telugu
	73	Teochew
	74	Thai
	75	Timorese
	76	Tiwi
	77	Tongan
	78	Turkish
	79	Ukranian
	80	Urdu
	81	Vietnamese
	82	Walmajarri (Walmadjari)
	83	Warlpiri
	84	Welsh
	85	Wik-Mungkan
	86	Yiddish
	95	Other languages, nfd
	96	Inadequately described
	97	Non verbal, so described (including sign languages e.g. Auslan, Makaton)
	98	Not stated

Guide for use: The classification used in this data element is a modified version of the 2-digit level Australian Standard Classification of Languages (ABS) classification.

All non-verbal means of communication, including sign languages, are to be coded to 97.

Code 96 should be used where some information, but insufficient, is provided.

Code 98 is to be used when no information is provided.

All Australian Indigenous languages not shown separately on the code list are to be coded to 07.

Collection methods: This information may be collected in a variety of ways. It may be collected by using a predetermined short-list of languages that are most likely to be encountered from the above code list accompanied by an open text field for 'Other language' or by using an open ended question that allows for recording of the language nominated by the person. Regardless of the method used for data collection the language nominated should be coded using the above ABS codes.

Related data: supersedes previous Preferred language, version 1

Administrative attributes

Source document: *Australian Standard Classification of Languages*, (ASCL) Australian Bureau of Statistics, Catalogue number 1267.0

Source organisation: NHDC, Australian Bureau of Statistics

National minimum data sets:

Alcohol and other drug treatment services from 1/07/2000 to

Comments:

The Australian Bureau of Statistics has developed a detailed four-digit language classification of 193 language units which was used in the 1996 Census. Although it is preferable to use the classification at a four-digit level, the requirements of administrative collections have been recognised and the ABS has developed a classification of 86 languages at a two-digit level from those most frequently spoken in Australia. Mapping of this 2 digit running code system to the 4 digit Australian Standard Classification of Language is available from ABS. The classification used in this data element is a modified version of the 2-digit level ABS classification.

The National Health Data Committee considered that the grouping of languages by geographic region was not useful in administrative settings. Thus the data domain includes an alphabetical listing of the 86 languages from the ABS 2 digit level classification with only one code for 'Other languages, nfd'. By removing the geographic groupings from the classification information about the broad geographic region of languages that are not specifically coded is lost. However, the NHDC considered that the benefits to data collectors gained from simplifying the code listing outweighed this disadvantage.

Proficiency in spoken English

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000643 Version number: 1

Data element type: DATA ELEMENT

Definition: A person's self stated proficiency in spoken English.

Context: This data element is important in identifying those people most likely to suffer disadvantage in terms of their ability to access services due to language and/or cultural difficulties.

In conjunction with Indigenous status, Main language other than English spoken at home and Country of birth, this data element forms the minimum core set of cultural and language indicators recommended by the Australian Bureau of Statistics.

Relational and representational attributes

Datatype: Numeric Field size: Min. Max. 1 Layout: N

Data domain:

0	Not applicable (person under 5 years of age)
1	Very well
2	Well
3	Not well
4	Not at all
9	Not stated/ inadequately described

Guide for use: This item is only used in conjunction with 'Main language other than English spoken at home'. The question should only be asked if a YES answer is given to the question "Do you speak a language other than English at home?"

Code 9 should only be used for past collections where this item was not collected or if the person does not respond to the question. It should not be a response included on the collection form.

Collection methods: Suggested question:

How well do you (does the person) speak English?

Very well	☐
Well	☐
Not well	☐
Not at all	☐

Generally this would be a self-reported question, but in some circumstances (particularly where a person does not speak English well)

assistance will be required in answering this question.

It is important that the person's self-assessed proficiency in spoken English be recorded wherever possible. This data element does not purport to be a technical assessment of proficiency but is a self-assessment in the four broad categories outlined above.

This data element is not relevant to and should not be collected for persons under the age of 5.

Related data: Is related to Main language other than English spoken at home, version 1
Is related to Country of birth, version 3

Administrative attributes

Source document: *Standards for Statistics on Cultural and Language Diversity*, ABS 1999, Cat No. 1289.0

Source organisation: Australian Bureau of Statistics

Comments: The ABS advises that the most useful information provided by this data element is in the distinction between the two category groups of Very well/Well and Not well/Not at all.

Type of accommodation

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000173 Version number: 2

Data element type: DATA ELEMENT

Definition: The type of accommodation setting in which the person usually lives/lived.

Context: Admitted patient mental health care permits analysis of the usual residential accommodation type of people prior to admission to admitted patient health care.

The setting in which the person usually lives can have a bearing on the types of treatment and support required by the person and the outcomes that result from their treatment.

Relational and representational attributes

Datatype: Alphabetic Field size: Min. 1 Max. 2 Layout: NN

Data domain:

1	Private residence (e.g. house, flat, bedsitter, caravan, boat, independent unit in retirement village), including privately and publicly rented homes
2	Psychiatric hospital
3	Residential aged care service
4	Specialised alcohol/other drug treatment residence
5	Specialised mental health community-based residential support service
6	Domestic-scale supported living facility (e.g. group home for people with disabilities)
7	Boarding/rooming house/hostel or hostel type accommodation, not including aged persons' hostel
8	Homeless persons' shelter
9	Shelter/refuge (not including homeless persons' shelter)
10	Other supported accommodation
11	Prison/remand centre/youth training centre
12	Public place (homeless)
13	Other accommodation, not elsewhere classified
14	Unknown/unable to determine

Guide for use: 'Usual' is defined as the type of accommodation the person has lived in for the most amount of time over the past three months prior to admission to admitted patient health care or first contact with a community service setting. If a person stays in a particular place of accommodation for four or more days a week over the period, that place of accommodation would be the person's type of usual accommodation. In practice, receiving an answer strictly in accordance with the above definition may be difficult to achieve. The place the person perceives as their usual accommodation will often prove to be the best approximation of their type of usual accommodation.

3	Includes nursing home beds in acute care hospitals.
4	Includes alcohol/other drug treatment units in psychiatric hospitals.

Guide for use (continued):

5	Specialised mental health community-based residential support services are defined as community-based residential supported accommodation specifically targeted at people with psychiatric disabilities which provides 24-hour support/rehabilitation on a residential basis.
6	Domestic-scale supported living facilities include group homes for people with disabilities, cluster apartments where a support worker lives on-site, community residential apartments (except mental health), congregate care arrangements. Support is provided by staff on either a live-in or rostered basis, and they may or may not have 24-hour supervision and care.
10	Includes other supported accommodation facilities such as hostels for people with disabilities and Residential Services/Facilities (Victoria and South Australia only). These facilities provide board and lodging and rostered care workers provide client support services.

Related data: is an alternative to Type of usual accommodation, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient mental health care — from 1/07/2000 to

Comments: The changes made to this data element are in accordance with the requirements of the National Mental Health Information Strategy Committee and take into consideration corresponding definitions in other data dictionaries (e.g. HACC Data Dictionary Version 1 and National Community Services Data Dictionary Version 2).

Type of usual accommodation

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000173 Version number: 1

Data element type: DATA ELEMENT

Definition: The type of physical accommodation the person lived in prior to admission.

Context: Admitted patient mental health care: permits analysis of the prior residential accommodation type of people admitted to residential aged care services or other institutional care.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	House or flat
2	Independent unit as part of retirement village or similar
3	Hostel or hostel type accommodation
4	Psychiatric hospital
5	Acute hospital
6	Other accommodation
7	No usual residence

Collection methods: The above classifications have been based on Question 16 of Form NH5. This item is not available for New South Wales State residential aged care services.

As this data item includes only details of physical accommodation before admission it was decided to have details of the relational basis of accommodation before admission collected as a separate data element (see data element 'Mode of admission').

The Commonwealth Department of Health and Aged Care has introduced a new Aged Care Application and Approval form which replaces the NH5.

Related data: is an alternative to Type of accommodation, version 2

Administrative attributes

Source organisation: National minimum data set working parties

National minimum data sets:

Admitted patient mental health care from 1/07/2000 to

Admitted patient election status

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000415 Version number: 1

Data element type: DATA ELEMENT

Definition: Accommodation chargeable status elected by patient on admission.

Context: Admitted patient care:

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Public

2 Private

Guide for use: To be collected at time of separation.

At the time of, or as soon as practicable after admission to a public hospital, the patient must elect in writing to be treated as either

- a public patient; or
- a private patient in single accommodation; or
- a private patient in shared accommodation.

This item is independent of patient's hospital insurance status. Private includes private-single and private-shared.

1 Public patient: a person, eligible for Medicare, who, on admission to a recognised hospital or soon after:

- receives a public hospital service free of charge; or
- elects to be a public patient; or
- whose treatment is contracted to a private hospital.

2 Private patient: a person who, on admission to a recognised hospital or soon after:

- elects to be a private patient treated by a medical practitioner of his or her choice; or
- elects to occupy a bed in a single room (where such an election is made, the patient is responsible for meeting certain hospital charges as well as the professional charges raised by any treating medical or dental practitioner); or
- a person, eligible for Medicare, who chooses to be admitted to a private hospital (where such a choice is made, the patient is responsible for meeting all hospital charges as well as the professional charges raised by any treating medical or dental practitioner).

Please see the various Commonwealth/State Health Care Agreements for definitions of patient(s) and patient services.

Related data: supersedes Patient accommodation eligibility status, version 2

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient care	from 1/07/2000 to

Compensable status

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000026 Version number: 3

Data element type: DATA ELEMENT

Definition: A compensable patient is an individual who is entitled to receive or has received a compensation payment with respect to an injury or disease.

A compensable patient is a person who:

- is entitled to claim damages under Motor Vehicle Third Party insurance or
- is entitled to claim damages under worker's compensation; or
- has an entitlement to claim under public liability or common law damages

Context: To assist in analyses of utilisation and health care funding.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Compensable

2 Non-compensable

9 Not stated/not known

Guide for use: This definition excludes eligible beneficiaries (Department of Veterans' Affairs), Defence Force personnel and persons covered by the Motor Accident Compensation Scheme, Northern Territory.

DVA beneficiaries are defined in "Department of Veterans' Affairs patient" data element.

Related data: supersedes previous data element Compensable status, version 2

Administrative attributes

Source organisation: National Health Data Committee

Comments: In Version 9 of the Dictionary, the data elements 'Admitted patient election status', 'Medicare eligibility status', 'Compensable status' and 'Department of Veterans' Affairs patient' were collected in the Admitted patient care NMDS in order to determine from where funding for a patient was obtained.

In Version 10, the data elements 'Compensable status' and 'Department of Veterans' Affairs patient' are replaced in the NMDS from 01/07/2001 with the data element 'Funding source for hospital patient'.

Department of Veterans' Affairs patient

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000421 Version number: 1

Data element type: DATA ELEMENT

Definition: An eligible person whose charges for this hospital admission are met by the Department of Veterans' Affairs.

Context: Health services: To assist in analyses of utilisation and health care funding.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Yes

2 No

Guide for use: Refer to the Veterans' Entitlements Act 1986 for details of eligible Department of Veterans' Affairs beneficiaries.

Related data: relates to Department of Veterans Affairs File Number, version 1

Administrative attributes

Source organisation: National Health Data Committee

Comments: In Version 9 of the Dictionary, the data elements 'Admitted patient election status', 'Medicare eligibility status', 'Compensable status' and 'Department of Veterans' Affairs patient' were collected in the Admitted patient care NMDS in order to determine from where funding for a patient was obtained.

In Version 10, the data elements 'Compensable status' and 'Department of Veterans' Affairs patient' are replaced in the NMDS from 01/07/2001 with the data element 'Funding source for hospital patient'.

Eligible veterans and war widow/widowers can receive free treatment at any public hospital, former Repatriation Hospitals (RHs) or a Veteran Partnering (VP) contracted private hospital as a private patient in a shared ward, with the doctor of their choice. Admission to a public hospital does not require prior approval from the Department of Veterans' Affairs.

When treatment cannot be provided within a reasonable time in the public health system at a former RH or a private VP hospital, there is a system of contracted non-VP private hospitals which will provide care.

Admission to a contracted private hospital requires prior financial authorisation from DVA. Approval may be given to attend a non-contracted private hospital when the service is not available at a public or contracted non-VP private hospital.

In an emergency a Repatriation patient can be admitted to the nearest hospital, public or private, without reference to DVA.

If an eligible veteran or war widow/widower chooses to be treated under Veterans' Affairs arrangements, which includes obtaining prior approval for non-VP private hospital care, DVA will meet the full cost of their treatment.

Funding source for hospital patient

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000632 Version number: 1

Data element type: DATA ELEMENT

Definition: Expected principal source of funds for an admitted patient episode or non-admitted patient service event.

Context: All admitted patient care

Hospital non-admitted patient care

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout NN

Data domain:

01	Australian Health Care Agreements
02	Private health insurance
03	Self-funded
04	Worker's compensation
05	Motor vehicle third party personal claim
06	Other compensation (e.g. public liability, common law, medical negligence)
07	Department of Veterans' Affairs
08	Department of Defence
09	Correctional facility
10	Other hospital or public authority (contracted care)
11	Reciprocal health care agreements (with other countries)
12	Other
99	Not known

Guide for use: The major funding source should be recorded if there is more than one source of funding. The final payment class recorded by the hospital should be used.

Australian Health Care Agreements (category 1) should be recorded as the funding source for admitted patients who elect to be treated as public patients. However, overseas visitors who are covered by a reciprocal health care agreement and elect to be treated as public patients (as detailed at http://www.health.gov.au/haf/docs/visthlth/2000hlth.htm#rhca) should be recorded as Reciprocal health care agreement (category 11).

Self-funded (category 3) includes funded by the patient, by the patient's family or friends, or by other benefactors.

Department of Veterans' Affairs (category 7) should be used for Department of Veterans' Affairs patients (as defined in the data element 'Department of Veterans' Affairs patient').

Compensable patients should be recorded as Worker's compensation (category 4), Motor vehicle third party personal claim (category 5) or Other compensation (category 6), as appropriate.

Overseas visitors for whom travel insurance is the major funding source should be recorded as Other (category 12).

Related data: relates to the data element concept Admitted patient, version 3
relates to the data element concept Non-admitted patient service event, version 1
relates to the data element Admitted patient election status, version 1

Administrative attributes

National minimum data sets:

Admitted patient care	from 1 July 2001 to
Admitted patient mental health care	from 1 July 2001 to
Admitted patient palliative care	from 1 July 2001 to

Hospital insurance status

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000075 Version number: 3

Data element type: DATA ELEMENT

Definition: Hospital insurance under one of the following categories:

Registered insurance—hospital insurance with a health insurance fund registered under the *National Health Act 1953* (C'wlth);

General insurance—hospital insurance with a general insurance company under a guaranteed renewable policy providing benefits similar to those available under registered insurance.

No hospital insurance or benefits coverage under the above.

Context: To assist in analysis of utilisation and health care financing

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Hospital insurance

2 No hospital insurance

9 Unknown

Guide for use: Persons covered by insurance for benefits of ancillary services only are included in 2. no hospital insurance.

The 'unknown' category should not be used in primary collections but can be used to record unknown insurance status in databases.

This item is to determine whether the patient has hospital insurance, not their method of payment for the episode of care.

Related data: supersedes previous data element Insurance status, version 2

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient care from 1/07/2000 to

Comments: Insurance status was reviewed and modified to reflect changes to new private health insurance arrangements under the Health Legislation (Private Health Insurance Reform) Amendment Act 1995.

Employee health benefits schemes became illegal with the implementation of Schedule 2 of the private health insurance reforms, effective on 1 October 1995.

Under Schedule 4 of the private health insurance reforms, on 1 July 1997, the definition of the 'basic private table' or 'basic table', and 'supplementary hospital table' and any references to these definitions was omitted from the National Health Act 1953. All hospital tables offered by registered private health insurers since 29 May 1995 have been referred to as 'Applicable Benefits Arrangements' and marketed under the insurer's own product name.

Medicare eligibility status

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000414 Version number: 1

Data element type: DATA ELEMENT

Definition: The patient's eligibility for Medicare as specified under the Commonwealth Health Insurance Act 1973.

Context: Admitted patient care: to facilitate analyses of hospital utilisation and policy relating to health care financing.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Eligible

2 Not eligible

9 Not stated/unknown

Guide for use: An eligible person includes a person who resides in Australia and is one of the following:

- an Australian citizen;
- a permanent resident;
- a New Zealand citizen;
- a temporary resident who has applied for permanent residency and who has either an authority to work in Australia or an immediate family member who is an Australian citizen or permanent resident;
- a person, or class of persons, who has been declared eligible for Medicare for the purposes of the Health Insurance Act 1973.
- Other persons, as temporary residents, who are fully eligible for Medicare include:
- a person who is a head or member of a diplomatic mission or consular post or is a member of such a person's family, where there is a Reciprocal Health Care Agreement in place between Australia and the country they represent (currently United Kingdom, Republic of Ireland, the Netherlands, Malta, Italy, Sweden and Finland)—with the exception of New Zealand diplomats.

Other persons, as visitors or temporary residents, who are eligible for Medicare, in certain circumstances, include:
persons who are visiting Australia and are eligible persons because there is a Reciprocal Health Care Agreement in place between Australia and their usual country of residence (currently United Kingdom, Republic of Ireland, the Netherlands, Malta (eligibility limited to 6 months), Italy (eligibility limited to 6 months), Sweden, Finland and New Zealand [it should be noted that the RHCA with New Zealand and the Republic of Ireland limits the access to medical services for their residents to that of public patients in public hospitals)—with the exception of New Zealand diplomats.]

With respect to hospital services, persons covered by an RHCA (except RHCA diplomats as they have full Medicare eligibility) are eligible only as public patients in a public hospital and are ineligible persons if they are admitted as a private patient in either a public or a private hospital.

Guide for use (continued):

It should also be noted that some patients can be both an 'eligible person' and either personally or a third party liable for the payment of charges for hospital services received; for example:

- prisoners
- patients with Defence Force personnel entitlements
- compensable patients
- Department of Veterans' Affairs beneficiaries
- Nursing Home Type Patients

Newborn babies take the eligibility status of the mother.

Administrative attributes

National minimum data sets:

Admitted patient care	from 1/07/2000 to

Pension status—residential aged care residents

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000383 Version number: 2

Data element type: DATA ELEMENT

Definition: Whether or not a person is in receipt of a pension and the nature of that pension (note that this does not mean the pension is necessarily the recipient's main source of income).

Context: This data element is likely to be a factor in determining equity of services and could be a surrogate indicator of income.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Aged pension—full pension without rent assistance
2	Aged pension—full pension plus rent assistance
3	Repatriation pension
4	Disability support pension
5	Other pension or benefit
6	No pension

Collection methods: This item is based on the form NH5, which has been replaced.

Related data: supersedes previous data element Pension status, version 1

Mental health legal status

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000092 Version number: 5

Data element type: DATA ELEMENT

Definition: Whether a person is treated on an involuntary basis under the relevant State or Territory mental health legislation, at any time during an episode of care for an admitted patient or treatment of a patient/client by a community based service during a reporting period.

Involuntary patients are persons who are detained in hospital or compulsorily treated in the community under mental health legislation for the purpose of assessment or provision of appropriate treatment or care.

Context: Mental health care: this data element is required to monitor trends in the use of compulsory treatment provisions under State and Territory mental health legislation by Australian hospitals and community health care facilities, including 24-hour community based residential services. For those hospitals and community mental health services which provide psychiatric treatment to involuntary patients, mental health legal status information is an essential data element within local record systems.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Involuntary patient

2 Voluntary patient

3 Not permitted to be reported under legislative arrangements in the jurisdiction

Guide for use: Code 3. This code is to be used for reporting to the NMDS–community mental health care, where applicable.

Approval is required under the State or Territory mental health legislation in order to detain patients for the provision of mental health care or for patients to be treated compulsorily in the community.

Code 1 involuntary status should only be used by facilities which are approved for this purpose. While each State and Territory mental health legislation differs in the number of categories of involuntary patient that are recognised, and the specific titles and legal conditions applying to each type, the legal status categories which provide for compulsory detention or compulsory treatment of the patient can be readily differentiated within each jurisdiction. These include special categories for forensic patients who are charged with or convicted of some form of criminal activity.

Each State/Territory health authority should identify which sections of their mental health legislation provide for detention or compulsory treatment of the patient and code these as involuntary status.

Guide for use (continued):	The mental health legal status of admitted patients treated within approved hospitals may change many times throughout the episode of care. Patients may be admitted to hospital on an involuntary basis and subsequently be changed to voluntary status; some patients are admitted as voluntary but are transferred to involuntary status during the hospital stay. Multiple changes between voluntary and involuntary status during an episode of care in hospital or treatment in the community may occur depending on the patient's clinical condition and his/her capacity to consent to treatment.
Collection methods:	Admitted patients: to be collected if the patient is involuntary at any time during the episode of care. Patients in 24-hour staffed community-based residential services: to be collected if the patient is involuntary at any time during the stay in the residence. Non-admitted patients: to be collected if the patient is involuntary at any time during a specified collection period.
Related data:	supersedes previous Mental health legal status, version 4

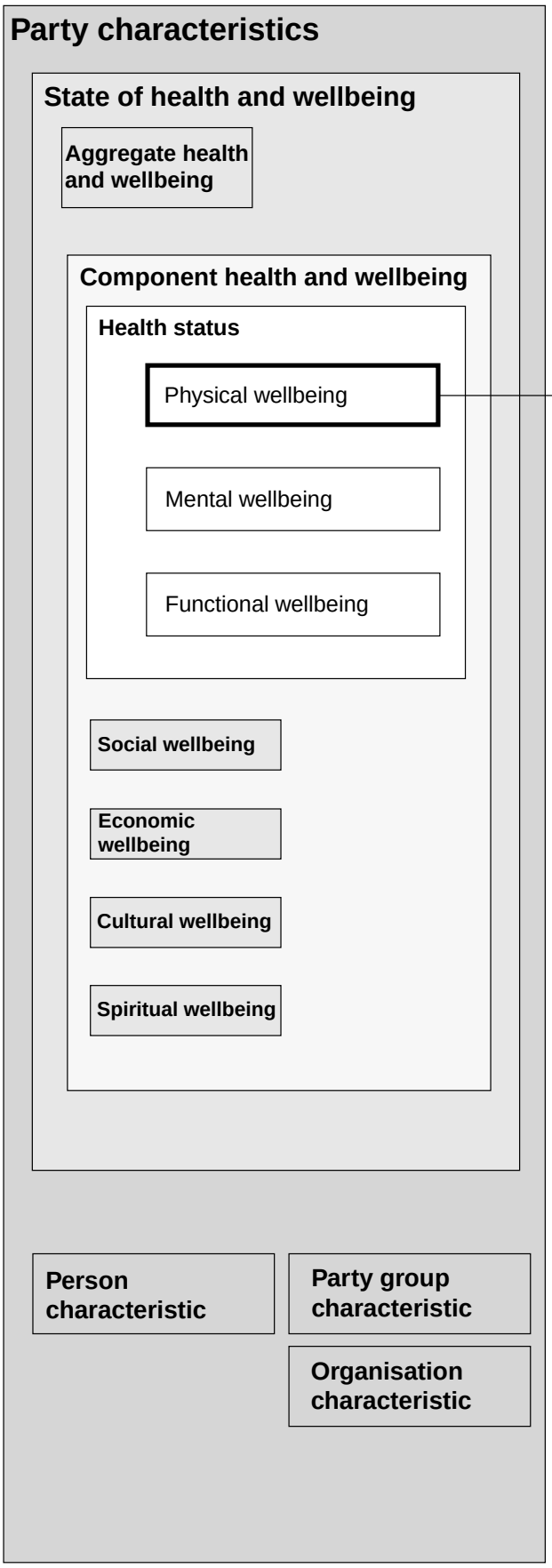
Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Admitted patient mental health care	from 1/07/2000 to
Community mental health care	from 1/07/2000 to

National Health Information Model entity



Data elements

- Additional diagnosis
- Apgar score at 1 minute
- Apgar score at 5 minutes
- Behaviour-related nursing requirements – at residential aged care admission
- Behaviour-related nursing requirements – at residential aged care, current status
- Birthweight *(concept)*
- Bodily location of main injury
- Complications of pregnancy
- Congenital malformations
- Congenital malformations – BPA code
- Continence status (faeces) of residential aged care resident – at admission
- Continence status (faeces) of residential aged care resident – current status
- Continence status (urine) of residential aged care resident – at admission
- Continence status (urine) of residential aged care resident – current status
- Date of completion of last previous pregnancy
- Diagnosis
- Diagnosis related group
- First day of the last menstrual period
- Gestational age *(concept)*
- Gestational age
- Infant weight, neonate, stillborn
- Major diagnostic category
- Maternal medical conditions
- Nature of main injury – non-admitted patient
- Neonatal morbidity
- Nursing diagnosis
- Other drugs of concern
- Outcome of last previous pregnancy
- Perinatal period *(concept)*
- Perineal status
- Postpartum complication
- Previous pregnancies
- Principal diagnosis
- Principal drug of concern
- Specialised nursing requirements – at residential aged care admission
- Specialised nursing requirements – current status
- Status of the baby

Additional diagnosis

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000005 Version number: 4

Data element type: DATA ELEMENT

Definition: A condition or complaint either coexisting with the principal diagnosis or arising during the episode of care or attendance at a health care facility.

Context: Additional diagnoses give information on factors which result in increased length of stay, more intensive treatment or the use of greater resources. They are used for casemix analyses relating to severity of illness and for correct classification of patients into Australian Refined Diagnosis related groups.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 3 Max. 6 Layout: ANN.NN

Data domain: ICD-10-AM (2nd edition)—disease codes

Guide for use: Record each additional diagnosis relevant to the episode of care in accordance with the ICD-10-AM (2nd edition) Australian Coding Standards. An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected.

Generally, External cause, Place of occurrence and Activity codes will be included in the string of additional diagnosis codes. In some data collections these codes may also be copied into specific fields.

The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status.

Collection methods: An additional diagnosis should be recorded and coded where appropriate upon separation of an episode of admitted patient care. The additional diagnosis is derived from and must be substantiated by clinical documentation.

Related data: supersedes previous Additional diagnosis—ICD-9-CM code, version 3

is used in the derivation of Diagnosis related group, version 1

supplements the data element Principal diagnosis, version 3

Administrative attributes

Source document: International Statistical Classification of Diseases and Related Health Problems—Tenth Revision—Australian Modification 2nd Edition (July 2000); National Centre for Classification in Health, Sydney.

Source organisation: National Centre for Classification in Health (Sydney)

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Admitted patient mental health care	from 1/07/2000 to
Community mental health care	from 1/07/2000 to
Admitted patient palliative care	from 1/07/2000 to

Comments:

Additional diagnoses are significant for the allocation of Australian Refined Diagnosis Related Groups. The allocation of patients to major problem or complication and co-morbidity Diagnosis Related Groups is made on the basis of the presence of certain specified Additional diagnoses. Additional diagnoses should be recorded when relevant to the patient's episode of care and not restricted by the number of fields on the morbidity form or computer screen.

External cause codes, although not diagnosis or condition codes, should be sequenced together with the additional diagnoses codes so that meaning is given to the data for use in injury surveillance and other monitoring activities.

Apgar score at 1 minute

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000344 Version number: 1

Data element type: DATA ELEMENT

Definition: Numerical score to evaluate the baby's condition at 1 minute after birth.

Context: Perinatal: required to analyse pregnancy outcome, particularly after complications of pregnancy, labour and birth. The Apgar score is an indicator of the health of a baby.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain: Apgar score (00–10), or 99 (not stated)

Guide for use: The score is based on the five characteristics of heart rate, respiratory condition, muscle tone, reflexes and colour. The maximum or best score being 10.

Related data: is a qualifier of Status of the baby, version 1

supersedes previous data element Apgar score, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Apgar score at 5 minutes

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000345 Version number: 1

Data element type: DATA ELEMENT

Definition: Numerical score to evaluate the baby's condition at 5 minutes after birth.

Context: Perinatal: required to analyse pregnancy outcome, particularly after complications of pregnancy, labour and birth. The Apgar score is an indicator of the health of a baby.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain: Apgar score (00–10), or 99 (not stated)

Guide for use: The score is based on the five characteristics of heart rate, respiratory condition, muscle tone, reflexes and colour. The maximum or best score being 10.

Related data: supersedes previous data element Apgar score, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Behaviour-related nursing requirements—on admission to residential aged care

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000018 Version number: 1

Data element type: DATA ELEMENT

Definition: A measure of the additional nursing and personal care time for residential aged care service residents at the time of admission required for residential aged care service residents resulting from certain behaviour (normally arising from the resident's mental state) such as disorientation, confusion, aggression, severe agitation or extreme anxiety, wandering and noisiness, and disruptive or self-destructive behaviour. Note that this is not intended to cover the routine or normal levels of social and emotional support.

Context: Residential aged care service statistics: along with functional profile, continence and specialised nursing procedures, behaviour constitutes one of the key indicators of dependency and disability for residential aged care service residents and serves to supplement Resident Classification Instrument level of dependency which is also in the dictionary.

Relational and representational attributes

Datatype: Alphabetic Field size: Min. 1 Max. 1 Layout: A

Data domain:

A	For additional attention
B	Less than 0.5 hours of direct individual attention per day
C	From 0.5 to 1.5 hours of individual attention per day or attention for two or more hours at least once a week on an episodic basis
D	More than 1.5 hours of individual attention per day

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Behaviour-related nursing requirements—in residential aged care, current status

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000374 Version number: 1

Data element type: DATA ELEMENT

Definition: A measure of the current status of additional nursing and personal care time required for residential aged care service residents resulting from certain behaviour (normally arising from the resident's mental state) such as disorientation, confusion, aggression, severe agitation or extreme anxiety, wandering and noisiness, and disruptive or self-destructive behaviour. Note that this is not intended to cover the routine or normal levels of social and emotional support.

Context: Residential aged care service statistics: along with functional profile, continence and specialised nursing procedures, behaviour constitutes one of the key indicators of dependency and disability for residential aged care service residents and serves to supplement Resident Classification Instrument level of dependency which is also in the dictionary.

Relational and representational attributes

Datatype: Alphabetic Field size: Min. 1 Max. 1 Layout: A

Data domain:

A	For additional attention
B	Less than 0.5 hours of direct individual attention per day
C	From 0.5 to 1.5 hours of individual attention per day or attention for two or more hours at least once a week on an episodic basis
D	More than 1.5 hours of individual attention per day

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Birthweight

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000021 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: The first weight of the foetus or baby obtained after birth. The World Health Organization further defines the following categories:

- Extremely low birthweight: less than 1,000 g (up to and including 999 g)
- Very low birthweight: less than 1,500 g (up to and including 1,499 g)
- Low birthweight: less than 2,500 g (up to and including 2,499 g)

Context: Perinatal:

Administrative attributes

Source document: International Classification of Diseases and Related Health Problems, 10th Revision, WHO, 1992

Source organisation: National Perinatal Data Development Committee

Comments: The definitions of low, very low, and extremely low birthweight do not constitute mutually exclusive categories. Below the set limits they are all-inclusive and therefore overlap (i.e. low includes very low and extremely low, while very low includes extremely low).

For live births, birthweight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. While statistical tabulations include 500 g groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured.

Bodily location of main injury

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000086 Version number: 1

Data element type: DATA ELEMENT

Definition: The bodily location of the injury chiefly responsible for the attendance of the person at the health care facility.

Context: Injury surveillance: the injury diagnosis is necessary for purposes including epidemiological research, casemix studies and planning. The data element Nature of main injury—non-admitted patient together with data element Bodily location of main injury indicates the diagnosis.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain:

01	Head (excludes face [02])
02	Face (excludes eye)
03	Neck
04	Thorax
05	Abdomen
06	Lower back (includes loin)
07	Pelvis (includes perineum, anogenital area and buttocks)
08	Shoulder
09	Upper arm
10	Elbow
11	Forearm
12	Wrist
13	Hand (include fingers)
14	Hip
15	Thigh
16	Knee
17	Lower leg
18	Ankle
19	Foot (include toes)
20	Unspecified bodily location
21	Multiple injuries (involving more than one bodily location)
22	Bodily location not required

Guide for use: If the full ICD-10-AM code is used to code the injury, this item is not required (see data elements Principal diagnosis and Additional diagnosis).

If any code from 01 to 12 or 26 to 29 in the data element Nature of main injury has been selected, the body region affected by that injury must be specified.

Guide for use (continued): Select the category that best describes the location of the injury. If two or more categories are judged to be equally appropriate, select the one that comes first on the code list. A major injury, if present, should always be coded rather than a minor injury. If a major injury has been sustained (e.g. a fractured femur), along with one or more minor injuries (e.g. some small abrasions), the major injury should be coded in preference to coding 'multiple injuries'. As a general guide, an injury which, on its own, would be unlikely to have led to the attendance may be regarded as 'minor'. Bodily location of main injury code is not required with other Nature of main injury codes (code 22 may be used as a filler to indicate that a specific body region code is not required).

Related data: used in conjunction with Nature of main injury—non-admitted patient, version 1

Administrative attributes

Source organisation: AIHW National Injury Surveillance Unit and National Data Standards for Injury Surveillance Advisory Group

National minimum data sets:

Injury surveillance from 1/07/1989 to

Comments: This item is related to the ICD-10-AM (2nd edition) injury and poisoning classification. However, coding to the full ICD-10-AM injury and poisoning classification (see data element Principal diagnosis) is not available in most settings where basic injury surveillance is undertaken. This item, in combination with the data element Nature of main injury—non-admitted patient, is a practicable alternative. Data coded to the full ICD-10-AM codes can be aggregated to match this item, facilitating data comparison. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Complications of pregnancy

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000028 Version number: 2

Data element type: DATA ELEMENT

Definition: Complications arising up to the period immediately preceding delivery that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome.

Context: Perinatal: complications often influence the course and outcome of pregnancy, possibly resulting in hospital admissions and/or adverse effects on the foetus and perinatal morbidity.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 3 Max. 6 Layout: NNN.NN

Data domain: ICD-10-AM (2nd edition)—disease codes

Guide for use: Examples of these conditions include threatened abortion, antepartum haemorrhage, pregnancy-induced hypertension and gestational diabetes. There is no arbitrary limit on the number of complications specified.

Verification rules: Complications should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM (2nd edition)

Related data: supersedes previous data element Complications of pregnancy—ICD-9-CM code, version 1

used in conjunction with Maternal medical conditions, version 2

Administrative attributes

Source document: International Statistical Classification of Diseases and Related Health Problems—Tenth Revision—Australian Modification 2nd Edition (July 2000) National Centre for Classification in Health, Sydney.

Source organisation: National Perinatal Data Development Committee

Congenital malformations

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000030 Version number: 2

Data element type: DATA ELEMENT

Definition: Structural abnormalities (including deformations) that are present at birth and diagnosed prior to separation from care.

Context: Admitted patient care: required to monitor trends in the reported incidence of congenital malformations, to detect new drug and environmental teratogens, to analyse possible causes in epidemiological studies, and to determine survival rates and the utilisation of paediatric services.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 3 Max. 6 Layout: ANN.NN

Data domain: ICD-10-AM (2nd edition)

Guide for use: Coding to the disease classification of ICD-10-AM (2nd edition) is the preferred method of coding admitted patients. However, for the perinatal data collection, the use of BPA is preferred as this is more detailed (see 'Congenital malformations—BPA classification').

Related data: supersedes previous data element Congenital malformations—ICD-9-CM code, version 1

used in conjunction with Neonatal morbidity, version 2

Administrative attributes

Source document: International Statistical Classification of Diseases and Related health Problems—10th Revision, Australian Modification 2nd Edition (July 2000) National Centre for Classification in Health, Sydney.

Source organisation: National Perinatal Data Development Committee

Congenital malformations—BPA code

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000029 Version number: 1

Data element type: DATA ELEMENT

Definition: Structural abnormalities (including deformations) that are present at birth and diagnosed prior to separation from care.

Context: Perinatal: required to monitor trends in the reported incidence of congenital malformations, to detect new drug and environmental teratogens, to analyse possible causes in epidemiological studies, and to determine survival rates and the utilisation of paediatric services.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 5 Max. 5 Layout: NNNNN

Data domain: British Paediatric Association (BPA) Classification of Diseases (1979)

Guide for use: Coding to the disease classification of ICD-10-AM (2nd edition) is the preferred method of coding admitted patients. For perinatal data collection, the use of BPA is preferred as this is more detailed.

Related data: used in conjunction with Neonatal morbidity, version 2

Administrative attributes

Source document: British Paediatric Association Classification of Diseases (1979)

Source organisation: National Perinatal Data Development Committee

Comments: There is no arbitrary limit on the number of conditions specified. Most perinatal data groups and birth defects registers in the States and Territories have used the 5-digit British Paediatric Association (BPA) Classification of Diseases to code congenital malformations since the early 1980s.

Continence status (faeces) of residential aged care resident—at admission

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000033 Version number: 2

Data element type: DATA ELEMENT

Definition: A measure of the level of incontinence (faeces) of a person at the time of admission to a residential aged care service in terms of the frequency with which the resident is incontinent.

Context: Residential aged care service statistics: along with continence, behaviour and specialised nursing procedures, functional profile constitutes one of the key indicators of dependency and disability for residential aged care service residents and serves to supplement the Resident Classification Instrument level of dependency.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 1 Max. 1 Layout: A

Data domain:

A	Continent
B	Incontinent, but not daily
C	Incontinent, occurring once daily
D	Incontinent, occurring regularly more than once daily

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Related data: supersedes previous data element Continence status at admission, version 1

Continence status (faeces) of residential aged care resident—current status

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000034 Version number: 2

Data element type: DATA ELEMENT

Definition: A measure of the residential aged care service resident's current level of incontinence (faeces) in terms of the frequency with which the resident is incontinent.

Context: Residential aged care service statistics: along with continence, behaviour and specialised nursing procedures, functional profile constitutes one of the key indicators of dependency and disability for residential aged care service residents and serves to supplement the Resident Classification Instrument level of dependency.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 1 Max. 1 Layout: A

Data domain:

A	Continent
B	Incontinent, but not daily
C	Incontinent, occurring once daily
D	Incontinent, occurring regularly more than once daily

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Continence status (urine) of residential aged care resident—at admission

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000375 Version number: 2

Data element type: DATA ELEMENT

Definition: A measure of the level of incontinence (urine) of a person at the time of admission to a residential aged care service in terms of the frequency with which the resident is incontinent.

Context: Residential aged care service statistics: along with continence, behaviour and specialised nursing procedures, functional profile constitutes one of the key indicators of dependency and disability for residential aged care service residents and serves to supplement the Resident Classification Instrument level of dependency.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 1 Max. 1 Layout: A

Data domain:

A	Continent
B	Incontinent, but not daily
C	Incontinent, occurring once daily
D	Incontinent, occurring regularly more than once daily

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Continence status (urine) of residential aged care resident—current status

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000376 Version number: 2

Data element type: DATA ELEMENT

Definition: A measure of the residential aged care service resident's current level of incontinence (urine) in terms of the frequency with which the resident is incontinent.

Context: Residential aged care service statistics: along with continence, behaviour and specialised nursing procedures, functional profile constitutes one of the key indicators of dependency and disability for residential aged care service residents and serves to supplement the Resident Classification Instrument level of dependency.

Relational and representational attributes

Datatype: Alphabetic Field size: Min. 1 Max. 1 Layout: A

Data domain:

A	Continent
B	Incontinent, but not daily
C	Incontinent, occurring once daily
D	Incontinent, occurring regularly more than once daily

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Date of completion of last previous pregnancy

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000037 Version number: 1

Data element type: DATA ELEMENT

Definition: Date on which the pregnancy preceding the current pregnancy was completed.

Context: Perinatal: interval between pregnancies may be an important risk factor for the outcome of the current pregnancy, especially for preterm birth and low birthweight.

Relational and representational attributes

Datatype: Numeric Field size: Min. 6 Max. 8 Layout: DDMMYYYY

Data domain: Valid dates

Guide for use: Estimate DD, if first day is unknown.

Related data: is a qualifier of Previous pregnancies, version 1

is qualified by Outcome of last previous pregnancy, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Comments: This data item is recommended by the World Health Organization. It is currently collected in some States and Territories.

Diagnosis

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000398 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A diagnosis is the decision reached, after assessment, of the nature and identity of the disease or condition of a patient.

Context: Health services: Diagnostic information provides the basis for analysis of health service usage, epidemiological studies and monitoring of specific disease entities.

Relational and representational attributes

Related data: relates to Complications of pregnancy, version 2

relates to Maternal medical conditions, version 2

relates to External cause—admitted patient, version 4

relates to Principal diagnosis, version 3

relates to Complication of labour and delivery, version 2

relates to Postpartum complication, version 2

relates to Neonatal morbidity, version 2

relates to Congenital malformations, version 2

relates to Additional diagnosis, version 4

Administrative attributes

Source organisation: National Health Data Committee

Comments: Classification systems which enable the allocation of a code to the diagnostic information:

- International Statistical Classification of Diseases and Related Health Problems—Tenth Revision—Australian Modification (2nd edition) (ICD-10-AM)
- British Paediatric Association Classification of Diseases (1979)
- North America Nursing Diagnosis Association (NANDA)
- International Classification of Primary Care (1987)
- International Classification of Impairments, Disabilities and Handicaps (1980)
- International Classification of Impairments, Disabilities and Handicaps Beta/1 draft revised classification (1997).

Diagnosis related group

Admin. status: CURRENT 1/07/1993

Identifying and definitional attributes

Knowledgebase ID: 000042 Version number: 1

Data element type: DATA ELEMENT

Definition: A patient classification scheme which provides a means of relating the number and types of patients treated in a hospital to the resources required by the hospital.

Context: The development of Australian Refined Diagnosis Related Groups has created a descriptive framework for studying hospitalisation. Diagnosis Related Groups provide a summary of the varied reasons for hospitalisation and the complexity of cases a hospital treats. Moreover, as a framework for describing the products of a hospital (that is, patients receiving services), they allow meaningful comparisons of hospitals' efficiency and effectiveness under alternative systems of health care provision.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 4 Max. 4 Layout: ANNA

Data domain: Australian Refined Diagnosis Related Groups, Commonwealth of Australia. Version effective from 1 July each year.

Related data: is derived from Sex, version 2

is derived from Date of birth, version 3

is derived from Mode of separation, version 3

is derived from Intended length of hospital stay, version 2

is derived from Infant weight, neonate, stillborn, version 3

is derived from Principal diagnosis, version 3

is derived from Additional diagnosis, version 4

is derived from Procedure, version 5

is derived from Separation date, version 5

is derived from Admission date, version 4

Administrative attributes

Source organisation: National Health Data Committee, National Centre for Classification in Health

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Admitted patient mental health care	from 1/07/2000 to

Comments: The Australian Refined Diagnosis Related Group is derived from a range of data collected on admitted patients, including diagnosis and procedure information, classified using ICD-10-AM (2nd edition). The data elements required are described in Related data elements.

First day of the last menstrual period

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000056 Version number: 1

Data element type: DATA ELEMENT

Definition: Date of the first day of the mother's last menstrual period (LMP).

Context: Perinatal: the first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid dates or 99999999 if first day is unknown

Guide for use: If the first day is unknown, it is unnecessary to record the month and year (i.e. record 99999999).

Related data: is used in the calculation of Gestational age, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/1997 to

Gestational age

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000059 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: The duration of gestation is measured from the first day of the last normal menstrual period. Gestational age is expressed in completed days or completed weeks (e.g. events occurring 280 to 286 completed days after the onset of the last normal menstrual period are considered to have occurred at 40 weeks of gestation).

WHO identifies the following categories:

Pre-term: less than 37 completed weeks (less than 259 days) of gestation

Term: from 37 completed weeks to less than 42 completed weeks (259 to 293 days) of gestation

Post-term: 42 completed weeks or more (294 days or more) of gestation.

Context: Perinatal:

Relational and representational attributes

Related data: relates to Gestational age, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Gestational age

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000060 Version number: 1

Data element type: DATA ELEMENT

Definition: The estimated gestational age of the baby in completed weeks as determined by clinical assessment.

Context: Perinatal: the first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain: Number representing the number of completed weeks, or 99 for not stated/ unknown.

Guide for use: This is derived from clinical assessment when accurate information on the date of the last menstrual period (LMP) is not available for this pregnancy.

Gestational age is frequently a source of confusion when calculations are based on menstrual dates. For the purposes of calculation of gestational age from the date of the first day of the last normal menstrual period and the date of delivery, it should be borne in mind that the first day is day zero and not day one.

Related data: relates to concept Gestational age, version 1

is calculated using First day of the last menstrual period, version 1

Administrative attributes

Source document: International Classification of Diseases and Related Health Problems, 10 Revision, WHO, 1992

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/1997 to

Infant weight, neonate, stillborn

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000010 Version number: 3

Data element type: DATA ELEMENT

Definition: The first weight of the live born or stillborn baby obtained after birth, or the weight of the neonate or infant on the date admitted if this is different from the date of birth.

Context: Weight is an important indicator of pregnancy outcome, is a major risk factor for neonatal morbidity and mortality and is required to analyse perinatal services for high-risk infants.

This item is required to generate Australian National Diagnosis Related Groups.

Relational and representational attributes

Datatype: Numeric Field size: Min. 4 Max. 4 Layout: NNNN

Data domain: 4-digit field representing the weight in grams

Guide for use: For live births, birthweight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. While statistical tabulations include 500 g groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured.

In perinatal collections the birthweight is to be provided for liveborn and stillborn babies.

Weight on the date the infant is admitted should be recorded if the weight is less than or equal to 9000g and age is less than 365 days.

Verification rules: For the provision of State and Territory hospital data to Commonwealth agencies this field must be consistent with diagnoses and procedure codes for valid grouping.

Related data: is used in the derivation of Diagnosis related group, version 1

supersedes previous data element Stillborn, live born baby, infant weight, version 2

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Perinatal	from 1/07/1997 to

Major diagnostic category

Admin. status: CURRENT 1/07/1993

Identifying and definitional attributes

Knowledgebase ID: 000088 Version number: 1

Data element type: DATA ELEMENT

Definition: Major Diagnostic Categories are 23 mutually exclusive categories into which all possible principal diagnoses fall. The diagnoses in each category correspond to a single body system or aetiology, broadly reflecting the speciality providing care.

Each category is partitioned according to whether or not a surgical procedure was performed. This preliminary partitioning into Major Diagnostic Categories occurs before a Diagnosis Related Group is assigned.

The Australian Refined Diagnosis Related Groups departs from the use of principal diagnosis as the initial variable in the assignment of some groups. A hierarchy of all exceptions to the principal diagnosis-based assignment to a Major Diagnostic Category has been created. As a consequence, certain Australian Refined Diagnosis Related Groups are not unique to a Major Diagnostic Category. This requires both a Major Diagnostic Category and an Australian Refined Diagnosis Related Group to be generated per patient.

Context: The generation of a Major Diagnostic Category to accompany each Australian National Diagnosis Related Group is a requirement of the latter as Diagnosis Related Groups are not unique.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain: Australian Refined Diagnosis Related Groups

Guide for use: Version effective 1 July each year

Related data: is derived from Date of birth, version 3

is derived from Admission date, version 3

is used in the derivation of Diagnosis related group, version 1

is derived from Infant weight, neonate, stillborn, version 3

is derived from Principal diagnosis, version 3

is derived from Additional diagnosis, version 4

Administrative attributes

Source organisation: Department of Health and Aged Care, Acute and Co-ordinated Care Branch

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Admitted patient mental health care	from 1/07/2000 to

Comments: This data item has been created to reflect the development of Australian Refined Diagnosis Related Groups (as defined in the data element Diagnosis related group) by the Acute and Co-ordinated Care Branch, Commonwealth Department of Health and Aged Care. Due to the modifications in the Diagnosis Related Group logic for the Australian Refined Diagnosis Related Groups, it is necessary to generate the Major Diagnostic Category to accompany each Diagnosis Related Group. The construction of the pre-Major Diagnostic Category logic means Diagnosis Related Groups are no longer unique. Certain pre-Major Diagnostic Category Diagnosis Related Groups may occur in more than one of the 23 Major Diagnostic Categories. For example, liver transplant DRG 005, may occur in any of the Major Diagnostic Categories according to the principal diagnosis. AR-DRGs 950–954 (excluding AR-DRG 952 in most cases) also require the allocation of a Major Diagnostic Category according to the principal diagnosis.

Maternal medical conditions

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000090 Version number: 2

Data element type: DATA ELEMENT

Definition: Pre-existing maternal diseases and conditions, and other diseases, illnesses or conditions arising during the current pregnancy, that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome.

Context: Perinatal: maternal medical conditions may influence the course and outcome of the pregnancy and may result in antenatal admission to hospital and/or treatment that could have adverse effects on the foetus and perinatal morbidity.

Relational and representational attributes

Datatype: Numeric Field size: Min. 3 Max. 6 Layout: ANN.NN

Data domain: ICD-10-AM (2nd edition)—disease codes

Guide for use: Examples of such conditions include essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease. There is no arbitrary limit on the number of conditions specified.

Verification rules: Conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM (2nd edition)

Related data: supersedes previous data element Maternal medical conditions—ICD-9-CM code, version 1

used in conjunction with Complications of pregnancy, version 2

Administrative attributes

Source document: International Statistical Classification of Diseases and Related Health Problems—Tenth Revision—Australian Modification 2nd Edition (July 2000) National Centre for Classification in Health, Sydney.

Source organisation: National Perinatal Data Development Committee

Nature of main injury—non-admitted patient

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000087 Version number: 1

Data element type: DATA ELEMENT

Definition: The nature of the injury chiefly responsible for the attendance of the person at the health care facility.

Context: Injury surveillance: injury diagnosis is necessary for purposes including epidemiological research, casemix studies and planning.This item together with item 'Bodily location of main injury' indicates the diagnosis.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 4 Layout: NN or NN.N

Data domain:

01	Superficial (excludes eye [13])
02	Open wound (excludes eye [13])
03	Fracture (excludes tooth [21])
04	Dislocation (includes ruptured disc, cartilage, ligament)
05	Sprain or strain
06	Injury to nerve (includes spinal cord; excludes intracranial injury [20])
07	Injury to blood vessel
08	Injury to muscle or tendon
09	Crushing injury
10	Traumatic amputation (includes partial amputation)
11	Injury to internal organ
12	Burn or corrosion (excludes eye [13])
13	Eye injury (excludes foreign body in external eye [14.1], includes burns)
14.1	Foreign body in external eye
14.2	Foreign body in ear canal
14.3	Foreign body in nose
14.4	Foreign body in respiratory tract (excludes foreign body in nose [14.3])
14.5	Foreign body in alimentary tract
14.6	Foreign body in genitourinary tract
14.7	Foreign body in soft tissue
14.9	Foreign body, other/unspecified
20	Intracranial injury (includes concussion)
21	Dental injury (includes fractured tooth)
22	Drowning, immersion
23	Asphyxia or other threat to breathing (excludes drowning [22])
24	Electrical injury
25	Poisoning, toxic effect (excludes venomous bite [26])
26	Effect of venom, or any insect bite

Data domain (continued):	27	Other specified nature of injury
	28	Injury of unspecified nature
	29	Multiple injuries of more than one 'nature'
	30	No injury detected

Guide for use:

If the full ICD-10-AM (2nd edition) code is used to code the injury, this item is not required (see data elements Principal diagnosis and Additional diagnosis).

When coding to the full ICD-10-AM code is not possible, use this item with the data element External cause of injury—non admitted patient, External cause of injury—human intent and Bodily location of main injury.

Select the item which best characterises the nature of the injury chiefly responsible for the attendance, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list. A major injury, if present, should always be coded rather than a minor injury. If a major injury has been sustained (e.g. a fractured femur), along with one or more minor injuries (e.g. some small abrasions), the major injury should be coded in preference to coding 'multiple injuries'. As a general guide, an injury which, on its own, would be unlikely to have led to the attendance may be regarded as 'minor'.

If the nature of the injury code is 01 to 12 or 26 to 29 then data element Bodily location of main injury should be used to record the bodily location of the injury. If another code is used, bodily location is implicit or meaningless. Data element Bodily location of main injury, category 22 may be used as a filler to indicate that specific body region is not required.

Verification rules: Left justified, zero filled.

Related data: used in conjunction with External cause—major external cause, version 3

used in conjunction with External cause—human intent, version 3

used in conjunction with Bodily location of main injury, version 1

Administrative attributes

Source organisation: AIHW National Injury Surveillance Unit and National Data Standards for Injury Surveillance Advisory Group

National minimum data sets:

Injury surveillance from 1/07/1989 to

Comments: This item is related to the ICD-10-AM injury and poisoning classification. However, coding to the full ICD-10-AM injury and poisoning classification (see data element Principal diagnosis) is not available in most settings where basic injury surveillance is undertaken. This item, in combination with the data element Bodily location of main injury, is a practicable alternative. Data coded to the full ICD-10-AM codes can be aggregated to match this item, facilitating data comparison. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Neonatal morbidity

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000102 Version number: 2

Data element type: DATA ELEMENT

Definition: Conditions or diseases of the baby.

Context: Perinatal: morbidity of a baby is an important determinant of outcome and duration of hospital stay.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 3 Max. 6 Layout: ANN.NN

Data domain: ICD-10-AM (2nd edition)

Guide for use: There is no arbitrary limit on the number of conditions specified.

Verification rules: Conditions should be coded within chapter of Volume 1, ICD-10-AM (2nd edition)

Related data: supersedes data element Neonatal morbidity—ICD-9-CM code, version 1

used in conjunction with Congenital malformations—BPA code, version 1

used in conjunction with Congenital malformations, version 2

Administrative attributes

Source document: International Statistical Classification of Diseases and Related health Problems—10th Revision, Australian Modification 2nd Edition (July 2000) National Centre for Classification in Health, Sydney.

Source organisation: National Perinatal Data Development Committee

Neonate

Admin. status: CURRENT 1/07/1995

Identifying and definitional attributes

Knowledgebase ID: 000103 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A live birth who is less than 28 days old.

Context: Perinatal:

Administrative attributes

Source document: International Classification of Diseases and Related Health Problems, 10th Revision, WHO, 1992

Source organisation: National Health Data Committee, National Perinatal Data Development Committee

Comments: The neonatal period is exactly four weeks or 28 completed days, commencing on the date of birth (day 0) and ending on the completion of day 27. For example, a baby born on 1 October remains a neonate until completion of the four weeks on 28 October and is no longer a neonate on 29 October.

Nursing diagnosis

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000110 Version number: 2

Data element type: DATA ELEMENT

Definition: Nursing diagnosis is a clinical judgement about individual, family or community responses to actual or potential health problems/life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.

Context: Enables analysis of information by diagnostic variables especially in relation to the development of outcome information, Goal of care and Nursing intervention. Nursing diagnosis and the data element Nursing intervention have shown to be more predictive of resource use than client's functional status or medical diagnosis.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 3 Max. 11 Layout: N.N.N.N.N.N

Data domain: The North American Nursing Diagnosis Association (NANDA) Taxonomy, 1997–1998

Guide for use: Up to seven nursing diagnoses may be nominated, according to the following:

1. Nursing diagnosis most related to the principal reason for admission (one only)

2–6. Other nursing diagnoses of relevance to the current episode.

The NANDA codes should be used in conjunction with a nursing diagnosis text. The NANDA coding structure is a standard format for reporting nursing diagnosis. It is not intended in any way to change or intrude upon nursing practice, provided the information available can transpose to the NANDA codes for the Community Nursing Services Minimum Data Set—Australia (CNMDSA).

Collection methods: In considering how nursing diagnosis could be implemented, agencies may opt to introduce systems transparent to the clinician if there is confidence that a direct and reliable transfer to NANDA codes can be made from information already in place.

Agencies implementing new information systems should consider the extent to which these can facilitate practice and at the same time lighten the burden of documentation. Direct incorporation of the codeset or automated mapping to it when the information is at a more detailed level are equally valid and viable options.

Related data: supersedes previous Nursing diagnosis, version 1

relates to Nursing interventions, version 2

relates to Goal of care, version 2

Administrative attributes

Source document: NANDA Nursing Diagnoses: Definitions and Classification 1997–1998. (1997), North American Nursing Diagnosis Association.

Source organisation: Australian Council of Community Nursing Services

Comments: The CNMDSA Steering Committee considered information from users of the data in relation to Nursing diagnosis. Many users have found the taxonomy wanting in its ability to describe the full range of persons and conditions seen by community nurses in the Australian setting. In the absence of an alternative taxonomy with wide acceptance, the CNMDSA Steering Committee has decided to retain NANDA. The University of Iowa has a written agreement with NANDA to expand the relevance of NANDA. The Australian Council of Community Nursing Services (ACCNS) has sought collaboration with a US project at the University of Iowa which is seeking to refine, extend, validate and classify the NANDA taxonomy.

Other drugs of concern

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000442 Version number: 1

Data element type: DATA ELEMENT

Definition: Any drugs apart from the 'Principal drug of concern' which the client perceives as being a health concern.

Context: Alcohol and other drug treatment services: This item complements 'Principal drug of concern'. The existence of other drugs of concern may have a role in determining the types of treatment required and may also influence treatment outcomes.

Relational and representational attributes

Datatype: Numeric Field size: Min. 4 Max. 4 Layout: NNNN

Data domain: Australian standard classification of illicit drugs and other substances of concern

Guide for use: This is a multiple response data item to allow for the coding of polydrug use. The data element can be used in conjunction with Principal drug of concern.

Verification rules: There should be no duplication with 'Principal drug of concern'.

Collection methods: More than one drug may be selected.
To be collected on commencement of treatment with a service.

Related data: relates to Principal drug of concern, version 1

Administrative attributes

Source organisation: Intergovernmental Committee on Drugs NMDS-WG

National minimum data sets:

Alcohol and other drug treatment services from 01/07/2000 to

Comments: This is consistent with the findings of the Pilot Study conducted by the National Drug and Alcohol Research Centre over a six week period between June and August 1998.

Outcome of last previous pregnancy

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000114 Version number: 1

Data element type: DATA ELEMENT

Definition: Outcome of the most recent pregnancy preceding this pregnancy.

Context: Perinatal: adverse outcome in previous pregnancy is an important risk factor for subsequent pregnancy.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Single live birth—survived at least 28 days
2	Single live birth—neonatal death (within 28 days)
3	Single stillbirth
4	Spontaneous abortion
5	Induced abortion
6	Ectopic pregnancy
7	Multiple live birth—all survived at least 28 days
8	Multiple birth—one or more neonatal deaths (within 28 days) or stillbirths

Guide for use: In the case of multiple pregnancy with foetal loss before 20 weeks, code on outcome of surviving foetus(es) beyond 20 weeks.

Related data: is a qualifier of Date of completion of last previous pregnancy, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Comments: This data item is recommended by the World Health Organization. It is collected in some States and Territories.

Perinatal period

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000124 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: The perinatal period commences at 20 completed weeks (140 days) of gestation and ends 28 completed days after birth.

Context: Perinatal:

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Comments: This definition of perinatal period differs from that recommended by WHO. In the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems, (WHO, 1992) the perinatal period is defined as commencing: 'at 22 completed weeks (154 days) of gestation (the time when birthweight is normally 500 g) and ends seven completed days after birth'.

At the time that WHO first recommended 500 g (and now 22 weeks) as the lower limits for reporting perinatal and infant mortality, Australia had already adopted legal and statistical definitions for birthweight (400 g) and gestational age (20 weeks) limits that were lower than the WHO limits. Also, the upper limit for the perinatal period in Australia was 28 days. These broader definitions in Australia obviously comply with, and extend, the WHO definitions.

To avoid unnecessary confusion between legal and statistical definitions in Australia, for the purposes of perinatal data collection it is recommended that the perinatal period commences at 20 completed weeks (140 days) of gestation and ends 28 completed days after birth.

Perineal status

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000125 Version number: 2

Data element type: DATA ELEMENT

Definition: State of the perineum following birth.

Context: Perinatal: perineal laceration (tear) may cause significant maternal morbidity in the postnatal period. Episiotomy is an indicator of management during labour and, to some extent, of intervention rates.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Intact
2	1st degree laceration/vaginal graze
3	2nd degree laceration
4	3rd degree laceration
5	Episiotomy
6	Combined laceration and episiotomy
7	4th degree laceration
8	Other
9	Not stated

Guide for use Vaginal tear is included in the same group as 1st degree laceration to be consistent with ICD-10-AM code. Other degrees of laceration are as defined in ICD-10-AM.

Related data: supersedes previous Perineal status, version 1

used in conjunction with Anaesthesia administered during labour, version 1

used in conjunction with Presentation at birth, version 1

used in conjunction with Method of birth, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Comments: While 4th degree laceration is more severe than an episiotomy it has not been placed in order of clinical significance within the data domain. Instead it has been added to the data domain as a new code rather than modifying the existing order of data domain code values. This is because information gatherers are accustomed to the existing order of the codes. Modifying the existing order may result in miscoding of data. This approach is consistent with established practice in classifications wherein a new data domain identifier (or code number) is assigned to any new value meaning that occurs, rather than assigning this new value domain meaning to an existing data domain identifier.

Postpartum complication

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000131 Version number: 2

Data element type: DATA ELEMENT

Definition: Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care.

Context: Perinatal: complications of the puerperal period may cause maternal morbidity, and occasionally death, and may be an important factor in prolonging the duration of hospitalisation after childbirth.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 3 Max. 6 Layout: ANN.NN

Data domain: ICD-10-AM (2nd edition)

Guide for use: There is no arbitrary limit on the number of conditions specified.

Verification rules: Complications should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM (2nd edition)

Related data: used in conjunction with Complication of labour and delivery, version 2

Administrative attributes

Source document: International Statistical Classification of Diseases and Related health Problems—10th Revision, Australian Modification 2nd Edition (July 2000) National Centre for Classification in Health, Sydney.

Source organisation: National Perinatal Data Development Committee

Comments: Examples of such conditions include postpartum haemorrhage, retained placenta, puerperal infections, puerperal psychosis, essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease.

Previous pregnancies

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000134 Version nuber: 1

Data element type: DATA ELEMENT

Definition: The total number of previous pregnancies, specified as pregnancies resulting in:

- live birth, or
- stillbirth—at least 20 weeks' gestational age or 400 g birthweight, or
- spontaneous abortion (less than 20 weeks' gestational age, or less than 400 g birthweight if gestational age is unknown), or
- induced abortion (termination of pregnancy before 20 weeks' gestation), or
- ectopic pregnancy.

Context: Perinatal: the number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes. A previous history of stillbirth or spontaneous abortion identifies the mother as high risk for subsequent pregnancies. A previous history of induced abortion may increase the risk of some outcomes in subsequent pregnancies.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain: 2-digit numeric field representing the number of pregnancies for each of the categories above, or 99 for not stated

Guide for use: A pregnancy resulting in multiple births should be counted as one pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

Related data: is qualified by Date of completion of last previous pregnancy, version 1

used in conjunction with Outcome of last previous pregnancy, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Principal diagnosis

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000136 Version number: 3

Data element type: DATA ELEMENT

Definition: The diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care in hospital (or attendance at the health care facility).

Context: Health services: the principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, casemix studies and planning purposes.

Admitted patient care: The principal diagnosis is a major determinant in the classification of Australian Refined Diagnosis Related Groups and Major Diagnostic Categories.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 3 Max. 6 Layout: ANN.NN

Data domain: ICD-10-AM (2nd edition)

Guide for use: The principal diagnosis must be determined in accordance with the Australian Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses.

The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status.

The first edition of ICD-10-AM, the Australian modification of ICD-10, was published by the National Centre for Classification in Health in 1998 and implemented from July 1998. The second edition was published for use in July 2000.

Verification rules: As a minimum requirement the Principal diagnosis code must be a valid code from ICD-10-AM (2nd edition).

Some diagnosis codes are too imprecise or inappropriate to be acceptable as a principal diagnosis and will group to 951Z, 955Z and 956Z in the Australian Refined Diagnosis Related Groups, Version 4. A list of these diagnosis codes is available from the Acute and Coordinated Care Branch, Health Services Division, Department of Health and Aged Care.

Diagnosis codes starting with a V, W, X or Y, describing the circumstances that cause an injury, rather than the nature of the injury, cannot be used as principal diagnosis. Diagnosis codes which are morphology codes, cannot be used as principal diagnosis.

Collection methods: A principal diagnosis should be recorded and coded upon separation, for each episode of patient care. The principal diagnosis is derived from and must be substantiated by clinical documentation.

Admitted patients where the principal diagnosis is recorded prior to discharge (as in the annual census of public psychiatric hospital inpatients), it is the current provisional principal diagnosis. Only use the admission diagnosis when no other diagnostic information is available. The current provisional diagnosis may be the same as the admission diagnosis.

Related data: supersedes previous Principal diagnosis—ICD-9-CM code, version 2
relates to Diagnosis related group, version 1
is used in the derivation of Major diagnostic category, version 1
is used as an alternative to Nature of main injury—non-admitted patient, version 1
is an alternative to Bodily location of main injury, version 1
relates to External cause—human intent, version 4
relates to External cause—admitted patient, version 4
relates to Additional diagnosis, version 4
relates to External cause—non-admitted patient, version 4
relates to Procedure, version 5

Administrative attributes

Source document: International Statistical Classification of Diseases and Related Health Problems—Tenth Revision—Australian Modification 2nd Edition (July 2000), National Centre for Classification in Health, Sydney

Source organisation: National Health Data Committee, National Centre for Classification in Health and National Data Standard for Injury Surveillance Advisory Group

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Admitted patient mental health care	from 1/07/2000 to
Community mental health care	from 1/07/2000 to
Admitted patient palliative care	from 1/07/2000 to

Principal drug of concern

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000443 Version number: 1

Data element type: DATA ELEMENT

Definition: The drug that has led a person to seek treatment from the service, as stated by the client.

Context: Alcohol and other drug treatment services: Required as an indicator of the client's treatment needs.

Relational and representational attributes

Datatype: Numeric Field size: Min. 4 Max. 4 Layout: NNNN

Data domain: Australian standard classification of illicit drugs and other substances of concern

Guide for use: A principal drug of concern may be indicated on a client's referral, however the criterion for nominating the principal drug of concern is the identification by the client of the drug.

Collection methods: To be collected on commencement of treatment with a service.

Related data: relates to Method of use for principal drug of concern, version 1

relates to Other drugs of concern, version 1

Administrative attributes

Source organisation: Intergovernmental Committee on Drugs NMDS-WG

National minimum data sets:

Alcohol and other drug treatment services from 01/07/2000 to

Specialised nursing requirements—at residential aged care admission

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000153 Version number: 1

Data element type: DATA ELEMENT

Definition: The additional nursing and personal care attention required at the time of admission to a residential aged care service as a result of the resident needing specialised nursing procedures, such as colostomy/catheter care, unstable diabetes management. This is not intended to include time spent in relation to routine nursing procedures.

Context: Residential aged care service statistics: along with functional profile, continence and behaviour, specialised nursing procedures constitute one of the key indicators of dependency and disability for residential aged care service residents and serve to supplement the Resident Classification Instrument dependency level. The data item has been based on the Resident Classification Instrument rather than the NH5 because the NH5 only provides the status at or before admission and does not provide current status.

Relational and representational attributes

Datatype: Alphabetic Field size: Min. 1 Max. 1 Layout: A

Data domain:

A	No specialised nursing procedures
B	Less than 0.5 hours of attention per day
C	From 0.5 to 1.5 hours of attention per day
D	More than 1 hour of attention per day

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Administrative attributes

Source organisation: National minimum data set working parties

Specialised nursing requirements—current status

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000154 Version number: 1

Data element type: DATA ELEMENT

Definition: A residential aged care service resident's current requirement for additional nursing and personal care attention as a result of the resident needing specialised nursing procedures, such as colostomy/catheter care, unstable diabetes management. This is not intended to include time spent in relation to routine nursing procedures.

Context: Residential aged care service statistics: along with functional profile, continence and behaviour, specialised nursing procedures constitute one of the key indicators of dependency and disability for residential aged care service residents and serve to supplement the Resident Classification Instrument dependency level. The data item has been based on the Resident Classification Instrument rather than the NH5 because the NH5 only provides the status at or before admission and does not provide current status.

Relational and representational attributes

Datatype: Alphabetic Field size: Min. 1 Max. 1 Layout: A

Data domain:

A	No specialised nursing procedures
B	Less than 0.5 hours of attention per day
C	From 0.5 to 1.5 hours of attention per day
D	More than 1 hour of attention per day

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Administrative attributes

Source organisation: National minimum data set working parties

Status of the baby

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000159 Version number: 1

Data element type: DATA ELEMENT

Definition: Status of the baby at birth.

Context: Perinatal: essential to analyse outcome of pregnancy.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Live birth

2 Stillbirth (foetal death)

9 Not stated

Guide for use: Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered liveborn (WHO, 1992 definition).

Stillbirth is a foetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more birthweight; the death is indicated by the fact that after such separation the foetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. (This is the same as the WHO definition of foetal death, except that there are no limits of gestational age or birthweight for the WHO definition.)

Related data: relates to concept Live birth, version 1

relates to concept Stillbirth (foetal death), version 1

used in conjunction with Resuscitation of baby, version 2

is qualified by Apgar score at 1 minute, version 1

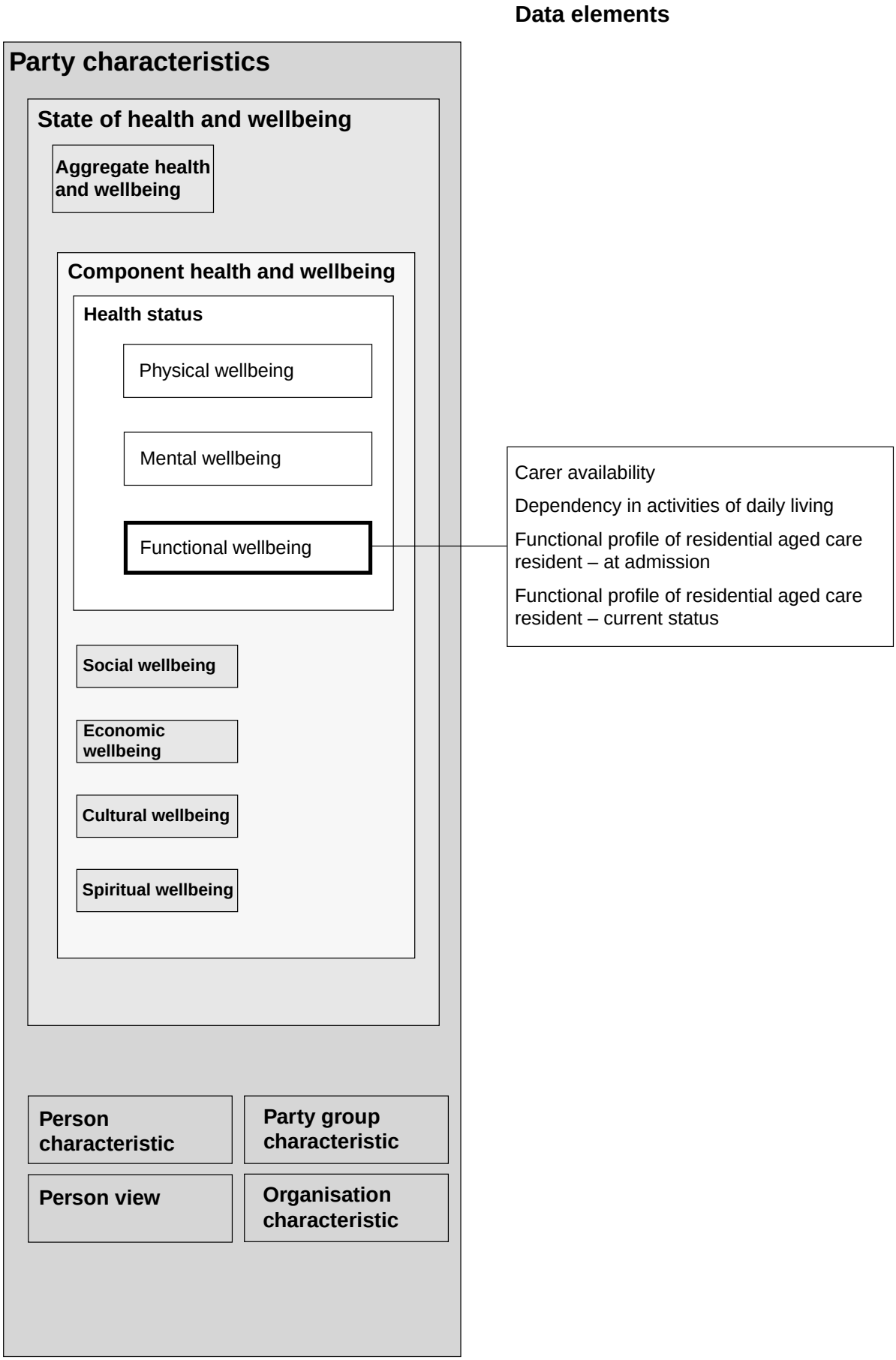
Administrative attributes

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/1997 to

National Health Information Model entity



Carer availability

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000022 Version number: 2

Data element type: DATA ELEMENT

Definition: A record of whether a person has been identified, such as a family member, friend or neighbour as providing regular on-going care, or assistance which is not linked to a formal service.

Context: The availability of informal care at home is often a determinant of a person's ability to remain in home care, especially if they are highly dependent. It is also an indicator of risk if a vulnerable person lives alone, or has no carer. As the focus of care increasingly moves to the community, it is important to monitor the degree of need, the amount of formal care given, and the presence of a carer. This helps to establish how much of the overall burden is being absorbed by the 'informal' caring system.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain:

01	Person independent
02	No carer available
03	Has a co-resident carer
04	Has a non-resident carer
05	Lives in a mutually dependent situation
06	Not applicable person in residential care
07	Not stated/inadequately described

Guide for use: This includes people who receive payment such as a special benefit or pension.

This excludes formal services such as delivered meals or home help, persons arranged by formal services such as volunteers, and funded group housing or similar situations. Availability infers carer willingness and ability to undertake the caring role and can apply when there are several carers. Where a potential carer is not prepared to undertake the role, or when their capacity to carry out necessary tasks is minimal, then the person must be coded as not having 'No carer available'.

Where there are several carers, a decision should be taken as to which of these is the main or primary carer and code accordingly. The following descriptions may assist in the selection of the most appropriate data.

1. PERSON INDEPENDENT indicates that the person has no need for assistance from informal carers.
2. NO CARER AVAILABLE means that the person needs a carer but has no one able to provide informal care.
3. HAS A CO-RESIDENT CARER (excludes Code 5) means that the person has a carer who is living in the same household.
4. HAS A NON-RESIDENT CARER means that the person has a carer who is living in a different household.

Guide for use (continued):

5. LIVES IN A MUTUALLY DEPENDENT SITUATION (excludes Code 3) refers to those households where the service recipient and another person are mutually dependent. The critical aspect of such households is that if either member becomes unavailable for any reason, the other is either at high risk or unable to remain at home.

6. NOT APPLICABLE PERSON IN RESIDENTIAL CARE—services are provided by a formal agency in a supported accommodation or other care facility.

99. NOT STATED/INSUFFICIENTLY DESCRIBED means that there is insufficient information to determine carer availability.

Collection methods: Carer availability is to be collected at admission and again at discharge. The discharge information refers to the status immediately prior to the discharge, and not the need of the service recipient after the event.

Related data: supersedes previous data element Carer availability, version 1

Administrative attributes

Source organisation: Australian Council of Community Nursing Services

Comments: The original item 'Carer Availability' in Version 1.0 of the CNMDSA has been split into two items 'Carer Availability' and 'Living Arrangement'. Users of the CNMDSA found the original item difficult to apply as it was seeking to do two things: describe the carer availability and the person's living arrangements within one item. The new item 'Living Arrangement' is introduced to clarify meaning and describe each item more clearly.

The reason for collection at both admission and discharge is that over a care episode, a change in carer status may occur either because the caring load increases, and/or, the carer's ability or willingness to undertake the role ceases or is diminished. This may necessitate discharge of the person from care, and has implications for health service utilisation. The coding options are therefore identical to enable comparison of the admission and discharge states. The discharge information refers to the person's state when care was being delivered, not after their discharge from care.

Dependency in activities of daily living

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000309 Version number: 2

Data element type: DATA ELEMENT

Definition: An indicator of a person's ability to carry out activities of daily living without assistance.

Context: Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored.

It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.

The following is an example of the minimum items, which are indicative of dependency.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 3 Layout: NNN

Data domain: Select the appropriate code from the options provided for each of the above dependency items.

a) Mobility* 1 2 3 4

b) Toileting 1 2 3 4

c) Transferring 1 2 3 4 5

d) Bathing 1 2 3 4

e) Dressing 1 2 3 4

f) Eating 1 2 3 4 5

g) Bed mobility 1 2 3 4 5

h) Bladder continence 1 2 3 4 5 6

i) Bowel continence 1 2 3 4 5

j) Extra surveillance* 1 2 3 4 5 6 7

k) Technical care** not required, or time in minutes

Guide for use: Services may elect to adopt the measures as defined in this item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc. Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

All items must be completed.

Guide for use (continued):

Select the appropriate code from the options provided for activities a) to g) when:

1 = Independent

2 = Requires observation or rare physical assistance

3 = Cannot perform the activity without some assistance

4 = Full assistance required (totally dependent); for bed mobility—a hoist is used

5 = For transferring—person is bedfast; for eating—tube-fed only; for bed mobility—2 persons physical assist is required

* applies to walking, walking aid or wheelchair

Select the appropriate code for h) Bladder continence when:

1 = Continent of urine (includes independence in use of device)

2 = Incontinent less than daily

3 = Incontinent once per 24 hour period

4 = Incontinent 2–6 times per 24 hour period

5 = Incontinent more than 6 times per 24 hour period

6 = Incontinent more than once at night only

Select the appropriate code for i) Bowel continence when:

1 = Continent of faeces (includes independence in use of device)

2 = Incontinent less than daily

3 = Incontinent once per 24 hour period

4 = Incontinent regularly, more than once per 24 hour period

5 = Incontinent more than once at night only

Select the appropriate code for j) Extra surveillance* when:

1 = No additional attention required

2 = Less than 30 minutes individual attention per day

3 = More than 30 and more than or equal to 90 minutes individual attention per day

4 = Requires at least two hours intervention per week on an episodic basis

5 = More than 90 minutes but less than almost constant individual attention

6 = Requires almost constant individual attention

7 = Cannot be left alone at all

* Extra surveillance refers to behaviour, which requires individual attention and/or planned intervention. Some examples of extra surveillance are:

- aggressiveness;
- wandering;
- impaired memory or attention;
- disinhibition and other cognitive impairment.

Guide for use (continued): *Select the appropriate code for* k) Technical care** not required, or time in minutes, when:

1 = No technical care requirements or

____ = Daytime technical (minutes per week)

____ = Evening technical (minutes per week)

____ = Night-time technical (minutes per week)

____ = Infrequent technical (minutes per month)

** Technical care refers to technical tasks and procedures for which nurses receive specific education and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. In the community nursing setting, carers may undertake some of these activities within, and under surveillance, of a nursing care-plan. Some examples of technical care activities are:

- medication administration (including injections);
- dressings and other procedures;
- venipuncture;
- monitoring of dialysis;
- implementation of pain management technology.

Collection methods: Commencement of Care episode. (There may be several visits in which assessment data are gathered.)

Related data: supersedes previous data element Client dependency, version 1

Administrative attributes

Source organisation: Australian Council of Community Nursing Services

Comments: There are a significant number of dependency instruments in use in the community and institutional care. The CNMDSA recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The data domain specified in this item consists of a number of standard elements, which can be used to map to and/or score from the majority of them.

Functional profile of residential aged care resident—at admission

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000057 Version number: 1

Data element type: DATA ELEMENT

Definition: A measure of the extent to which a person requires assistance in relation to a range of normal activities at the time of admission to a residential aged care service.

Context: Residential aged care service statistics: along with continence, behaviour and specialised nursing procedures, functional profile constitutes one of the key indicators of dependency and disability for residential aged care service residents and serves to supplement the Resident Classification Instrument level of dependency.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 2 Max. 2 Layout: AN

Data domain: Code comprising alphabetic (A–D) and numeric value (1–5)

1	Transferring to/from bed/chair/walking aid
2	Mobility
3	Bath/shower
4	Dressing/undressing (including fitting of artificial limbs and appliances)
5	Eating (fluids and solid food)
A	Requires no assistance
B	Requires observation/encouragement but no hands-on assistance
C	Requires some hands-on assistance
D	Requires full assistance

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Administrative attributes

Source organisation: National minimum data set working parties

Functional profile of residential aged care resident—current status

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000058 Version number: 1

Data element type: DATA ELEMENT

Definition: A measure of the extent to which a residential aged care service resident requires assistance in relation to a range of normal activities.

Context: Residential aged care service statistics: along with continence, behaviour and specialised nursing procedures, functional profile constitutes one of the key indicators of dependency and disability for residential aged care service residents and serves to supplement the Resident Classification Instrument level of dependency.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 2 Max. 2 Layout: AN

Data domain: Code comprising alphabetic (A–D) and numeric value (1–5)

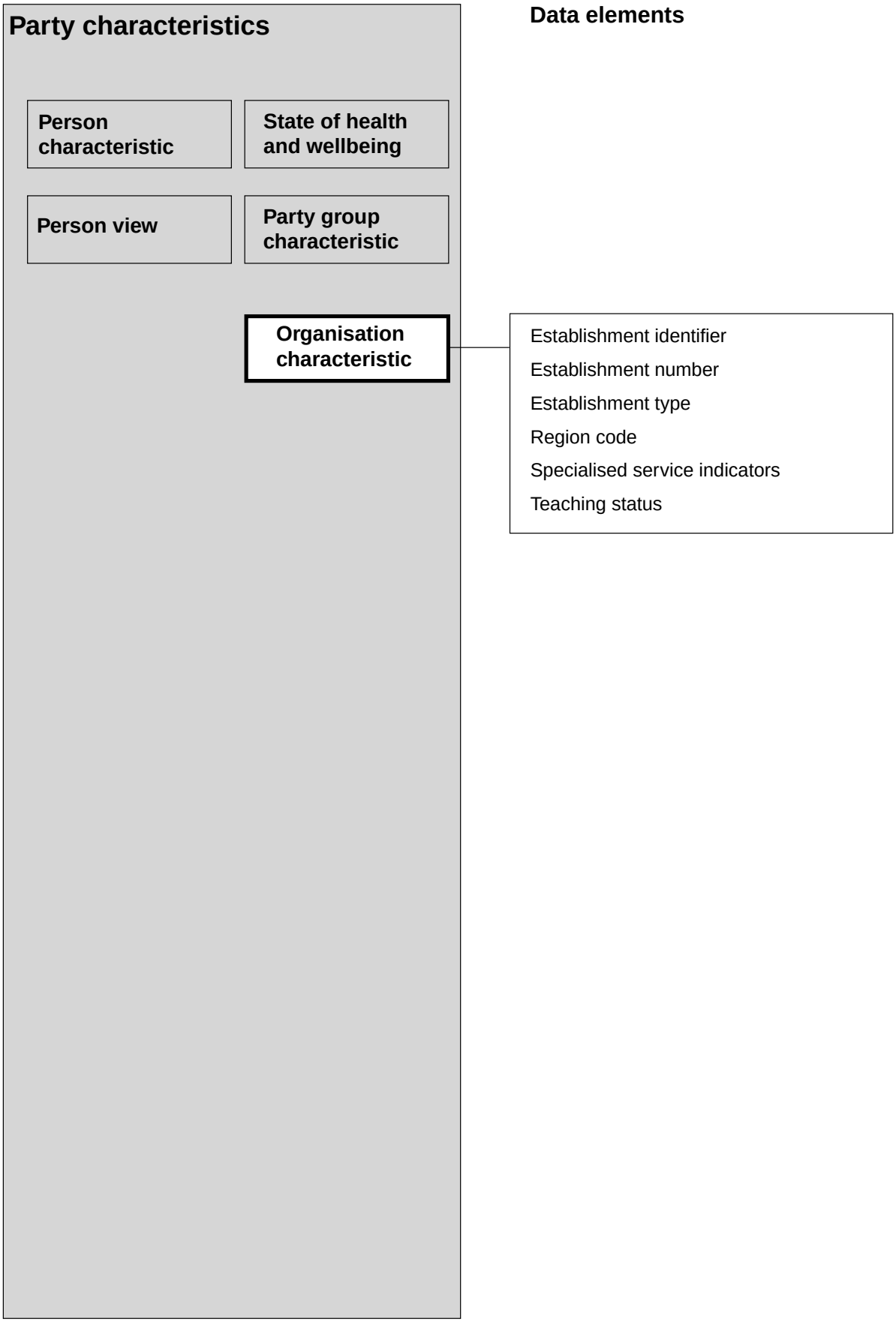
1	Transferring to/from bed/chair/walking aid
2	Mobility
3	Bath/shower
4	Dressing/undressing (including fitting of artificial limbs and appliances)
5	Eating (fluids and solid food)
A	Requires no assistance
B	Requires observation/encouragement but no hands-on assistance
C	Requires some hands-on assistance
D	Requires full assistance

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Administrative attributes

Source organisation: National minimum data set working parties

National Health Information Model entity



Establishment identifier

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000050 Version number: 3

Data element type: COMPOSITE ELEMENT

Definition: Identifier for the establishment in which episode or event occurred. Each separately administered health care establishment to have a unique identifier at the national level.

Context: Admitted patient care:
Admitted patient palliative care:
Admitted patient mental health care:
Alcohol and other drug treatment services:
Community mental health care:
Community mental health establishments:
Perinatal:
Public hospital establishments:

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 8 Max. 8 Layout: NNANNNNN

Data domain: Concatenation of:
N—State identifier
N—Establishment sector
A—Region code
NNNNN—Establishment number

Guide for use: If data is supplied on computer media, this item is only required once in the header information. If information is supplied manually, this item should be provided on each form submitted.

Related data: is composed of State identifier, version 2
is composed of Establishment sector, version 3
is composed of Region code, version 2
is composed of Establishment number, version 3
supersedes previous data element Establishment identifier, version 2

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments	from 1/07/1997 to
Admitted patient care	from 1/07/1997 to
Admitted patient mental health care	from 1/07/1997 to
Perinatal	from 1/07/1997 to
Community mental health care	from 1/07/1998 to
Community mental health establishments	from 1/07/1998 to
Admitted patient palliative care	from 1/07/2000 to
Alcohol and other drug treatment services	from 1/07/2000 to

Comments: A residential establishment is considered to be separately administered if managed as an independent institution for which there are financial, budgetary and activity statistics. For example, if establishment-level data for components of an area health service are not available separately at a central authority, this is not grounds for treating such components as a single establishment unless such data are not available at any level in the health care system.

This item is now being used to identify hospital contracted care. The use of this item will lead to reduced duplication in reporting patient activity and will enable linkage of services to one episode of care.

Establishment number

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000377 Version number: 3

Data element type: DATA ELEMENT

Definition: An identifier for establishment, unique within the State or Territory.

Context: Admitted patient care:
Admitted patient palliative care:
Admitted patient mental health care:
Alcohol and other drug treatment services:
Emergency department waiting times:
Perinatal:
Public hospital establishments:

Relational and representational attributes

Datatype: Numeric Field size: Min. 5 Max. 5 Layout: NNNNN

Data domain: Valid establishment number

Related data: is a composite part of Establishment identifier, version 3
supersedes Establishment number, version 2

Administrative attributes

National minimum data sets:

Public hospital establishments	from 1/07/1989 to
Admitted patient care	from 1/07/1989 to
Admitted patient mental health care	from 1/07/1997 to
Admitted patient mental health care	from 1/07/1997 to
Perinatal	from 1/07/1997 to
Emergency Department waiting times	from 1/07/1999 to
Elective surgery waiting times	from 1/07/2001 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Establishment type

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000327 Version number: 1

Data element type: DATA ELEMENT

Definition: Type of establishment (defined in terms of legislative approval, service provided and patients treated) for each separately administered establishment.

Residential establishments are considered to be separately administered if managed as an independent unit in terms of financial, budgetary and activity statistics. The situation where establishment-level data, say for components of an area health service, were not available separately at a central authority was not grounds for treating such a group of establishments as a single establishment unless such data were not available at any level in the health care system.

Non-residential health services are classified in terms of separately administered organisations rather than in terms of the number of sites at which care is delivered. Thus, domiciliary nursing services would be counted in terms of the number of administered entities employing nursing staff rather than in terms of the number of clinic locations used by the staff.

Establishments can cater for a number of activities and in some cases separate staff and financial details are not available for each activity. In the cases it is necessary to classify the establishment according to its predominant residential activity (measured by costs) and to allocate all the staff and finances to that activity. Where non-residential services only are provided at one establishment, that establishment is classified according to the predominant non-residential activity (in terms of costs).

Context: Health services: type of establishment is required in order to aggregate establishment-level data into meaningful summary categories (for example, public hospitals, residential aged care services) for reporting and analysis.

Relational and representational attributes

Datatype: AlphaNumeric Field size: Min. 2 Max. 6 Layout: AN.N.N

Data domain:

N7.1	Public day centre/hospital
N7.2	Public freestanding day surgery centre
N7.3	Private day centre/hospital
N7.4	Private freestanding day surgery centre
N8.1.1	Public community health centre
N8.1.2	Private (non-profit) community health centre
N8.2.1	Public domiciliary nursing service
N8.2.2	Private (non-profit) domiciliary nursing service
N8.2.3	Private (profit) domiciliary nursing service
R1.1	Public acute care hospital
R1.2	Private acute care hospital
R1.3.1	Veterans Affairs hospital
R1.3.2	Defence force hospital
R1.3.3	Other Commonwealth hospital

Data domain (continued):

R2.1	Public psychiatric hospital
R2.2	Private psychiatric hospital
R3.1	Private charitable residential aged care service
R3.2	Private profit residential aged care service
R3.3	Government residential aged care service
R3.4	Private charitable nursing home for young disabled
R3.5	Private profit nursing home for young disabled
R3.6	Government nursing home for young disabled
R4.1	Public alcohol and drug treatment centre
R4.2	Private alcohol and drug treatment centre
R5.1	Charitable hostels for the aged
R5.2	State government hostel for the aged
R5.3	Local government hostel for the aged
R5.4	Other charitable hostel
R5.5	Other state government hostel
R5.6	Other local government hostel
R6.1	Public hospice
R6.2	Private hospice

Guide for use:

Establishments are classified into 10 major types subdivided into major groups:

- residential establishments (R)
- non-residential establishments (N)

R1 Acute care hospitals

Establishments which provide at least minimal medical, surgical or obstetric services for in-patient treatment and/or care, and which provide round-the-clock comprehensive qualified nursing service as well as other necessary professional services. They must be licensed by the State health department, or controlled by government departments. Most of the patients have acute conditions or temporary ailments and the average stay per admission is relatively short.

Hospitals specialising in dental, ophthalmic aids and other specialised medical or surgical care are included in this category. Hospices (establishments providing palliative care to terminally ill patients) that are freestanding and do not provide any other form of acute care are classified to R6.

R2 Psychiatric hospitals

Establishments devoted primarily to the treatment and care of in-patients with psychiatric, mental, or behavioural disorders. Private hospitals formerly approved by the Commonwealth Department of Health under the *Health Insurance Act 1973* (Cwlth) (now licensed/approved by each State health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Centres for the non-acute treatment of drug dependence, developmental and intellectual disability are not included here (see below). This code also excludes institutions mainly providing living quarters or day care.

R3 Residential aged care services

Establishments which provide long-term care involving regular basic nursing care to chronically ill, frail, disabled or convalescent persons or senile in-patients. They must be approved by the Commonwealth Department of Health and Family Services and/or licensed by the State, or controlled by government departments.

Private profit residential aged care services are operated by private profit making individuals or bodies.

Guide for use (continued):

Private charitable residential aged care services are participating residential aged care services operated by religious and charitable organisations.

Government residential aged care services are residential aged care services either operated by or on behalf of a State or Territory government.

R4 Alcohol and drug treatment centres

Freestanding centres for the treatment of drug dependence on an in-patient basis.

R5 Hostels and residential services

Establishments run by public authorities or registered non-profit organisation to provide board, lodging or accommodation for the aged, distressed or disabled who cannot live independently but do not need nursing care in a hospital or residential aged care service. Only hostels subsidised by the Commonwealth are included.

Separate dwellings are not included, even if subject to an individual rental rebate arrangement. Residents are generally responsible for their own provisions, but may be provided in some establishments with domestic assistance (meals, laundry, personal care). Night shelters providing only casual accommodation are excluded.

R6 Hospices

Establishments providing palliative care to terminally ill patients. Only freestanding hospices which do not provide any other form of acute care are included in this category.

N7 Same-day establishments

Includes both the traditional day centre/hospital and also freestanding day surgery centres.

Day centres/hospitals are establishments providing a course of acute treatment on a full-day or part-day non-residential attendance basis at specified intervals over a period of time. Sheltered workshops providing occupational or industrial training are excluded.

Freestanding day surgery centres are hospital facilities providing investigation and treatment for acute conditions on a day-only basis and are approved by the Commonwealth for the purposes of basic table health insurance benefits.

N8 Non-residential health services

Services administered by public authorities or registered non-profit organisations which employ full-time equivalent medical or paramedical staff (nurses, nursing aides, physiotherapists, occupational therapists and psychologists, but not trade instructors or teachers). This definition distinguishes health services from welfare services (not within the scope of the National Minimum Data Project) and thereby excludes such services as sheltered workshops, special schools for the intellectually disabled, meals on wheels and baby clinics offering advisory services but no actual treatment. Non-residential health services should be enumerated in terms of services or organisations rather than in terms of the number of sites at which care is delivered.

Non-residential health services provided by a residential establishment (for example, domiciliary nursing service which is part of a public hospital) should not be separately enumerated.

N8.1 Community health centres

Public or registered non-profit establishments in which a range of non-residential health services is provided in an integrated and coordinated manner, or which provides for the coordination of health services elsewhere in the community.

Guide for use (continued):

N8.2 Domiciliary nursing service

Public or registered non-profit or profit making establishments providing nursing or other professional paramedical care or treatment to patients in their own homes or in (non-health) residential institutions. Establishments providing domestic or housekeeping assistance are excluded by the general definition above.

Note that national minimum data sets currently include only community health centres and domiciliary nursing services.

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments	from 1/07/2000 to
Admitted patient care	from 1/07/2000 to
Alcohol and other drug treatment services	from 1/07/2000 to

Comments:

In the current data element, the term establishment is used in a very broad sense to mean bases, whether institutions, organisations or the community from which health services are provided. Thus, the term covers conventional health establishments and also organisations which may provide services in the community.

This data element is currently under review by the Organisational Units Working Group of the National Health Data Committee. Recommendations will provide a comprehensive coverage of the health service delivery sector.

Region code

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000378 Version number: 2

Data element type: DATA ELEMENT

Definition: An identifier for location of health services in an area.

Context: Admitted patient care:
Admitted patient palliative care:
Admitted patient mental health care:
Alcohol and other drug treatment services:
Perinatal:
Public hospital establishments:

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 1 Max. 2 Layout: A

Data domain: Valid region code

Guide for use: Domain values are specified by individual States/Territories

Related data: is a composite part of Establishment identifier, version 3

Administrative attributes

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Admitted patient mental health care	from 1/07/2000 to
Elective surgery waiting times	from 1/07/2001 to
Perinatal	from 1/07/1997 to
Public hospital establishments	from 1/07/2000 to

Specialised service indicators

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000321 Version number: 1

Data element type: DATA ELEMENT

Definition: Specialised services provided in establishments.

Context: Health services: essential to provide a broad picture of the availability of these key specialised services by State and region and to assist with planning if services are over supplied in one region relative to another.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 1 Max. 5 Layout: AN.NN

Data domain:

1 Yes

2 No

Guide for use: Each of the following specialised services should be coded separately.

E4.1 Obstetric/maternity service

A specialised facility dedicated to the care of obstetric/maternity patients.

E4.2 Specialist paediatric service

A specialised facility dedicated to the care of children aged 14 or less.

E4.3 Psychiatric unit/ward

A specialised unit/ward dedicated to the treatment and care of admitted patients with psychiatric, mental, or behavioural disorders.

E4.4. Intensive care unit (level III)

A specialised facility dedicated to the care of paediatric and adult patients requiring intensive care and sophisticated technological support services.

E4.5 Hospice care unit

A facility dedicated to the provision of palliative care to terminally ill patients.

E4.6 Residential aged care service care unit

A facility dedicated to the provision of nursing home care.

E4.7 Geriatric assessment unit

Facilities dedicated to the Commonwealth-approved assessment of the level of dependency of (usually) aged individuals either for purposes of initial admission to a long-stay institution or for purposes of reassessment of dependency levels of existing long-stay institution residents.

E4.8 Domiciliary care service

A facility/service dedicated to the provision of nursing or other professional paramedical care or treatment and non-qualified domestic assistance to patients in their own homes or in residential institutions not part of the establishment.

E4.9 Alcohol and drug unit

A facility/service dedicated to the treatment of alcohol and drug dependence.

Guide for use (continued):

E4.10 Acute spinal cord injury unit (SS)

A specialised facility dedicated to the initial treatment and subsequent ongoing management and rehabilitation of patients with acute spinal cord injury, largely conforming to Australian Health Minister's Advisory Council guidelines for service provision.

E4.11 Coronary care unit

A specialised facility dedicated to acute care services for patients with cardiac diseases.

E4.12 Cardiac surgery unit (SS)

A specialised facility dedicated to operative and peri-operative care of patients with cardiac disease.

E4.13 Acute renal dialysis unit (SS)

A specialised facility dedicated to dialysis of renal failure patients requiring acute care.

E4.14 Maintenance renal dialysis centre (SS)

A specialised facility dedicated to maintenance dialysis of renal failure patients. It may be a separate facility (possibly located on hospital grounds) or known as a satellite centre or a hospital-based facility but is not a facility solely providing training services.

E4.15 Burns unit (level III) (SS)

A specialised facility dedicated to the initial treatment and subsequent rehabilitation of the severely injured burns patient (usually >10 per cent of patients body surface affected).

E4.16 Major plastic/reconstructive surgery unit (SS)

A specialised facility dedicated to general purpose plastic and specialised reconstructive surgery, including maxillofacial, microsurgery and hand surgery.

E4.17 Oncology (cancer treatment) unit (SS)

A specialised facility dedicated to multidisciplinary investigation, management, rehabilitation and support services for cancer patients. Treatment services include surgery, chemotherapy and radiation.

E4.18 Neonatal intensive care unit (level III) (SS)

A specialised facility dedicated to the care of neonates requiring care and sophisticated technological support. Patients usually require intensive cardiorespiratory monitoring, sustained assistance ventilation, long-term oxygen administration and parenteral nutrition.

E4.19 In-vitro fertilisation unit

A specialised facility dedicated to the investigation of infertility provision of in-vitro fertilisation services.

E4.20 Comprehensive epilepsy centre (SS)

A specialised facility dedicated to seizure characterisation, evaluation of therapeutic regimes, pre-surgical evaluation and epilepsy surgery for patients with refractory epilepsy.

E4.21 Transplantation unit

A specialised facility dedicated to organ retrieval, transplantation and ongoing care of the transplant recipient.

- bone marrow
- liver
- renal
- pancreas
- heart, including heart-lung

Guide for use (continued):

E4.22 Clinical genetics unit (SS)

A specialised facility dedicated to diagnostic and counselling services for clients who are affected by, at risk of or anxious about genetic disorders.

E4.23 Sleep centre

A specialised facility linked to a sleep laboratory dedicated to the investigation and management of sleep disorders.

E4.24 Neuro surgical unit

A specialised facility dedicated to the surgical treatment of neurological conditions.

E4.25 Infectious diseases unit

A specialised facility dedicated to the treatment of infectious diseases.

E4.26 AIDS unit

A specialised facility dedicated to the treatment of AIDS patients.

E4.27 Diabetes unit

A specialised facility dedicated to the treatment of diabetics.

E4.28 Rehabilitation unit

Dedicated units within recognised hospitals which provide post-acute rehabilitation and are designed as such by the State health authorities (see data element 'Care type').

Related data: relates to Establishment type, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments — from 1/07/2000 to

Teaching status

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000322 Version number: 1

Data element type: DATA ELEMENT

Definition: An indicator (yes/no) to identify the non-direct patient care activity of teaching for a particular establishment. This is where teaching (associated with a university) is a major program activity of the establishment. It is primarily intended to relate to teaching hospitals affiliated with universities providing undergraduate medical education as advised by the relevant State health authority.

Context: Health services: the non-direct care activity of teaching can involve the consumption of considerable resources. In comparisons of cost in relation to establishment output, it is important to be aware of particular establishments which are devoting substantial resources to activities not relating to output as measured in terms of either in-patient bed days or outpatient occasions of service. Teaching can be one of the variables in any regression analysis undertaken.

In this context, teaching relates to teaching hospitals affiliated with universities providing undergraduate medical education as advised by the relevant State health authority.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Yes
2	No
9	Unknown

Related data: relates to Establishment type, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments from 1/07/2000 to

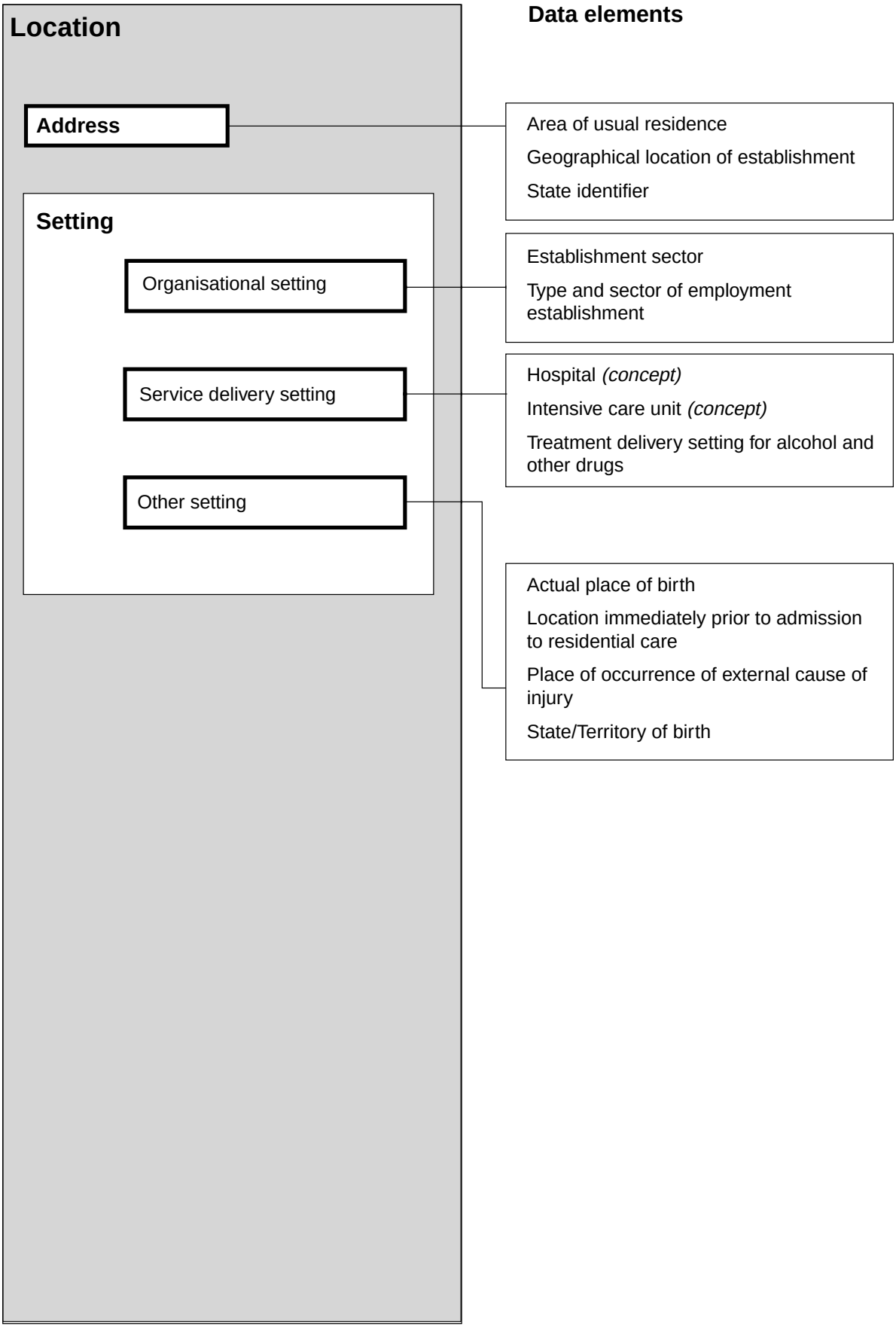
Comments:

The initial intention based on the Taskforce on National Hospital Statistics approach had been to have non-direct care activity indicators for all of the following non-direct patient care activities:

- teaching,
- research,
- group or community contacts,
- public health activities,
- mobile centre and/or part-time service.

However, the Resources Working Party decided to delete 2, 3, 4 and 5 and place the emphasis on teaching where teaching (associated with a university) was a major program activity of the hospital. The working party took the view that it was extremely difficult to identify research activities in health institutions because many staff consider that they do research as part of their usual duties. The research indicator was thus deleted and the teaching indicator was agreed to relate to teaching hospitals affiliated with universities providing undergraduate medical education, as advised by the relevant State health authority. If a teaching hospital is identified by a yes/no indicator then it is not necessary to worry about research (based on the assumption that if you have teaching, you have research).

National Health Information Model entity



Area of usual residence

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000016 Version number: 3

Data element type: DATA ELEMENT

Definition: Geographical location of usual residence of the person.

Context: Geographical location is reported using Statistical Local Area to enable accurate aggregation of information to larger areas within the Australian Standard Geographical Classification (such as Statistical Subdivisions and Statistical Divisions) as well as detailed analysis at the Statistical Local Area level. The use of Statistical Local Areas also allows analysis relating the data to information compiled by the Australian Bureau of Statistics on the demographic and other characteristics of the population of each Statistical Local Area

Analyses facilitated by the inclusion of Statistical Local Area information include:

- comparison of the use of services by persons residing in different geographical areas,
- characterisation of catchment areas and populations for establishments for planning purposes, and
- documentation of the provision of services to residents of States or Territories other than the State or Territory of the provider.

Relational and representational attributes

Datatype: Numeric Field size: Min. 5 Max. 5 Layout: NNNNN

Data domain: The geographical location is reported using a five digit numerical code. The first digit is the single-digit code to indicate State or Territory. The remaining four digits are the numerical code for the Statistical Local Area (SLA) within the State or Territory.

The single digit codes for the States and Territories and the four digit codes for the SLAs are as defined in the Australian Standard Geographical Classification (Australian Bureau of Statistics, catalogue number 1216.0).

Guide for use: The Australian Standard Geographical Classification (ASGC) is updated on an annual basis with a date of effect of 1 July each year. Therefore, the edition effective for the data collection reference year should be used.

The codes for Statistical Local Areas are unique within each State and Territory, but not within the whole country. Thus, to define a unique location, the code of the State or Territory is required in addition to the code for the Statistical Local Area.

The Australian Bureau of Statistics' National Localities Index (NLI) (ABS Catalogue number 1252.0) can be used to assign each locality or address in Australia to a Statistical Local Area.

The NLI is a comprehensive list of localities in Australia with their full code (including State or Territory and Statistical Local Area) from the main structure of the ASGC.

Guide for use (continued): For the majority of localities, the locality name (suburb or town, for example) is sufficient to assign a Statistical Local Area. However, some localities have the same name. For most of these, limited additional information such as the postcode or State can be used with the locality name to assign the Statistical Local Area. In addition, other localities cross one or more Statistical Local Area boundaries and are referred to as split localities. For these, the more detailed information of the number and street of the person's residence is used with the Streets Sub-index of the NLI to assign the Statistical Local Area.

If the information available on the person's address indicates that it is in a split locality but is insufficient to assign an Statistical Local Area, the code for the Statistical Local Area which includes most of the split locality should be reported. This is in accordance with the NLI assignment of Statistical Local Areas when a split locality is identified and further detail about the address is not available.

The NLI does not assign a Statistical Local Area code if the information about the address is insufficient to identify a locality, or is not an Australian locality. In these cases, the appropriate codes for undefined Statistical Local Area within Australia (State or Territory unstated), undefined Statistical Local Area within a stated State or Territory, no fixed place of abode (within Australia or within a stated State or Territory) or overseas should be used.

Related data: supersedes previous data element Area of usual residence, version 2

Administrative attributes

Source document: Australian Standard Geographical Classification (ASGC)

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Admitted patient mental health care	from 1/07/2000 to
Admitted patient palliative care	from 1/07/2000 to
Community mental health care	from 1/07/2001 to

Geographical location of establishment

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000260 Version number: 2

Data element type: DATA ELEMENT

Definition: Geographical location of the establishment. For establishments with more than one geographical location, the location is defined as that of the main administrative centre.

Context: Health services: To enable the analysis of service provision in relation to demographic and other characteristics of the population of a geographic area.

Relational and representational attributes

Datatype: Numeric Field size: Min. 5 Max. 5 Layout: NNNNN

Data domain: The geographical location is reported using a five digit numerical code to indicate the Statistical Local Area (SLA) within the reporting State or Territory, as defined in the Australian Standard Geographical Classification (Australian Bureau of Statistics, catalogue number 1216.0).

Guide for use: The Australian Standard Geographical Classification (ASGC) is updated on an annual basis with a date of effect of 1 July each year. Therefore, the edition effective for the data collection reference year should be used.

The Australian Bureau of Statistics' National Localities Index (NLI) can be used to assign each locality or address in Australia to an SLA. The NLI is a comprehensive list of localities in Australia with their full code (including SLA) from the main structure of the ASGC.

For the majority of localities, the locality name (suburb or town, for example) is sufficient to assign an SLA. However, some localities have the same name. For most of these, limited additional information such as the postcode or State can be used with the locality name to assign the SLA.

In addition, other localities cross one or more SLA boundaries and are referred to as split localities. For these, the more detailed information of the number and street of the establishment is used with the Streets Sub-index of the NLI to assign the SLA.

Related data: supersedes previous data element Geographic location, version 1

relates to Establishment type, version 1

Administrative attributes

Source document: Australian Standard Geographical Classification (Australian Bureau of Statistics Catalogue No. 1216.0)

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments	from 1/07/2000 to
Community mental health establishments	from 1/07/1998 to
Alcohol and other drug treatment services	from 1/07/2000 to

Comments: The geographical location does not provide direct information on the geographical catchment area or catchment population of the establishment.

State identifier

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000380 Version number: 2

Data element type: DATA ELEMENT

Definition: An identifier for State or Territory.

Context: Admitted patient care:
Admitted patient palliative care:
Admitted patient mental health care:
Alcohol and other drug treatment services:
Perinatal:
Public hospital establishments:

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	New South Wales
2	Victoria
3	Queensland
4	South Australia
5	Western Australia
6	Tasmania
7	Northern Territory
8	Australian Capital Territory
9	Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)

Related data: is a composite part of Establishment identifier, version 3

Administrative attributes

Source document: Domain values are derived from the Australian Standard Geographic Classification (Australian Bureau of Statistics, Catalogue Number 1216.0)

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments	from 1/07/2000 to
Admitted patient care	from 1/07/2000 to
Admitted patient mental health care	from 1/07/2000 to
Perinatal	from 1/07/1997 to

Establishment sector

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000379 Version number: 3

Data element type: DATA ELEMENT

Definition: A section of the health care industry.

Context: Public hospital establishments: and Admitted patient care:.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain: 1 Public
2 Private

Related data: relates to Hospital, version 1
is a composite part of Establishment identifier, version 3
supersedes Establishment sector, version 2

Administrative attributes

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Admitted patient mental health care	from 1/07/2000 to
Elective surgery waiting times	from 1/07/2001 to
Perinatal	from 1/07/1997 to
Public hospital establishments	from 1/07/2000 to

Type and sector of employment establishment

Admin. status: CURRENT 1/07/1995

Identifying and definitional attributes

Knowledgebase ID: 000166 Version number: 1

Data element type: DATA ELEMENT

Definition: For each health profession, type of employment establishment is a self reporting, condensed industry of employment classification that can be cross-referenced to the Australian and New Zealand Standard Industrial Classification.

Sector of employment establishment is government (public) or non-government (private), according to whether or not the employer is a Commonwealth, State or local government agency.

Context: Health labour force: to analyse distribution of service providers by setting (defined by industry of employer and sector), cross-classified with main type of work and/or specialty area.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain:

01	Private medical practitioner rooms/surgery (including 24-hour medical clinics)
02	Other public non-residential health care facility (e.g. Aboriginal health service, ambulatory centre, outpatient clinic, day surgery centre, medical centre, community health centre)
03	Other private non-residential health care (e.g. Aboriginal health service, ambulatory centre, outpatient clinic, day surgery centre, medical centre, community health centre)
04	Hospital—acute care* (including psychiatric or specialist hospital) hospital (public)
05	Hospital—acute care (including psychiatric or specialist hospital) hospital (private)
06	Residential health care (e.g. residential aged care service, hospice, physical disabilities residential centre) facility (public)
07	Residential health care (e.g. residential aged care service, hospice, physical disabilities residential centre) facility (private)
08	Tertiary education institution (public)
09	Tertiary education institution (private)
10	Defence forces
11	Government department or agency (e.g. laboratory, research organisation etc.)
12	Private industry/private enterprise (e.g. insurance, pathology, bank)
13	Other (specified) Public
14	Other (specified) Private
99	Unknown/ inadequately described/not stated

Guide for use: Establishments are coded into self reporting groupings in the public and private sectors. This can be seen below in the code list for medical practitioners.

Minor variations in ordering of sequence and disaggregation of the principal categories will be profession-specific as appropriate; where a more detailed set of codes is used, the essential criterion is that there should not be an overlap of the detailed codes across the Australian and New Zealand Standard Industrial Classification category definitions.

Note:

Public psychiatric hospitals are non-acute care facilities, whereas private psychiatric hospitals are acute care facilities. To minimise the possibility of respondent confusion and mis-reporting, public psychiatric hospitals are included in the grouping for acute care public hospitals.

Day surgery centres, outpatient clinics and medical centres approved as hospitals under the Health Insurance Act 1973 (Cwlth) have emerged as a new category for investigation. These will be included in a review of the National Health Labour Force Collection questions and coding frames.

Administrative attributes

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/1989 to

Hospital

Admin. status: CURRENT 1/07/1994

Identifying and definitional attributes

Knowledgebase ID: 000064 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A health care facility established under Commonwealth, State or Territory legislation as a hospital or a free-standing day procedure unit and authorised to provide treatment and/or care to patients.

Context: Admitted patient care:
Admitted patient palliative care:
Admitted patient mental health care:
Public hospital establishments:

Relational and representational attributes

Related data: relates to Establishment sector, version 3

Administrative attributes

Source organisation: National Health Data Committee

Comments: A hospital thus defined may be located at one physical site or may be a multi campus hospital. A multi campus hospital treats movements of patients between sites as ward transfers.

For the purposes of these definitions, the term hospital includes satellite units managed and staffed by the hospital.

This definition includes, but is not limited to, hospitals as recognised under Australian Health Care Agreements.

Residential aged care services as approved under the National Health Act 1953 (Cwlth) or equivalent State legislation are excluded from this definition.

This definition includes entities with multipurpose facilities (e.g. those which contain both recognised and non-recognised components).

Intensive care unit

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000078 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: An intensive care unit (ICU) is a designated ward of a hospital which is specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises the skills of medical, nursing and other staff trained and experienced in the management of these problems.

Context: Admitted patient care:

Administrative attributes

Source organisation: National Intensive Care Working Group

Comments: There are five different types and levels of ICU defined according to three main criteria: the nature of the facility, the care process and the clinical standards and staffing requirements. All levels and types of ICU must be separate and self-contained facilities in hospitals and, for clinical standards and staffing requirements, substantially conform to relevant guidelines of the Australian Council on Healthcare Standards. The five types of ICU are briefly described below:

Adult intensive care unit, level 3: must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for patients in need of intensive care services and have extensive backup laboratory and clinical service facilities to support the tertiary referral role. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an indefinite period; or care of a similar nature.

Adult intensive care unit, level 2: must be capable of providing complex, multisystem life support and be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for a period of at least several days, or for longer periods in remote areas or care of a similar nature (see ACHS guidelines)

Adult intensive care unit, level 1: must be capable of providing basic multisystem life support usually for less than a 24 hour period. It must be capable of providing mechanical ventilation and simple invasive cardiovascular monitoring for a period of at least several hours; or care of a similar nature.

Paediatric intensive care unit: must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for children needing intensive care and have extensive backup laboratory and clinical service facilities to support this tertiary role. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an indefinite period to infants and children less than 16 years of age; or care of a similar nature.

Comments (continued): Neonatal intensive care unit, level 3: must be capable of providing complex, multisystem life support for an indefinite period. It must be capable of providing mechanical ventilation and invasive cardiovascular monitoring; or care of a similar nature.

Definitions for high-dependency unit, coronary care unit are under development.

Treatment delivery setting for alcohol and other drugs

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000646 Version number: 1

Data element type: DATA ELEMENT

Definition: The setting in which the main treatment is provided.

Context: Alcohol and other drug treatment services: Required to identify the settings in which treatment is occurring, allowing for trends in treatment patterns to be monitored.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Non-residential treatment facility
2	Residential treatment facility
3	Home
4	Outreach setting
8	Other

Guide for use: Code 1 refers to any non-residential centre that provides alcohol and other drug treatment services, including hospital outpatient services and community health centres.

Code 2 refers to community-based settings in which clients reside either temporarily or long-term in a facility, that is not their home or usual place of residence, to receive alcohol and other drug treatment. This does not include ambulatory situations.

Code 3 refers to the client's own home or usual place of residence.

Code 4 refers to an outreach environment, excluding a client's home or usual place of residence, where treatment is provided. An outreach environment may be any public or private location that is not covered by codes 1–3. Mobile/outreach alcohol and other drug treatment service providers would usually provide treatment within this setting.

Verification rules: Only one code to be selected.

Related data: Related to the data element, Main treatment type for alcohol and other drugs, version 1.

Administrative attributes

Source organisation: Intergovernmental Committee on Drugs NMDS-WG

National minimum data sets:

Alcohol and other drug treatment services from 1/07/2001

Actual place of birth

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000003 Version number: 1

Data element type: DATA ELEMENT

Definition: The actual place where the birth occurred.

Context: Perinatal: used to analyse the risk factors and outcomes by place of birth. While most deliveries occur within hospitals an increasing number of births now occur in other settings. It is important to monitor the births occurring outside hospitals and to ascertain whether or not the actual place of delivery was planned.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Hospital, excluding birth centre
2	Birth centre, attached to hospital
3	Birth centre, free standing
4	Home
8	Other
9	Not stated

Guide for use: This is to be recorded for each baby the woman delivers from this pregnancy.

4 Home — should be reserved for those births that occur at the home intended

8 Other — use when birth occurs at a home other than that intended

— may also include a community health centre or be used for babies 'born before arrival'

Related data: is a qualifier of Intended place of birth, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/2000 to

Comments: The development of a definition of a birth centre is currently under consideration by the Commonwealth in conjunction with the States and Territories.

Location immediately prior to admission to residential aged care

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000084 Version number: 1

Data element type: DATA ELEMENT

Definition: Source from which the patient was transferred/referred to the hospital.

Context: Residential aged care service statistics: to assist in analyses of intersectoral patient flow and health care planning.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Home (usual residence)
2	Home of relative (but not usual residence)
3	Hostel
4	Other residence
5	Acute hospital
6	Other hospital
7	Residential aged care service (check on transfers)
8	Other location
9	Unknown

Administrative attributes

Source organisation: National Health Data Committee

Place of occurrence of external cause of injury

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000384 Version number: 5

Data element type: DATA ELEMENT

Definition: The place where the external cause of injury, poisoning or adverse effect occurred.

Context: Enables categorisation of injury and poisoning according to factors important for injury control. Necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 2 Layout: NN

Data domain:

0	Home
1	Residential institution
2	School, other institution and public administrative area
21	School
22	Health service area
23	Building used by general public or public group
3	Sports and athletics area
4	Street and highway
5	Trade and service area
6	Industrial and construction area
7	Farm
8	Other specified places
9	Unspecified place

Guide for use: Admitted patients: Use the appropriate codes as fourth and fifth characters to Y92 when using the ICD-10-AM (2nd edition). Used with all ICD-10-AM external cause codes V01–Y89 and assigned according to the Australian Coding Standards.

Non-admitted patients: to be used for injury surveillance purposes for non-admitted patients when it is not possible to use ICD-10-AM codes. Select the code which best characterises the type of place where the person was situated when the injury occurred on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list.

Verification rules: Admitted patients: to be used with ICD-10-AM (2nd edition) external cause codes V01–Y89.

Related data: supersedes previous data element Place of Occurrence of External Cause of Injury—admitted patient, version 4

supersedes previous data element Place of Occurrence of External Cause of Injury—non-admitted patient, version 3

used in conjunction with External Cause—admitted patient, version 4

used in conjunction with External Cause—non-admitted patient, version 4

Administrative attributes

Source organisation: National Health Data Committee and National Centre for Classification in Health.

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Injury surveillance	from 1/07/2000 to

State/Territory of birth

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000155 Version number: 1

Data element type: DATA ELEMENT

Definition: The State/Territory in which the birth occurred.

Context: Perinatal: to enable analyses by State/Territory of delivery.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

0	Not applicable (includes resident overseas, no fixed address)
1	New South Wales
2	Victoria
3	Queensland
4	South Australia
5	Western Australia
6	Tasmania
7	Northern Territory
8	Australian Capital Territory
9	External Australian territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)

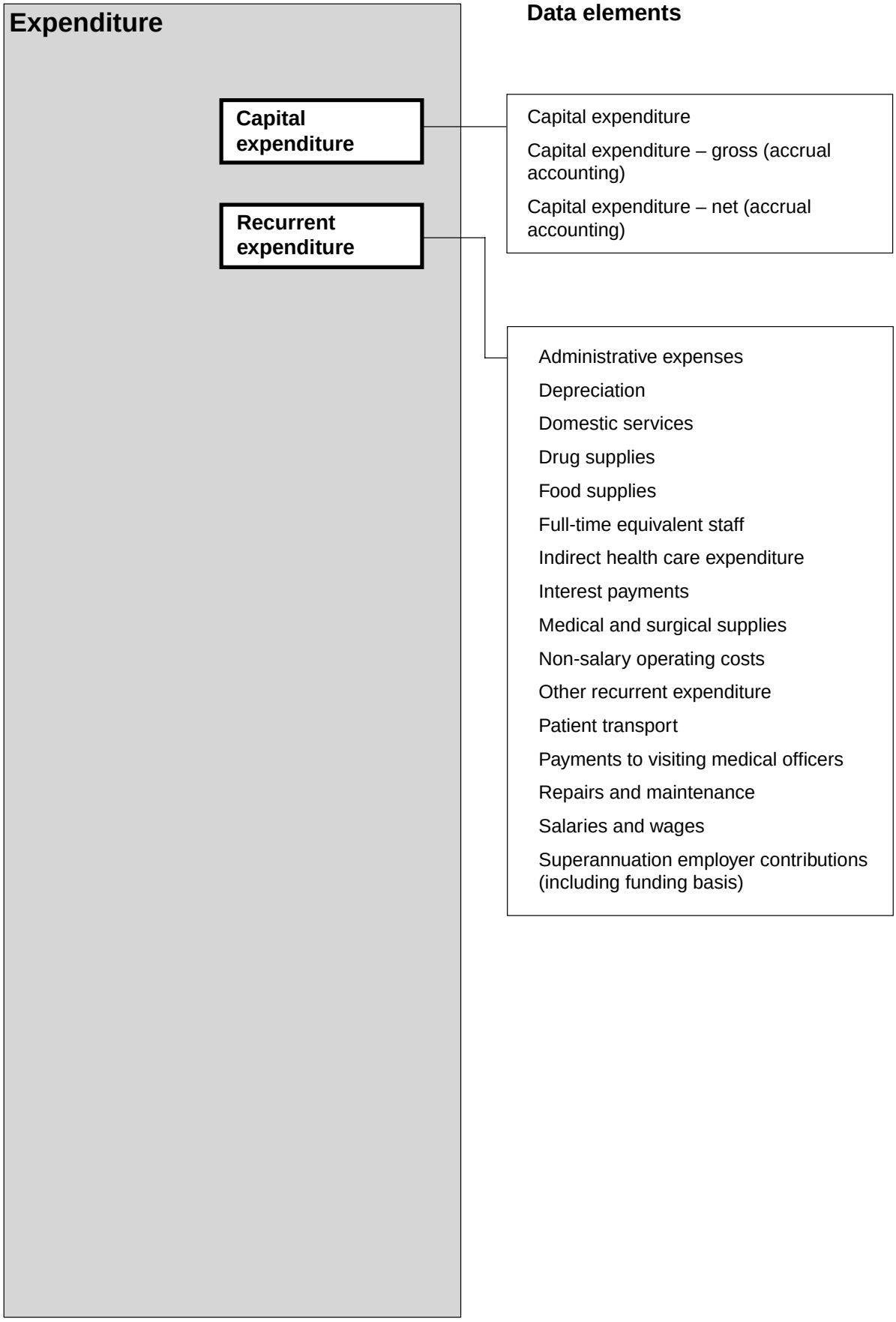
Administrative attributes

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/1997 to

National Health Information Model entity



Capital expenditure

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000248 Version number: 1

Data element type: DATA ELEMENT

Definition: Gross capital expenditure is capital expenditure as reported by the particular establishment having regard to State health authority and other authoritative guidelines as to the differentiation between capital and recurrent expenditure. (A concise indication of the basis on which capital and recurrent expenditure have been differentiated is to form part of national minimum data sets).

Context: Health expenditure: capital expenditure is a significant, though variable, element of total health establishment expenditure. Just as recurrent expenditure is broken down into a number of major categories to enable a proper analysis of health expenditure at the national level, so capital expenditure is to be broken down into a number of major categories.

Capital expenditure in the context of hospitals and closely related establishments is a relatively undeveloped area. Nevertheless, there is a considerable interest in health establishment capital expenditure data at the national level from many different potential users.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain:

1	Land and buildings
2	Computer equipment/installations
3	Major medical equipment
4	Plant and (other) equipment
5	Expenditure in relation to intangible assets
6	Other capital expenditure

Guide for use: Expenditure calculated separately for each type described below:

1. Land and buildings

This includes outlays on construction, major alterations and additions to buildings that relate to the establishment. Included are transfer and similar costs in respect of the purchase (sale) of second hand dwellings and installation of new permanent fixtures such as stoves, air conditioning, lighting, plumbing and other fixed equipment normally installed before dwellings are occupied. Costs relating to repair and maintenance replacement of buildings that amount to recurrent expenditure should not be included.

2. Computer equipment/installations

Expenditure of a capital nature on computer installations and equipment such as mainframe computers, mini-computers, extensive personal computer networks and related hardware should be included here.

3. Major medical equipment

Expenditure on major items of medical equipment such as CT scanners, MRI equipment, X-ray equipment, ICU monitors and transplant equipment should be included here.

Guide for use (continued):

4. Plant and (other) equipment

Details of expenditure on plant and other equipment should be included here. Plant and/or equipment that is an integral part of any building or construction (and is thus included under expenditure on land and buildings), equipment included above under major medical equipment, motor vehicles and items of equipment that would normally be classified as recurrent expenditure should not be included.

5. Expenditure in relation to intangible assets

This category bears specific regard to the private sector. Included here is any expenditure during the financial year in respect of intangible assets such as formation expenses or goodwill.

6. Other capital expenditure

Any expenditure of a capital nature not included elsewhere should be included here. For example, if any State or establishment treats expenditure on new and second hand motor vehicles (including ambulances) as capital expenditure, this should be included as should any expenditure on furniture and fittings if treated by a State or establishment as expenditure of a capital nature.

Related data: relates to Capital expenditure—net (accrual accounting), version 2

relates to Capital expenditure—gross (accrual accounting), version 2

Administrative attributes

Source organisation: National minimum data set working parties

National minimum data sets:

Public hospital establishments	from 1/07/2000 to

Capital expenditure—gross (accrual accounting)

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000325 Version number: 2

Data element type: DATA ELEMENT

Definition: Expenditure in a period on the acquisition or enhancement of an asset (excluding financial assets).

Context: Health expenditure: gross capital expenditure is a significant, though variable, element of total health establishment expenditure. Just as recurrent expenditure is broken down into a number of major categories to enable a proper analysis of health expenditure at the national level, so capital expenditure is to be broken down into a number of major categories.

Capital expenditure in the context of hospitals and closely related establishments is a relatively undeveloped area. Nevertheless, there is a considerable interest in health establishment capital expenditure data at the national level from many different potential users.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain:

1	Land
2	Buildings and building services (including plant)
3	Constructions (other than buildings)
4	Information technology
5	Major medical equipment
6	Transport
7	Other equipment
8	Intangible

Guide for use: This definition is for use where the accrual method of accounting has been adopted. To be coded separately for each type of gross capital expenditure described below:

1. Land

A solid section of the earth's surface which is held by the entity under a certificate of title or reserve, leased in by the entity or allocated to the entity by another agency.

2. Buildings and building services (including plant)

An edifice that has a service potential constructed, acquired or held by a financial lease for the specific purposes of the entity. Includes hospitals, hostels, residential aged care services and other buildings used for providing the service. Includes expenditure on installation, alteration and improvement of fixtures, facilities and equipment that are an integral part of the building and that contribute to the primary function of a building to either directly or indirectly support the delivery of products and services.

Excludes repair and replacement of worn-out or damaged fixtures (to be treated as maintenance).

Guide for use (continued):

3. Constructions (other than buildings)

Expenditure on construction, major alterations and additions to fixed assets other than buildings such as car parks, roads, bridges, storm water channels, dams, drainage and sanitation systems, sporting facilities, gas, water and electricity mains, communication systems, landscaping and grounds reticulation systems. Includes expenditure on land reclamation, land clearance and raising or levelling of building sites.

4–7. Equipment

An asset, not an integral part of any building or construction, used by an entity to support the delivery of products and services. Items may be fixed or moveable.

4. Information technology

Computer installations and equipment such as mainframe and mini-computers, personal computer networks and related hardware.

5. Major medical equipment

Major items of medical equipment such as medical imaging (CT scanners, MRI, radiology), ICU monitors and transplant equipment.

6. Transport

Expenditure on vehicles or equipment used for transport such as motor vehicles, aircraft, ships, railway, tramway rolling stock, and attachments (such as trailers). Includes major parts such as engines.

7. Other equipment

Includes machinery and equipment not elsewhere classified, such as furniture, art objects, professional instruments and containers.

8. Intangible

An asset which does not have physical substance, such as copyright, design, patent, trademark, franchise or licence.

Verification rules: Australian dollars. Rounded to the nearest whole dollar.

Related data: supersedes previous data element Capital expenditure, version 1

relates to Capital expenditure—net (accrual accounting), version 2

Administrative attributes

Source organisation: National minimum data set working parties

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Comments: The capital expenditure data elements on an accrual accounting basis and on a cash accounting basis will remain in use until all health authorities have adopted accrual accounting.

Capital expenditure—net (accrual accounting)

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000396 Version number: 2

Data element type: DATA ELEMENT

Definition: Gross capital expenditure less trade-in values of replaced items and receipts from the sale of replaced or otherwise disposed items.

Context: Health expenditure: net capital expenditure is a significant, though variable, element of total health establishment expenditure. Just as recurrent expenditure is broken down into a number of major categories to enable a proper analysis of health expenditure at the national level, so capital expenditure is to be broken down into a number of major categories.

Capital expenditure in the context of hospitals and closely related establishments is a relatively undeveloped area. Nevertheless, there is a considerable interest in health establishment capital expenditure data at the national level from many different potential users.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain:

1	Land
2	Buildings and building services (including plant)
3	Constructions (other than buildings)
4	Information technology
5	Major medical equipment
6	Transport
7	Other equipment
8	Intangible

Guide for use: To be calculated separately for each type of net capital expenditure described in 'capital expenditure—gross (accrual accounting)'.

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Related data: supersedes previous data element Capital expenditure, version 1

relates to Capital expenditure—gross (accrual accounting), version 2

Administrative attributes

Source organisation: National minimum data set working parties

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Administrative expenses

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000244 Version number: 1

Data element type: DATA ELEMENT

Definition: All expenditure incurred by establishments (but not central administrations) of a management expenses/administrative support nature such as any rates and taxes, printing, telephone, stationery and insurance (including workers compensation).

Context: Health expenditure: considered to be a sufficiently significant element of non-salary recurrent expenditure as to be separately identified at the national level and also readily and easily collectable.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain: Dollar amount

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Related data: relates to Establishment type, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Depreciation

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000246 Version number: 1

Data element type: DATA ELEMENT

Definition: Depreciation represents the expensing of a long-term asset over its useful life and is related to the basic accounting principle of matching revenue and expenses for the financial period. Depreciation charges for the current financial year only should be shown as expenditure. Where intangible assets are amortised (such as with some private hospitals) this should also be included in recurrent expenditure.

Context: Health expenditure: this item has been retained for national minimum data sets because of its significance for the private sector. Current period depreciation charges form a significant component of expenditure for any health establishment whose financial statements are based on accrual accounting.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain: Dollar amount

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Related data: relates to Establishment type, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Comments: With the long-term trend towards accrual accounting in the public sector, this item will ultimately become significant for public sector establishments. Public sector establishments in some States have adopted modified accrual accounting identifying depreciation only, before reaching full accrual accounting. Depreciation is now reported (March 1999) for most public sector establishments and should be reported as a separate recurrent expenditure.

Depreciation should be identified separately from other recurrent expenditure categories.

Domestic services

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000241 Version number: 1

Data element type: DATA ELEMENT

Definition: The costs of all domestic services including electricity, other fuel and power, domestic services for staff, accommodation and kitchen expenses but not including salaries and wages, food costs or equipment replacement and repair costs. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Context: Health expenditure: this is a significant element of non-salary recurrent expenditure for most establishments within the data set and is thus required for any health expenditure analysis at the national level.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain: Dollar amount

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Related data: relates to Establishment type, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments	from 1/07/2000 to
Community mental health establishments	from 1/07/1998 to

Comments: The possibility of separating fuel, light and power from domestic services which would bring the overall non-salary recurrent expenditure categories closer to the old Hospitals and Allied Services Advisory Council categories was briefly considered by the Resources Working Party but members did not hold strong views in this area.

Drug supplies

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000238 Version number: 1

Data element type: DATA ELEMENT

Definition: The cost of all drugs including the cost of containers. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Context: Health expenditure: this is a significant element of non-salary recurrent expenditure and also national level data on drug expenditure in hospitals is of considerable interest in its own right to a wide range of persons and organisations.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain: Dollar amount

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Related data: relates to Establishment type, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Food supplies

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000240 Version number: 1

Data element type: DATA ELEMENT

Definition: The cost of all food and beverages but not including kitchen expenses such as utensils, cleaning materials, cutlery and crockery. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Context: Health expenditure: this is a significant element of non-salary recurrent expenditure for most establishments within the data set and is thus required for any health expenditure analysis at the national level.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain: ***Dollar amount***

Verification rules: ***Australian dollars. Rounded to nearest whole dollar.***

Related data: ***relates to Establishment type, version 1***

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Full-time equivalent staff

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000252 Version number: 2

Data element type: DERIVED DATA ELEMENT

Definition: Full time equivalent staff units are the on-job hours paid for (including overtime) and hours of paid leave of any type for a staff member (or contract employee where applicable) divided by the number of ordinary time hours normally paid for a full-time staff member when on the job (or contract employee where applicable) under the relevant award or agreement for the staff member (or contract employee occupation where applicable). Hours of unpaid leave are to be excluded.

Contract staff employed through an agency are included where the contract is for the supply of labour (e.g. nursing) rather than of products (e.g. photocopier maintenance). In the former case, the contract would normally specify the amount of labour supplied and could be reported as full-time equivalent units.

Context: Health expenditure: to assist in analyses of the resource use and activity of public hospital establishments. Inclusion of these data, classified by staffing category, allows analysis of costs per unit of labour and analysis of staffing inputs against establishment outputs.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 5 Layout: NNNNN

Data domain: Average full-time equivalent staff units for each staffing category.

Guide for use: Staffing categories:

C1.1 Salaried medical officers

C1.2 Registered nurses

C1.3 Enrolled nurses

C1.4 Student nurses

C1.5 Trainee/pupil nurses

C1.6 Other personal care staff

C1.7 Diagnostic and health professionals

C1.8 Administrative and clerical staff

C1.9 Domestic and other staff

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Guide for use (continued): Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each. (Salary costs should be apportioned on the same basis).

Related data: supersedes previous Total full-time equivalent staff, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments	from 1/07/2000 to
Community mental health establishments	from 1/07/1998 to

Comments: This National Health Data Dictionary entry was amended during 1996–97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Indirect health care expenditure

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000326 Version number: 1

Data element type: DATA ELEMENT

Definition: Expenditures on health care that cannot be directly related to programs operated by a particular establishment (that is, can only be indirectly related to particular establishments). To be provided at the State level but disaggregated into patient transport services, public health and monitoring services, central and statewide support services, central administrations and other indirect health care expenditure.

Context: Health expenditure: to improve and substantiate financial reporting in relation to indirect health care expenditure and assist in understanding differences in costs for similar establishments in different States and regions, due to differences in the extent to which support services and other services to residents/inpatients and outpatients of establishments may be provided by the establishment itself or by other bodies.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain: Dollar amount

Guide for use: Indirect health care expenditure is to be reported separately for each of the following categories:

1. Patient transport services

Public or registered non-profit organisations which provide patient transport (or ambulance) for services associated with inpatient or residential episodes at residential establishments within the scope of this data set.

This category excludes patient transport services provided by other types of establishments (for example, public hospitals) as part of their normal services. This category includes centralised and statewide patient transport services (for example, Queensland Ambulance Transport Brigade) which operate independently of individual inpatient establishments.

2. Public health and monitoring services

Public or registered non-profit services and organisations with centralised, statewide or national public health or monitoring services. These include programs concerned primarily with preventing the occurrence of diseases and mitigating their effect, and includes such activities as mass chest X-ray campaigns, immunisation and vaccination programs, control of communicable diseases, ante-natal and post-natal clinics, preschool and school medical services, infant welfare clinics, hygiene and nutrition advisory services, food and drug inspection services, regulation of standards of sanitation, quarantine services, pest control, anti-cancer, anti-drug and anti-smoking campaigns and other programs to increase public awareness of disease symptoms and health hazards, occupational health services, Worksafe Australia, the Australian Institute of Health and Welfare and the National Health and Medical Research Council.

Guide for use: (continued)

Included here would be child dental services comprising expenditure incurred (other than by individual establishments) or dental examinations, provision of preventive and curative dentistry, dental health education for infants and school children and expenditure incurred in the training of dental therapists.

3. Central and statewide support services

Public or registered services which provide central or statewide support services for residential establishments within the scope of this data set. These include central pathology services, central linen services and frozen food services and blood banks provided on a central or statewide basis such as Red Cross.

4. Central administrations

Expenditures relating to central health administration, research and planning for central and regional offices of State, Territory and Commonwealth health authorities and related departments (for example, the Department of Veterans' Affairs).

5. Other

Any other indirect health care expenditure as defined above not catered for in the above categories. This might include such things as family planning and parental health counselling services and expenditure incurred in the registration of notifiable diseases and other medical information.

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Comments: Resources Working Party members were concerned about the possibility that double counting of programs at the hospital and again at the State level and were also concerned at the lack of uniformity between States. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

Interest payments

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000245 Version number: 1

Data element type: DATA ELEMENT

Definition: Payments made by or on behalf of the establishment in respect of borrowings (e.g. interest on bank overdraft) provided the establishment is permitted to borrow. This does not include the cost of equity capital (i.e. dividends on shares) in respect of profit making private establishments.

Context: Health expenditure: this item has been retained in the data set because of its significance for the private sector. Private profit making establishments will seek to fund their operations either by loan borrowings (debt capital) or raising shares (equity capital). The cost of either can be significant, although the cost of the latter (that is, dividends on shares) would come out of profits.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain: Dollar amount

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Related data: relates to Establishment type, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Comments: The item would not have been retained if the data set was restricted to the public sector. In some States, public hospitals may not be permitted to borrow funds or it may be entirely a State treasury matter, not identifiable by the health authority. Even where public sector establishment borrowings might be identified, this appears to be a sensitive area and also of less overall significance than in the private sector.

Medical and surgical supplies

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000239 Version number: 1

Data element type: DATA ELEMENT

Definition: The cost of all consumables of a medical or surgical nature (excluding drug supplies) but not including expenditure on equipment repairs. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Context: Health expenditure: as for the data element 'Drug supplies' this is a significant element of non-salary expenditure and national-level data on medical and surgical supplies is of considerable interest in its own right to a wide range of persons and organisations.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain: Dollar amount

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Related data: relates to Establishment type, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Non-salary operating costs

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000360 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: Total expenditure relating to non-salary operating items.

Context: Health care: this data element is required to monitor trends of expenditure in the sector.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain: Dollar amount

Guide for use: Report all expenditure in thousands of dollars ($000's). Total is calculated from expenditure including: Payments to visiting medical officers, Superannuation employer contributions (including funding basis), Drug supplies; Medical and surgical supplies; Food supplies; Domestic services; Repairs and maintenance; Patient transport; Administrative expenses; Interest payments; Depreciation; Other recurrent expenditure.

Expenditure should include both the specific costs directly associated with the service and indirect costs for example personnel services.

Research and academic units that function as an integral part of ambulatory care should be reported against the appropriate service.

Related data: is calculated using Payments to visiting medical officers, version 1

is calculated using Superannuation employer contributions (including funding basis), version 1

is calculated using Drug supplies, version 1

is calculated using Medical and surgical supplies, version 1

is calculated using Food supplies, version 1

is calculated using Domestic services, version 1

is calculated using Repairs and maintenance, version 1

is calculated using Patient transport, version 1

is calculated using Administrative expenses, version 1

is calculated using Interest payments, version 1

is calculated using Depreciation, version 1

is calculated using Other recurrent expenditure, version 1

Administrative attributes

National minimum data sets:

Community mental health establishments from 1/07/1998 to

Other recurrent expenditure

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000247 Version number: 1

Data element type: DATA ELEMENT

Definition: Other payments are all other recurrent expenditure not included elsewhere in any of the recurrent expenditure categories. Gross expenditure should be reported with no revenue offsets (except for inter-hospital transfers).

Context: Health expenditure: this category is required for balancing purposes and to capture all those additional expenditures which can be significant in aggregate.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain: Dollar amount

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Related data: relates to Establishment type, version 1

Administrative attributes

Source organisation: National minimum data set working parties

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Patient transport

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000243 Version number: 1

Data element type: DATA ELEMENT

Definition: The direct cost of transporting patients excluding salaries and wages of transport staff.

Context: Health expenditure: considered to be a significant element of non-salary recurrent expenditure for many establishments within the data set and is thus required for any health expenditure analysis at the national level.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain: Dollar amount

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Related data: relates to Establishment type, version 1

Administrative attributes

Source organisation: ***National minimum data set working parties***

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Payments to visiting medical officers

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000236 Version number: 1

Data element type: DATA ELEMENT

Definition: All payments made by a public hospital establishment to visiting medical officers for medical services provided to hospital (public) patients on an honorary, sessionally paid, or fee for service basis.

A visiting medical officer is a medical practitioner appointed by the hospital board to provide medical services for hospital (public) patients on an honorary, sessionally paid, or fee for service basis. This category includes the same Australian Standard Classification of Occupations codes as the salaried medical officers category.

Context: Health expenditure: this is a significant element of expenditure for many hospitals (although not for other establishments) and needed for health financing and health expenditure analysis at the national level. Any analysis of health expenditures at the national level would tend to break down if significant components of expenditure were not available.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain: Dollar amount

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Related data: relates to Establishment type, version 1

Administrative attributes

Source organisation: National minimum data set working parties

National minimum data sets:

Public hospital establishments	from 1/07/2000 to
Community mental health establishments	from 1/07/1998 to

Comments: Although accepting the need to include visiting medical officer payments, the Resources Working Party decided not to include data on visiting medical officer services (whether hours or number of sessions or number of services provided) due to collection difficulties and the perception that use of visiting medical officers was purely a hospital management issue.

Repairs and maintenance

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000242 Version number: 1

Data element type: DATA ELEMENT

Definition: The costs incurred in maintaining, repairing, replacing and providing additional equipment, maintaining and renovating building and minor additional works. Expenditure of a capital nature should not be included here. Do not include salaries and wages of repair and maintenance staff. Gross expenditure should be reported with no revenue offsets (except for inter-hospital transfers).

Context: Health expenditure: this is a significant element of non-salary recurrent expenditure for most establishments within the data set and is thus required for any health expenditure analysis at the national level.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain: Dollar amount

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Related data: relates to Establishment type, version 1

Administrative attributes

Source organisation: National minimum data set working parties

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Salaries and wages

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000254 Version number: 1

Data element type: DATA ELEMENT

Definition: Salary and wage payments for all employees of the establishment (including contract staff employed by an agency, provided staffing (ME) data is also available). This is to include all paid leave (recreation, sick and long-service) and salary and wage payments relating to workers compensation leave for the following staffing categories (see below).

Generally, salary data by staffing categories should be broadly consistent with full-time equivalent staffing numbers. Where staff provide services to more than one hospital, their salaries should be apportioned between all hospitals to whom services are provided on the basis of hours worked in each hospital.

Salary payments for contract staff employed through an agency should be included under salaries for the appropriate staff category provided they are included in full-time equivalent staffing. If they are not salary, payments should be shown separately.

Context: Health expenditure: salaries and wages invariably constitute the major component of recurrent and, indeed, total expenditure for the establishments forming part of this data set and are vital to any analysis of health expenditure at the national level. The categories correspond with those relating to full-time equivalent staffing which is a requirement for any proper analysis of average salary costs.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain: Expenditure for each staffing category.

Guide for use: Figures should be supplied for each of the staffing categories:

C1.1 Salaried medical officers

C1.2 Registered nurses

C1.3 Enrolled nurses

C1.4 Student nurses

C1.5 Trainee/pupil nurses

C1.6 Other personal care staff

C1.7 Diagnostic and health professionals

C1.8 Administrative and clerical staff

C1.9 Domestic and other staff

Collection methods: For contract staff, see comments under the data element Total full-time equivalent staff. Salary data for contract staff, provided the contract is for the supply of labour (e.g. nursing) rather than products (e.g. photocopier maintenance), should be shown under the appropriate staff salary category provided that corresponding staffing (full-time equivalent) data is available. If not, it should be shown separately.

Related data: relates to Establishment type, version 1
relates to Full-time equivalent staff, version 2

Administrative attributes

Source organisation: National minimum data set working parties

National minimum data sets:

Public hospital establishments	from 1/07/2000 to
Community mental health establishments	from 1/07/1998 to

Superannuation employer contributions (including funding basis)

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000237 Version number: 1

Data element type: DATA ELEMENT

Definition: Superannuation employer contributions

Contributions paid or (for an emerging cost scheme) that should be paid (as determined by an actuary) on behalf of establishment employees either by the establishment or a central administration such as a State health authority, to a superannuation fund providing retirement and related benefits to establishment employees.

Funding basis

The following different funding bases are identified:

- paid by hospital to fully funded scheme;
- paid by Commonwealth government or State government to fully funded scheme; and
- unfunded or emerging costs schemes where employer component is not presently funded.

Fully funded schemes are those in which employer and employee contributions are paid into an invested fund. Benefits are paid from the fund. Most private sector schemes are fully funded.

Emerging cost schemes are those in which the cost of benefits is met at the time a benefit becomes payable; that is, there is no ongoing invested fund from which benefits are paid. The Commonwealth superannuation fund is an example of this type of scheme as employee benefits are paid out of general revenue.

Context: Health expenditure: superannuation employer contributions are a significant element of establishment expenditure and, as such, are required for health expenditure analysis at the national level.

The funding basis is required for cost comparison purposes particularly in the case of unfunded or emerging cost schemes where no actual contribution is being presently made but ultimately employer liability will have to be funded.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain: Dollar amount

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Related data: relates to Establishment type, version 1

Administrative attributes

Source organisation: National minimum data set working parties

National minimum data sets:

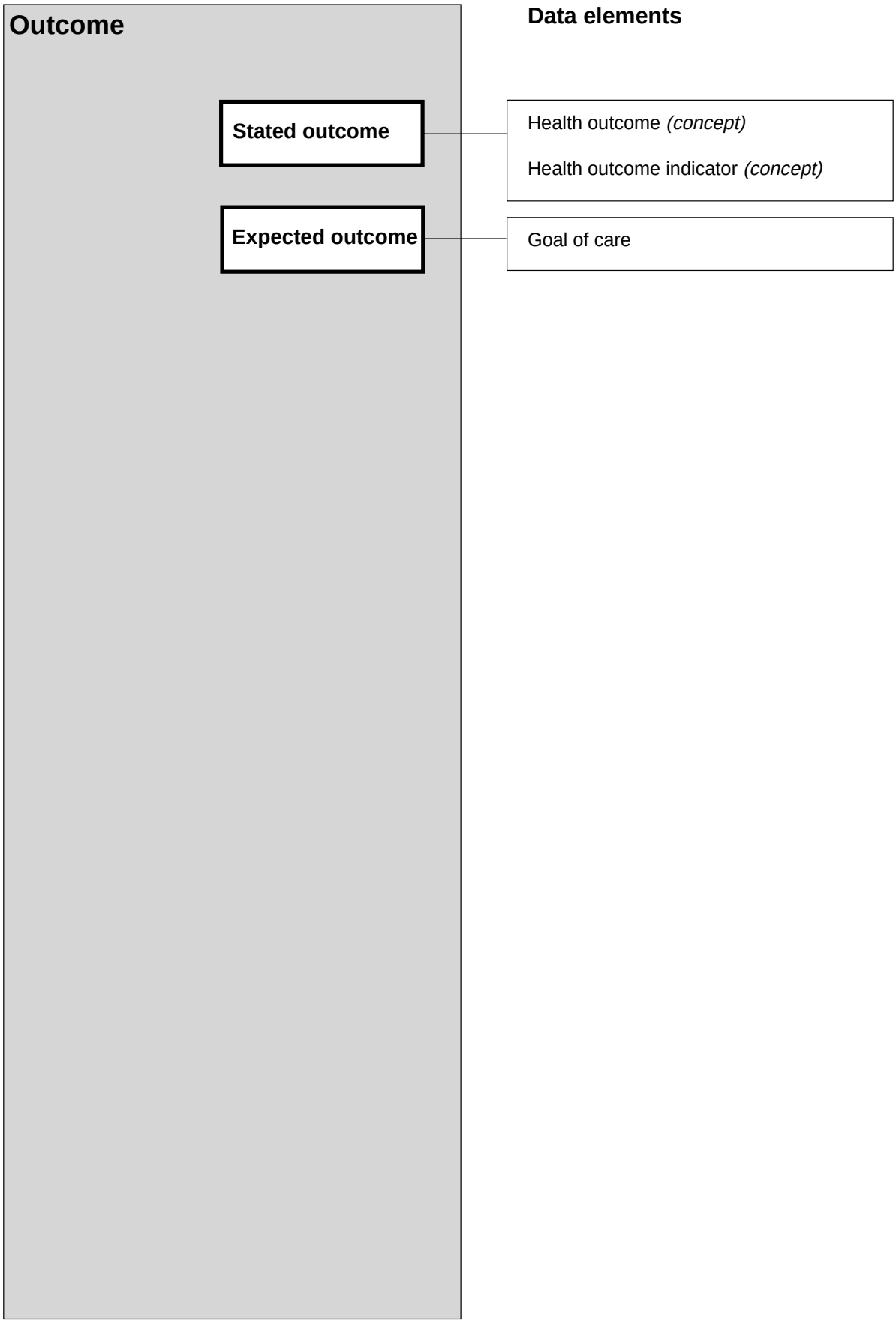
Public hospital establishments from 1/07/2000 to

Comments: The definition specifically excludes employee superannuation contributions (not a cost to the establishment) and superannuation final benefit payments.

In private enterprise some superannuation schemes are partially funded but this is considered too complex a distinction for national minimum data sets.

It is noted that the emergence of salary sacrifice schemes allows employees to forego salary for higher superannuation contributions. If these become significant, national minimum data sets may have to take them into account at a future stage.

National Health Information Model entity



Health outcome

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000062 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A change in the health of an individual, or a group of people or a population, which is wholly or partially attributable to an intervention or a series of interventions

Context: Admitted patient and non-admitted patient health care.

Administrative attributes

Source organisation: National Health Information Management Group

Health outcome indicator

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000063 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A statistic or other unit of information which reflects, directly or indirectly, the effect of an intervention, facility, service or system on the health of its target population, or the health of an individual.

- A generic indicator provides information on health, perceived health or a specific dimension of health using measurement methods that can be applied to people in any health condition.
- A condition-specific indicator provides information on specific clinical conditions or health problems, or aspects of physiological function pertaining to specific conditions or problems.

Epidemiological terminology

- An association exists between two phenomena (such as an intervention and a health outcome) if the occurrence or quantitative characteristics of one of the phenomena varies with the occurrence or quantitative characteristics of the other.
- One phenomenon is attributable to another if there is a casual link between the phenomena. Attribution depends upon the weight of evidence for causality.
- Association is necessary (but not sufficient) for attribution. Associations may be fortuitous or causal. The term relationship is to be taken as synonymous with association.

Context: Admitted patient and non-admitted patient health care.

Administrative attributes

Source organisation: National Health Information Management Group

Goal of care

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000111 Version number: 2

Data element type: DATA ELEMENT

Definition: The goal or expected outcome of a plan of care, negotiated by the service provider and recipient, which outlines the overall aim of actions planned by a community service and relates to a person's health need. This goal reflects a total care plan and takes into account the possibility that a range of community services may be provided within a specified time frame.

Context: This item focuses on the broad goal which the person and services provider hope to achieve within an expected time period and takes into account the intervention or services provided by a range of community services.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain:

01 Well person for preventative/maintenance/health promotion program;

02 Person will make a complete recovery;

03 Person will not make a complete recovery; but will rehabilitate to a state where formal on-going service is no longer required;

04 Person has a long-term care need and the goal is aimed at on-going support to maintain at home;

05 Person in end-stage of illness the goal is aimed at support to stay at home in comfort and dignity and facilitation of choice of where to die;

06 Person is unable to remain at home for extended period and goal is aimed at institutionalisation at a planned and appropriate time;

07 For assessment only/not applicable.

Guide for use: GOAL 1 service recipients are those making contact with the health service primarily as a part of a preventative/maintenance health promotion program. This means they are well and do not require care for established health problems. They include well antenatal persons attending or being seen by the service for screening or health education purposes.

GOAL 2 describes those persons whose condition is self-limiting and from which complete recovery is anticipated, or those with established or long term health problems who are normally independent in their management. Goal 2 service recipient includes:

- post surgical or acute medical service recipients whose care at home is to facilitate convalescence. Such admissions to home care occur as a result of early discharge from hospital;
- post-surgical complication such as wound infection;
- or because the person is at risk during the recovery phase and requires surveillance for a limited period;
- persons recovering from an acute illness and referred from the general practitioner or other community based facility;

Guide for use (continued):

- persons with disability or established health problem normally independent of health services, and currently recovering from an acute condition or illness as above.

GOAL 3 refers to those service recipients whose care plan is aimed at returning them to independent functioning at home either through self-care or with informal assistance, such that formal services will be discontinued. The distinguishing characteristic of this group is that complete recovery is not expected but some functional gain may be possible. Further, the condition is not expected to deteriorate rapidly or otherwise cause the client to be at risk without contact or surveillance from the community service.

GOAL 4 refers to those service recipients whose health problem/condition is not expected to resolve and who will require ongoing maintenance care from the nursing service. Such clients are distinguished from those in Goal 3 in that their condition is of an unknown or long-term nature and not expected to cause death in the foreseeable future. They may require therapy for restoration of function initially and intermittently, and may also have intermittent admissions for respite. However, the major part of their care is planned to be at home.

GOAL 5 refers to persons whose focus of care is palliation of symptoms and facilitation of the choice to die at home.

GOAL 6 includes persons who have a limited ability to remain at home because of their intensive care requirements and the inability of formal and informal services to meet these needs. Admission to admitted patient care is therefore a part of the care planning process and the timing dependent upon the capacity and/or wish to remain at home. The distinguishing feature of this group is that the admission is not planned to be an intermittent event to boost the capacity for home care but is expected to be of a more permanent (or indeterminate) nature.

Excluded from this group are persons with established health problems or permanent disability, if the contact is related to the condition. For example, persons with diabetes and in a diabetes program would be included in Goal 3; however, such persons would be included in goal 6 if the contact with the service is not related to an established health problem but is primarily for preventative/maintenance care as described above.

GOAL 7 service recipients are those for whom the reason for the visit is to undertake an assessment. This may include clients in receipt of a Domiciliary Nursing Care Benefit (DNCB) for whom the purpose of the visit is to determine ongoing DNCB eligibility and requirements for care. Implicit in this visit is review of the person's health status and circumstances, to ensure that their ongoing support does not place them or their carer at avoidable risk.

Verification rules: Only one option is permissible and where Code 7 is selected, Code 9 must be used in Nursing interventions.

Collection methods: At time of formal review of the client, the original Goal of care should be retained and not over-written by the system. The goal of care relates to the episode bounded by the Date of first contact with community nursing service and Date of last contact and in this format provides a focussing effect at the time of planning for care.

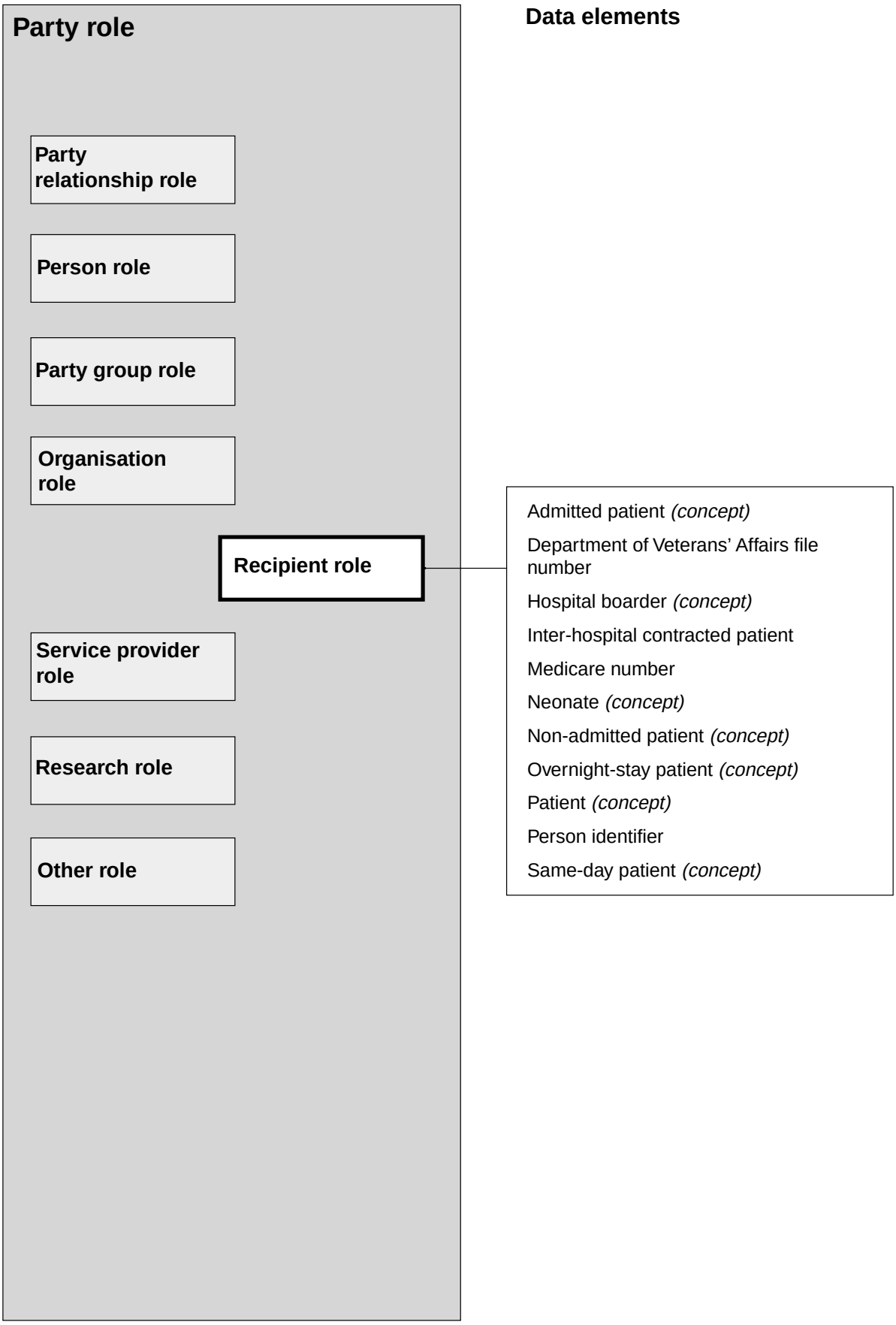
Related data: supersedes previous data element Nursing goal, version 1
relates to Date of first contact, version 2
relates to Nursing diagnosis, version 2
relates to Nursing interventions, version 2
relates to Date of last contact, version 2

Administrative attributes

Source organisation: Australian Council of Community Nursing Services

Comments: Agencies who had previously implemented this item should note changes to the code set in data domain.

National Health Information Model entity



Admitted patient

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000011 Version number: 3

Data element type: DATA ELEMENT CONCEPT

Definition: A patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients). The patient may be admitted if one or more of the following apply:

- the patient's condition requires clinical management and/or facilities not available in their usual residential environment;
- the patient requires observation in order to be assessed or diagnosed;
- the patient requires at least daily assessment of their medication needs;
- the patient requires a procedure(s) that cannot be performed in a stand-alone facility, such as a doctor's room without specialised support facilities and/or expertise available (e.g. cardiac catheterisation);
- there is a legal requirement for admission (e.g. under child protection legislation);
- the patient is aged nine days or less

Context: Admitted patient care:

Relational and representational attributes

Guide for use: This data element should be used in conjunction with the definition of same-day patient in the data element Same-day patient.

Part 2 of Schedule 3 of the National Health Act (type C) professional attention may be used as a guide for the medical services not normally requiring hospital treatment and therefore not generally related to admitted patients.

All babies born in hospital are admitted patients.

Related data: supersedes previous data element concept Admitted patient, version 2

relates to Patient days, version 3

relates to Newborn qualification status, version 2

relates to Number of qualified days for newborns, version 2

relates to Care type, version 4

Administrative attributes

Comments: This definition includes all babies who are nine days old or less. However, all newborn days of stay are further divided into categories of qualified and unqualified for Australian Healthcare Agreements and health insurance benefit purposes. A newborn day is acute (qualified) when a newborn meets at least one of the following criteria:

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient;
- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Health Minister for the purpose of the provision of special care;

Comments (continued):

- remains in hospital without its mother;
- is admitted to the hospital without its mother.

Acute (qualified) newborn days are eligible for health insurance benefit purposes and should be counted under the Australian Health Care Agreements.

Days when the newborn does not meet these criteria are classified as unqualified (if they are nine days old or less) and should be recorded as such. Unqualified newborn days should not be counted under the Australian Health Care Agreements and are not eligible for health insurance benefit purposes.

Department of Veterans' Affairs file number

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000204 Version number: 1

Data element type: DATA ELEMENT

Definition: The Department of Veterans' Affairs file number of the person.

Context: Admitted patient care: admitted patient mental health care. This number must be recorded by a service provider each time a service is provided to a person who holds the entitlement for reimbursement purposes.

Relational and representational attributes

Datatype: AlphaNumeric Field size: Min. 7 Max. 7 Layout: AAANNNN

Data domain: Valid identification number

Guide for use: The file reference is a seven digit identifier that can have a State code (N,V,Q,S,W,T) included, and in some circumstances a file type code is added. ACT is included in NSW (N) and NT with SA (S).

Individuals are identified by an alphanumeric code at the end of the file number. A veteran's spouse and children have the same file number but are identified within the DVA Client Database with a segment link or suffix. The segment link and suffix are different and can change. For example, the suffix usually changes when a wife becomes a widow.

Changes to the information system in the Department of Veteran's Affairs may permit the identification of all individual States and Territories in the future.

Administrative attributes

Source organisation: Department of Veteran's Affairs, National Health Data Committee

Hospital boarder

Admin. status: CURRENT 1/07/1994

Identifying and definitional attributes

Knowledgebase ID: 000065 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.

Context: Admitted patient care:

Relational and representational attributes

Guide for use: A boarder thus defined is not admitted to the hospital. However, a hospital may register a boarder.

Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either a qualified or unqualified day.

Administrative attributes

Source organisation: National Health Data Committee

Inter-hospital contracted patient

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000079 Version number: 2

Data element type: DERIVED DATA ELEMENT

Definition: An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital), and for which the activity is recorded by both hospitals.

Context: Admitted patient care: to identify patients receiving services that have been contracted between hospitals. This item is used to eliminate potential double counting of hospital activity in the analysis of patterns of health care delivery and funding and epidemiological studies.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Inter-hospital contracted patient from public sector hospital
2	Inter-hospital contracted patient from private sector hospital
3	Other
9	Not reported

Guide for use: A specific arrangement should apply (either written or verbal) whereby one hospital contracts with another hospital for the provision of specific services. The arrangement may be between any combination of hospital; for example, public to public, public to private, private to private, or private to public.

Collection methods: All services provided at both the originating and destination hospitals should be recorded and reported by the originating hospital. The destination hospital should record the admission as an 'Inter-hospital contracted patient' so that these services can be identified in the various statistics produced about hospital activity. This data element will be derived as follows.

If Contract role = B (Hospital B, that is, the provider of the hospital service; contracted hospital), and Contract type = 2, 3, 4 or 5 (that is, a hospital (Hospital A) purchases the activity, rather than a health authority or other external purchaser, and admits the patient for all or part of the episode of care, and/or records the contracted activity within the patient's record for the episode of care)

Then record a value of 1, if Hospital A is a public hospital or record a value of 2, if Hospital A is a private hospital.

Otherwise if the Contract role is not B, and/or the Contract type is not 2, 3, 4 or 5 record a value of 3.

Related data: supersedes the data element Inter-hospital same-day contracted patient, version 1

used in conjunction with Contracted hospital care, version 1

is derived from Contract type, version 1

is derived from Contract role, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient care	from 1/07/2000 to

Medicare number

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000091 Version number: 1

Data element type: DATA ELEMENT

Definition: Personal identifier allocated by the Health Insurance Commission to eligible persons under the Medicare scheme.

Context: Medicare utilisation statistics and Admitted patient care:

Relational and representational attributes

Datatype: Numeric Field size: Min. 11 Max. 11 Layout: N(11)

Data domain: Full Medicare number for an individual (i.e. family number plus person number)

Administrative attributes

Source organisation: National Health Data Committee

Comments: Under Medicare, each eligible family in the population is assigned a unique identifying number. This number, together with age and sex, provides an essentially unique identifier.

Non-admitted patient

Admin. status: CURRENT 1/07/1994

Identifying and definitional attributes

Knowledgebase ID: 000104 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A patient who does not undergo a hospital's formal admission process.

There are three categories of non-admitted patient:

- Emergency Department patient
- outpatient
- other non-admitted patient (treated by hospital employees off the hospital site—includes community/outreach services)

Relational and representational attributes

Related data: relates to concept Patient, version 1

Administrative attributes

Source organisation: National Health Data Committee

Overnight-stay patient

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000116 Version number: 3

Data element type: DATA ELEMENT CONCEPT

Definition: A patient who, following a clinical decision, receives hospital treatment for a minimum of one night i.e. who is admitted to and separated from the hospital on different dates.

Context: Admitted patient care:

Relational and representational attributes

Guide for use: An overnight-stay patient in one hospital cannot be concurrently an overnight-stay patient in another hospital, unless they are receiving contracted care. If not under a hospital contract, a patient must be separated from one hospital and admitted to the other hospital on each occasion of transfer.

An overnight-stay patient of a hospital (originating hospital) who attends another hospital (the destination hospital) on a contracted basis is to be regarded by the originating hospital as an overnight-stay patient, as if the patient had not left for contracted hospital care.

Treatment provided to an intended same-day patient who is subsequently classified as an overnight-stay patient is regarded as part of the overnight episode.

A non-admitted (emergency/outpatient) service provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care.

Patients who leave of their own accord, die or are transferred on their first day in hospital are not overnight-stay patients.

Related data: supersedes previous Overnight-stay patient, version 2

relates to concept Admitted patient, version 3

Administrative attributes

Source organisation: National Health Data Committee

Patient

Admin. status: CURRENT 1/07/1995

Identifying and definitional attributes

Knowledgebase ID: 000117 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A patient is a person for whom a hospital accepts responsibility for treatment and/or care. There are two categories of patient, admitted and non-admitted patients. Boarders are not patients.

Context: Admitted patient care: and public hospital establishments.

Relational and representational attributes

Related data: relates to concept Admitted patient, version 3

Administrative attributes

Source organisation: National Health Data Committee

Comments: While the concept of a person for whom a service provider accepts responsibility for treatment or care is also applicable to non-admitted patient and public hospital establishments care and to welfare services, different terminology is often used in these other care settings e.g. client, resident.

Person identifier

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000127 Version number: 1

Data element type: DATA ELEMENT

Definition: Person identifier unique within establishment or agency.

Context: This item could be used for editing at the establishment or collection authority level and, potentially, for episode linkage. There is no intention that this item would be available beyond collection authority level.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. Max. Layout: Optional

Data domain: Valid patient identification number

Guide for use: Individual establishments or collection authorities may use their own alphabetic, numeric or alphanumeric coding systems.

Administrative attributes

Source organisation: National minimum data set working parties

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Admitted patient mental health care	from 1/07/2000 to
Perinatal	from 1/07/1997 to
Community mental health care	from 1/07/2000 to
Admitted patient palliative care	from 1/07/2000 to
Alcohol and other drug treatment services	from 1/07/2000 to

Comments: For admitted patient care statistics, person identifier used in conjunction with other data elements recording individual episodes of care or events. To date, there has been limited development of patient-based data i.e. linking data within hospital morbidity collections about all episodes of care for individuals.

Same-day patient

Admin. status: CURRENT 1/07/1994

Identifying and definitional attributes

Knowledgebase ID: 000146 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A same-day patient is a patient who is admitted and separates on the same date, and who meets one of the following minimum criteria:

- That the patient receive Same-day Surgical and Diagnostic Services as specified in bands 1A, 1B, 2, 3, and 4 but excluding uncertified type C Professional Attention Procedures within the Health Insurance Basic Table as defined in s.4 (1) of the National Health Act 1953 (Cwlth); or
- That the patient receive type C Professional Attention Procedures as specified in the Health Insurance Basic Table as defined in s.4 (1) of the National Health Act 1953 (Cwlth) with accompanying certification from a medical practitioner that an admission was necessary on the grounds of the medical condition of the patient or other special circumstances that relate to the patient.

Context: Admitted patient care:

Relational and representational attributes

Guide for use: Same-day patients may be either intended to be separated on the same day, or intended overnight-stay patients who left of their own accord, died or were transferred on their first day in the hospital.

Treatment provided to an intended same-day patient who is subsequently classified as an overnight-stay patient shall be regarded as part of the overnight episode.

Non-admitted (emergency or outpatient) services provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care.

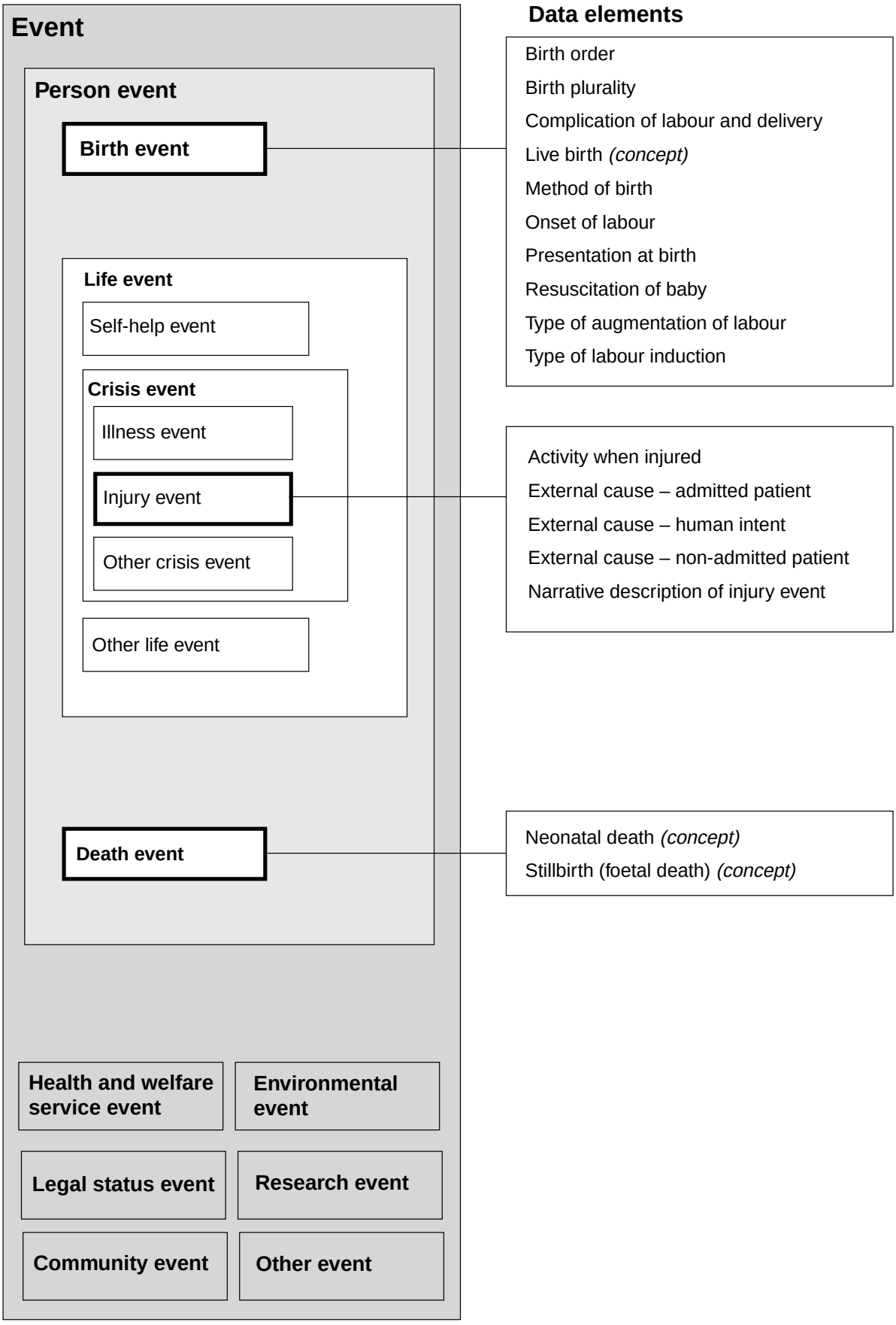
Data on same-day patients are derived by a review of admission and separation dates.

Related data: relates to concept Admitted patient, version 3

Administrative attributes

Source organisation: National Health Data Committee

National Health Information Model entity



Birth order

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000019 Version number: 1

Data element type: DATA ELEMENT

Definition: The order of each baby of a multiple birth.

Context: Perinatal: required to analyse pregnancy outcome according to birth order and identify the individual baby resulting from a multiple birth pregnancy. Multiple births have higher risks of perinatal mortality and morbidity. Multiple birth pregnancies are often associated with obstetric complications, labour and delivery complications, higher rates of neonatal morbidity, low birthweight, and a higher perinatal death rate.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Singleton or first of a multiple birth
2	Second of a multiple birth
3	Third of a multiple birth
4	Fourth of a multiple birth
5	Fifth of a multiple birth
6	Sixth of a multiple birth
8	Other
9	Not stated

Related data: is a qualifier of Birth plurality, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/1997 to

Birth plurality

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000020 Version number: 1

Data element type: DATA ELEMENT

Definition: The total number of births resulting from this pregnancy.

Context: Perinatal: multiple pregnancy increases the risk of complications during pregnancy, labour and delivery and is associated with higher risk of perinatal morbidity and mortality.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Singleton
2	Twins
3	Triplets
4	Quadruplets
5	Quintuplets
6	Sextuplets
8	Other
9	Not stated

Guide for use: Plurality of a pregnancy is determined by the number of live births or by the number of foetuses that remain in utero at 20 weeks gestation and that are subsequently born separately. In multiple pregnancies, or if gestational age is unknown, only live births of any birthweight or gestational age, or foetuses weighing 400 g or more, are taken into account in determining plurality. Foetuses aborted before 20 completed weeks or foetuses compressed in the placenta at 20 or more weeks are excluded.

Related data: is qualified by Birth order, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/1997 to

Complication of labour and delivery

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000027 Version number: 2

Data element type: DATA ELEMENT

Definition: Medical and obstetric complications (necessitating intervention) arising after the onset of labour and before the completed delivery of the baby and placenta.

Context: Perinatal: complications of labour and delivery may cause maternal morbidity and may affect the health status of the baby at birth.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 3 Max. 6 Layout: ANN.NN

Data domain: ICD-10-AM (2nd edition)

Guide for use: There is no arbitrary limit on the number of conditions specified.

Verification rules: Complications should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM (2nd edition)

Related data: used in conjunction with Presentation at birth, version 1

used in conjunction with Method of birth, version 1

used in conjunction with Perineal status, version 1

supersedes previous data element Complication of labour and delivery—ICD-9-CM code, version 1

used in conjunction with Postpartum complication, version 2

Administrative attributes

Source document: International Statistical Classification of Diseases and Related health Problems—10th Revision, Australian Modification 2nd Edition (July 2000) National Centre for Classification in Health, Sydney.

Source organisation: National Perinatal Data Development Committee

Live birth

Admin. status: CURRENT 1/07/1994

Identifying and definitional attributes

Knowledgebase ID: 000083 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A live birth is defined by the World Health Organization to be the complete expulsion or extraction from the mother of a baby, irrespective of the duration of the pregnancy which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.

Context: Perinatal:

Relational and representational attributes

Related data: relates to Status of the baby, version 1

Administrative attributes

Source document: International Classification of Diseases and Related Health Problems, 10th Revision, Vol. 1, WHO 1992

Source organisation: National Health Data Committee, National Perinatal Data Development Committee

Method of birth

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000093 Version number: 1

Data element type: DATA ELEMENT

Definition: The method of complete expulsion or extraction from its mother of a product of conception.

Context: Perinatal: the method of delivery may affect the health status of the mother and the baby at birth and during the postpartum period.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Spontaneous vaginal
2	Forceps (assisted vaginal birth)
3	Vaginal breech
4	Caesarean section
5	Vacuum extraction
8	Other
9	Not stated

Guide for use: In a vaginal breech with forceps to the aftercoming head, code as vaginal breech.

Related data: used in conjunction with Presentation at birth, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/1997 to

Onset of labour

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000113 Version number: 2

Data element type: DATA ELEMENT

Definition: Manner in which labour started.

Context: Perinatal: how labour commenced is closely associated with method of birth and maternal and neonatal morbidity. Induction rates vary for maternal risk factors and obstetric complications and are important indicators of obstetric intervention.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Spontaneous
2 Induced
3 No labour
9 Not stated

Guide for use: Labour commences at the onset of regular uterine contractions, which act to produce progressive cervical dilatation, and is distinct from spurious labour or pre-labour rupture of membranes.

Verification rules: 'No labour' can only be associated with caesarean section.

Collection methods: If prostaglandins were given to induce labour and there is no resulting labour until after 24 hours, then code the onset of labour as spontaneous.

Related data: supersedes previous data element Onset of labour, version 1

used in conjunction with Type of labour induction, version 1

used in conjunction with Method of birth, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/2000 to

Presentation at birth

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000133 Version number: 1

Data element type: DATA ELEMENT

Definition: Presenting part of the foetus (at lower segment of uterus) at birth.

Context: Perinatal: presentation types other than vertex are associated with higher rates of caesarean section, instrumental delivery, perinatal mortality and neonatal morbidity.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Vertex
2	Breech
3	Face
4	Brow
8	Other
9	Not stated

Related data: used in conjunction with Method of birth, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Resuscitation of baby

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000145 Version number: 2

Data element type: DATA ELEMENT

Definition: Active measures taken immediately after birth to establish independent respiration and heart beat, or to treat depressed respiratory effort and to correct metabolic disturbances.

Context: Perinatal: required to analyse need for resuscitation after complications of labour and delivery and to evaluate level of services needed for different birth settings.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	None
2	Suction only
3	Oxygen therapy only
4	Intermittent positive pressure respiration (IPPR) through bag and mask
5	Endotracheal intubation and IPPR
6	External cardiac massage and ventilation
9	Not stated

Guide for use: This item does not include drug therapy. Code the most severe measure used. If oxygen is given by bag and mask without IPPR, code as 'oxygen therapy'.

Related data: supersedes previous Resuscitation of baby, version 1

used in conjunction with Status of the baby, version 1

used in conjunction with Apgar score at 1 minute, version 1

used in conjunction with Apgar score at 5 minutes, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Type of augmentation of labour

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000167 Version number: 2

Data element type: DATA ELEMENT

Definition: Methods used to assist progress of labour.

Context: Perinatal: type of augmentation determines the progress and duration of labour and may influence the method of delivery and the health status of the baby at birth.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

0	None
1	Oxytocin
2	Prostaglandins
3	Artificial rupture of membranes (ARM)
4	Other
5	Not stated

Guide for use: More than one method of augmentation can be recorded, except where 0=none applies.

Verification rules: Collection units need to edit carefully the use of prostaglandins as an augmentation method. Results from checking records have shown that either the onset of labour was incorrect or that the augmentation method was incorrectly selected.

Related data: supersedes previous Type of augmentation of labour, version 1

used in conjunction with Onset of labour, version 2

used in conjunction with Type of labour induction, version 1

used in conjunction with Method of birth, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/2000 to

Comments: Prostaglandin is listed as a method of augmentation in the data domain. Advice from RANZCOG and the manufacturer indicates that vaginal prostaglandin use is not recommended or supported as a method of augmentation of labour as it may significantly increase the risk of uterine hyperstimulation. In spite of this, the method is being used and it is considered important to monitor its use for augmentation.

Type of labour induction

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000171 Version number: 1

Data element type: DATA ELEMENT

Definition: Methods used to induce labour.

Context: Perinatal: type of induction determines the progress and duration of labour and may influence the method of delivery and the health status of the baby at birth.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

0	None
1	Oxytocin
2	Prostaglandins
3	Artificial rupture of membranes (ARM)
4	Other

Guide for use: More than one method of induction can be recorded, except where 0=none applies.

Related data: used in conjunction with Onset of labour, version 2

used in conjunction with Type of augmentation of labour, version 2

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Activity when injured

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000002 Version number: 2

Data element type: DATA ELEMENT

Definition: The type of activity being undertaken by the person when injured.

Context: Injury surveillance: enables categorisation of injury and poisoning according to factors important for injury control. Necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research. This item is the basis for identifying work-related and sport-related injuries.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 2 Layout: NN

Data domain:

0	Sports activity
00	Football, rugby
01	Football, Australian
02	Football, soccer
03	Hockey
04	Squash
05	Basketball
06	Netball
07	Cricket
08	Roller blading
09	Other and unspecified sporting activity
1	Leisure activity (excluding sporting activity)
2	Working for income
3	Other types of work
4	Resting, sleeping, eating or engaging in other vital activities
5	Other specified activities
9	Unspecified activities

Guide for use: Admitted patients: Use the appropriate codes as fourth and fifth characters to Y93 when using the ICD-10-AM (2nd edition). Used with ICD-10-AM external cause codes V01–Y34 and assigned according to the Australian Coding Standards.

Non-admitted patients: To be used for injury surveillance purposes for non-admitted patients when it is not possible to use ICD-10-AM codes. Select the code which best characterises the type of activity being

undertaken by the person when injured, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list

Verification rules: Admitted patients: to be used with ICD-10-AM (2nd edition) external cause codes V01 –Y34 only.

Related data: supersedes previous data element Activity when injured—version 1
used in conjunction with External Cause—major external cause, version 3
used in conjunction with External cause—human intent, version 4
is a qualifier of Narrative description of injury event, version 1
used in conjunction with Nature of main injury —non-admitted patient, version 1
used in conjunction with Bodily location of main injury, version 1

Administrative attributes

Source document: ICD-10-AM (2nd edition)

Source organisation: National Centre for Classification in Health, National Injury Surveillance Unit

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Injury surveillance	from 1/07/2000 to

External cause—admitted patient

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000053 Version number: 4

Data element type: DATA ELEMENT

Definition: Environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect.

Context: Injury surveillance: Enables categorisation of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research. It is also used as a quality of care indicator of adverse patient outcomes.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 3 Max. 6 Layout: ANN.NN

Data domain: ICD-10-AM (2nd edition)

Guide for use: This code must be used in conjunction with an injury or poisoning codes and can be used with other disease codes. Admitted patients should be coded to the complete ICD-10-AM (2nd edition) classification.

An external cause code should be sequenced following the related injury or poisoning code, or following the group of codes, if more than one injury or condition has resulted from this external cause. Provision should be made to record more than one external cause if appropriate.

External cause codes in the range W00 to Y34, except Y06 and Y07 must be accompanied by a place of occurrence code (data element Place of occurrence of external cause).

External cause codes V01 to Y34 must be accompanied by an activity code (data element Activity when injured).

Verification rules: As a minimum requirement, the external cause codes must be listed in the ICD-10-AM (2nd edition) classification.

Related data: used in conjunction with Activity when injured, version 2

used in conjunction with Place of occurrence of external cause, version 2

supersedes previous data element External cause—admitted patient—ICD-9-CM code, version 3

used in conjunction with Principal diagnosis, version 3

used in conjunction with Additional diagnosis, version 4

Administrative attributes

Source document: International Statistical Classification of Diseases and Related Health Problems—Tenth Revision—Australian Modification 2nd Edition (July 2000) National Centre for Classification in Health, Sydney.

Source organisation: National Health Data Committee, National Centre for Classification in Health and National Data Standards for Injury Surveillance Advisory Group

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Injury surveillance	from 1/07/1989 to

Comments: An extended activity code is being developed in consultation with the National Injury Surveillance Unit, Flinders University, Adelaide.

External cause—human intent

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000382 Version number: 4

Data element type: DATA ELEMENT

Definition: The most likely role of human intent in the occurrence of the injury or poisoning as assessed by clinician.

Context: Injury surveillance: enables categorisation of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain:

01	Accident—injury not intended
02	Intentional self harm
03	Sexual assault
04	Maltreatment by parent
05	Maltreatment by spouse or partner
06	Other and unspecified assault
07	Event of undetermined intent
08	Legal intervention (including police) or operations of war
09	Adverse effect or complications of medical and surgical care
10	Other specified intent
11	Intent not specified

Guide for use: Select the item which best characterises the role of intent in the occurrence of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list.

This item must always be accompanied by an External cause—non-admitted patient code.

This data domain is for use in injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM code (e.g. non-admitted patients in Emergency Departments).

Related data: supersedes previous External cause—human intent, version 3

used in conjunction with Place of occurrence of external cause of injury, version 5

used in conjunction with Narrative description of injury event, version 1

used in conjunction with Nature of main injury—non-admitted patient, version 1

used in conjunction with Bodily location of main injury, version 1

used in conjunction with Activity when injured, version 2

Administrative attributes

Source organisation: National Health Data Committee; National Data Standards for Injury Surveillance Advisory Group

National minimum data sets:

Injury surveillance from 1/07/1989 to

External cause—non-admitted patient

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000381 Version number: 4

Data element type: DATA ELEMENT

Definition: Event, circumstance or condition associated with the occurrence of injury, poisoning or adverse effect.

Context: Injury surveillance: enables categorisation of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain:

01	Motor vehicle—driver
02	Motor vehicle—passenger or unspecified occupant
03	Motorcycle—driver
04	Motorcycle—passenger or unspecified
05	Pedal cyclist or pedal cycle passenger
06	Pedestrian
07	Other or unspecified transport-related circumstance
08	Horse-related (includes fall from, struck or bitten by)
09	Fall—low (on same level or < 1 metre or no information on height)
10	Fall—high (drop of 1 metre or more)
11	Drowning, submersion—swimming pool
12	Drowning, submersion—other than swimming pool (excludes drowning associated with water craft [07])
13	Other threat to breathing (including strangling and asphyxiation)
14	Fire, flames, smoke
15	Hot drink, food, water, other fluid, steam, gas or vapour
16	Hot object or substance, not otherwise specified
17	Poisoning—drugs or medicinal substance
18	Poisoning—other substance
19	Firearm
20	Cutting, piercing object
21	Dog-related
22	Animal-related (excluding Horse [08] and Dog [21])
23	(deleted)
24	Machinery in operation
25	Electricity
26	Hot conditions (natural origin) sunlight

Data domain (continued):	27	Cold conditions (natural origins)
	28	Other specified external cause
	29	Unspecified external cause
	30	Struck by or collision with person
	31	Struck by or collision with object

Guide for use: This data domain is for use in injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM (2nd edition) code (e.g. Non-admitted patients in Emergency Departments).

Select the item which best characterises the circumstances of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate select the one that comes first in the code list.

The External cause—non-admitted patient group must always be accompanied by an External cause—human intent code (see data element External cause—human intent—injury surveillance).

Related data: supersedes previous External cause—major external cause, version 3

used in conjunction with Place of occurrence of external cause of injury, version 5

used in conjunction with Narrative description of injury event, version 1

used in conjunction with Nature of main injury—non-admitted patient, version 1

used in conjunction with Bodily location of main injury, version 1

used in conjunction with Activity when injured, version 2

used in conjunction with External cause—human intent, version 4

Administrative attributes

Source organisation: National Health Data Committee; National Centre for Classification in Health; and National Data Standards for Injury Surveillance Advisory Group

Comments: This item has been developed to cater for the information requirements of the wide range of settings undertaking injury surveillance who do not have the capability of recording the complete ICD-10-AM external cause codes. This code list has been derived from the ICD-10-AM external cause classification. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Narrative description of injury event

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000099 Version number: 1

Data element type: DATA ELEMENT

Definition: A text description of the injury event.

Context: Injury surveillance: the narrative of the injury event is very important to injury control workers as it identifies features of the event not revealed by coded data.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 0 Max. 100 Layout: free text

Data domain: Text up to 100 characters in length

Guide for use: Write a brief description of how the injury occurred. It should indicate what went wrong (the breakdown event), the mechanism by which this event led to injury and the object(s) or substance(s) most important in the event. The type of place at which the event occurred, and the activity of the person who was injured should also be indicated.

Related data: is qualified by External cause—human intent, version 3

is qualified by Activity when injured, version 2

Administrative attributes

Source organisation: National Injury Surveillance Unit

National minimum data sets:

Injury surveillance from 1/07/1989 to

Comments: This is a basic item for injury surveillance. The text description of the injury event is structured to indicate context, place, what went wrong and how the event resulted in injury. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Neonatal death

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000101 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: The death of a live birth which occurs during the first 28 days of life. This may be subdivided into early neonatal deaths, occurring during the first seven days of life, and late neonatal deaths, occurring after the seventh day but before 28 completed days of life.

Context: Perinatal:

Relational and representational attributes

Related data: relates to Status of the baby, version 1

Administrative attributes

Source document: International Classification of Diseases, 10th Revision, WHO, 1992

Source organisation: National Perinatal Data Development Committee

Comments: Age at death during the first day of life (day zero) should be recorded in units of completed minutes or hours of life. For the second (day one), third (day two) and through 27 completed days of life, age at death should be recorded in days (WHO 1992).

Stillbirth (foetal death)

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000160 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A foetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more birthweight; the death is indicated by the fact that after such separation the foetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

Context: Perinatal:

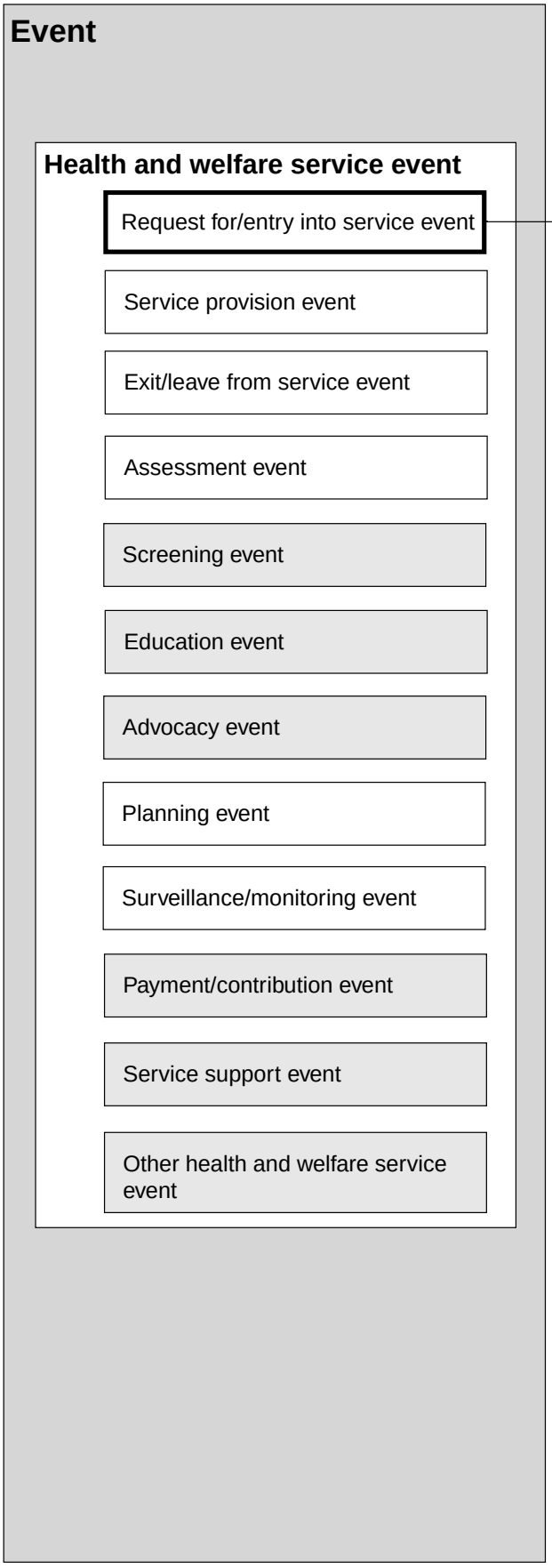
Administrative attributes

Source organisation: National Perinatal Data Development Committee

Comments: The WHO definition of live birth, and the legal definition used in Australian States and Territories, do not specify any lower limit for gestational age or birthweight. In practice, liveborn foetuses of less than 20 weeks' gestation are infrequently registered as live births. In analysing data from the perinatal collections, it is recommended that the same criteria of gestational age and birthweight should be used for live births and stillbirths. Births for which gestational age and birthweight have not been recorded (usually occurring outside hospitals) should be included in the perinatal collections if it seems likely that the criteria have been met.

Terminations of pregnancy performed at gestational ages of 20 or more weeks should be included in perinatal collections and should be recorded either as stillbirths or, in the unlikely event of showing evidence of life, as live births.

National Health Information Model entity



Data elements

- Admission *(concept)*
- Admission date
- Admission time
- Client type
- Commencement of treatment episode for alcohol and other drugs *(concept)*
- Contract establishment identifier
- Contract procedure flag
- Contract role
- Contract type
- Contracted care commencement date
- Date of commencement of treatment episode for alcohol and other drugs
- Date of first contact
- Date patient presents
- Hospital waiting list *(concept)*
- Listing date for care
- Mode of admission
- Patient listing status
- Patient presentation at Emergency Department *(concept)*
- Previous specialised treatment
- Reason for removal from elective surgery waiting list
- Source of referral to alcohol and other drug treatment service
- Source of referral to public psychiatric hospital
- Time patient presents
- Type of residential aged care admission
- Type of visit to emergency department
- Waiting list category

Admission

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000007 Version number: 3

Data element type: DATA ELEMENT CONCEPT

Definition: Admission is the process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specified criteria that a patient requires same-day or overnight care or treatment. An admission may be formal or statistical.

Formal admission: The administrative process by which a hospital records the commencement of treatment and/or care and/or accommodation of a patient.

Statistical admission is the administrative process by which a hospital records the commencement of a new episode of care, with a new care type, for a patient within one hospital stay.

Context: Admitted patient care:

Relational and representational attributes

Guide for use: This treatment and/or care provided to a patient following admission occurs over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).

Related data: supersedes previous data element concept Admission, version 2

relates to concept Episode of care, version 1

relates to concept Admitted patient, version 3

relates to Admission date, version 4

relates to Admission time, version 2

relates to concept Separation, version 3

Administrative attributes

Source organisation: National Health Data Committee

Comments: See the data element concept Admitted patient for the minimum criteria which must be met before a patient can be admitted to hospital.

Admission date

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000008 Version number: 4

Data element type: DATA ELEMENT

Definition: Date on which an admitted patient commences an episode of care.

Context: Required to identify the period in which the admitted patient episode and hospital stay occurred and for derivation of length of stay.

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid date

Verification rules: Right justified and zero filled.

Admission date ≤ separation date.

Admission date ≥ date of birth

Related data: is used in the calculation of Length of stay, version 3

supersedes previous data element Admission date, version 3

is used in the derivation of Diagnosis related group, version 1

is used in the calculation of Emergency Department waiting time to admission, version 1

relates to Type of visit to Emergency Department, version 2

relates to Departure status, version 1

used in conjunction with Care type, version 4

relates to concept Admitted patient, version 3

is used in the calculation of Waiting time at admission, version 1

relates to concept Admission, version 3

relates to Admission time, version 2

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Admitted patient mental health care	from 1/07/2000 to
Admitted patient palliative care	from 1/07/2000 to

Admission time

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000358 Version number: 2

Data element type: DATA ELEMENT

Definition: Time at which an admitted patient commences an episode of care.

Context: Admitted patient care: Required to identify the time of commencement of the episode or hospital stay, for calculation of waiting times and length of stay.

Relational and representational attributes

Datatype: Numeric Field size: Min. 4 Max. 4 Layout: HHMM

Data domain: Expressed as hours and minutes using 24-hour clock

Related data: relates to Type of visit to Emergency Department, version 2
supersedes previous data element Admission time, version 1
relates to Departure status, version 1
relates to concept Admitted patient, version 3
relates to concept Admission, version 3
used in conjunction with Admission date, version 4

Administrative attributes

Source organisation: National Health Data Committee

Client type

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000426 Version number: 1

Data element type: DATA ELEMENT

Definition: The status of a person in terms of whether contact with the service concerns their own alcohol and/or other drug use or that of another person.

Context: Alcohol and other drug treatment services: Required to differentiate between clients to provide a basis for description of the people accessing alcohol and other drug treatment services.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Own drug use

2 Other's drug use

3 Both own and other's drug use

9 Not stated/inadequately described

Guide for use:

Code 1 A client who contacts a service to receive treatment or assistance concerning their own alcohol and/or other drug use. These clients are sometimes referred to as primary clients..

Code 2 A client who contacts a service to receive support and/or assistance in relation to the alcohol and/or other drug use of another person. These clients are sometimes referred to as secondary clients.

Code 3 A client who contacts a service to receive treatment or assistance concerning both their own alcohol and/or other drug use and the alcohol and/or other drug use of another person.

Collection methods: To be collected on commencement of treatment with a service.

Administrative attributes

Source organisation: Intergovernmental Committee on Drugs NMDS-WG

National minimum data sets:

Alcohol and other drug treatment services from 1/07/2000 to

Commencement of treatment episode for alcohol and other drugs

Admin. status: CURRENT 01/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000427 Version number: 2

Data element type: DATA ELEMENT CONCEPT

Definition: Commencement of a treatment episode for alcohol and other drugs is the first service contact when assessment and/or treatment occurs with the treatment provider.

Context: Alcohol and other drug treatment services:

Relational and representational attributes

Guide for use: A client is identified as commencing a treatment episode if one or more of the following apply:

- they are a new client;
- they are a client recommencing treatment after they have had no contact with the treatment provider for a period of three months or had any plan in place for further contact;
- their 'principal drug of concern for alcohol and other drugs' has changed;
- their 'main treatment type for alcohol and other drugs' has changed; or
- their 'treatment delivery setting for alcohol and other drugs' has changed.

Related data: supersedes previous concept Commencement of treatment, version 1

relates to the data element Date of commencement of treatment episode for alcohol and other drugs, version 2

Administrative attributes

Source organisation: Intergovernmental Committee on Drugs NMDS-WG

Contract establishment identifier

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000416 Version number: 1

Data element type: DATA ELEMENT

Definition: The establishment identifier of the other hospital involved in the contracted care.

Context: Admitted patient care: and public hospital establishments.

Relational and representational attributes

Datatype: Numeric Field size: Min. 6 Max. 6 Layout: NNANNN

Data domain: Valid identification number

Guide for use: The contracted hospital will record the establishment identifier of the contracting hospital.

The contracting hospital will record the establishment identifier of the contracted hospital.

Related data: relates to Establishment identifier, version 3

relates to concept Contracted hospital care, version 1

relates to Contract type, version 1

relates to Contract role, version 1

relates to Contracted care commencement date, version 1

relates to Contracted care completion date, version 1

relates to Total contract patient days, version 1

relates to Contract procedure flag, version 1

Contract procedure flag

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000417 Version number: 1

Data element type: DATA ELEMENT

Definition: Designation that a procedure was not performed in this hospital but was performed by another hospital as a contracted service.

Context: Admitted patient care:

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Contracted admitted procedure

2 Contracted non-admitted procedure

Otherwise blank

Guide for use: Procedures performed at another hospital under contract (Hospital B) are recorded by both hospitals, but flagged by the contracting hospital only (Hospital A). This flag is to be used by the contracting hospital to indicate a procedure performed by a contracted hospital. It also indicates whether the procedure was performed as an admitted or non-admitted service.

Allocation of procedure codes should not be affected by the contract status of an episode: the Australian Coding Standards should be applied when coding all episodes. In particular, procedures which would not otherwise be coded should not be coded solely because they were performed at another hospital under contract.

Procedures performed by a health care service (i.e. not a recognised hospital) should be coded if appropriate. Some jurisdictions may require these to be separately identified and they could be distinguished from contracted hospital procedures through the use of an additional code in the contract procedure flag data item.

Related data: relates to concept Contracted hospital care, version 1

relates to Contract type, version 1

relates to Contract role, version 1

relates to Contract establishment identifier, version 3

relates to Contracted care commencement date, version 1

relates to Contracted care completion date, version 1

relates to Total contract patient days, version 1

Contract role

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000418 Version number: 1

Data element type: DATA ELEMENT

Definition: Identifies whether the hospital is the purchaser of hospital care (contracting hospital) or the provider of an admitted or non-admitted service (contracted hospital).

Context: Admitted patient care: and public hospital establishments.

Relational and representational attributes

Datatype: Alphabetic Field size: Min. 1 Max. 1 Layout: A

Data domain:

A Hospital A

B Hospital B

Guide for use: Hospital A is the contracting hospital (purchaser).

Hospital B is the contracted hospital (provider).

Related data: relates to concept Contracted hospital care, version 1

relates to Contract type, version 1

relates to Contract establishment identifier, version 3

relates to Contracted care commencement date, version 1

relates to Contracted care completion date, version 1

relates to Total contract patient days, version 1

relates to Contract procedure flag, version 1

Contract type

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000419 Version number: 1

Data element type: DATA ELEMENT

Definition: Contract Type describes the contract arrangement between the contractor and the contracted hospital. Contract types are distinguished by the physical movement of the patient between the contracting (where applicable) and contracted hospitals.

Context: Admitted patient care: and public hospital establishments.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Contract type B

2 Contract type ABA

3 Contract type AB

4 Contract type (A)B

5 Contract type BA

Guide for use: The contracting hospital (purchaser) is termed Hospital A.

The contracted hospital (provider) is termed Hospital B.

1 Contract Type B

A health authority/other external purchaser contracts hospital B for admitted service which is funded outside the standard funding arrangements.

2 Contract Type ABA

- Patient admitted by Hospital A.
- Hospital A contracts Hospital B for admitted or non-admitted patient service.
- Patient returns to Hospital A on completion of service by Hospital B.

Example: a patient has a hip replacement at Hospital A, then receives aftercare at Hospital B, under contract to Hospital A. Complications arise and the patient returns to Hospital A for the remainder of care.

3 Contract Type AB

- Patient admitted by Hospital A.
- Hospital A contracts Hospital B for admitted or non-admitted patient service.
- Patient does not return to Hospital A on completion of service by Hospital B.

Example: a patient has a hip replacement at Hospital A and then receives aftercare at Hospital B, under contract to Hospital A. Patient is separated from Hospital B.

Guide for use (continued):

4 Contract Type (A)B

This contract type occurs where a Hospital A contracts Hospital B for the whole episode of care. The patient does not attend Hospital A.

Example: a patient is admitted for endoscopy at Hospital B under contract to Hospital A.

5 Contract Type BA

Hospital A contracts Hospital B for an admitted patient service following which the patient moves to Hospital A for remainder of care.

Example: a patient is admitted to Hospital B for a gastric resection procedure under contract to Hospital A and Hospital A provides after care.

Related data:

relates to concept Contracted hospital care, version 1

relates to Contract role, version 1

relates to Contract establishment identifier, version 3

relates to Contracted care commencement date, version 1

relates to Contracted care completion date, version 1

relates to Total contract patient days, version 1

relates to Contract procedure flag, version 1

Contracted care commencement date

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000420 Version number: 1

Data element type: DATA ELEMENT

Definition: The date the period of contracted care commenced.

Context: Admitted patient care:

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid dates

Guide for use: This item is to be used by the contracting hospital to record the commencement date of the contracted hospital care and will be the admission date for the contracted hospital.

Related data: relates to concept Contracted hospital care, version 1

relates to Contract type, version 1

relates to Contract role, version 1

relates to Contract establishment identifier, version 3

relates to Contracted care completion date, version 1

relates to Total contract patient days, version 1

relates to Contract procedure flag, version 1

Administrative attributes

Source organisation: National Health Data Committee

Date of commencement of treatment episode for alcohol and other drugs

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000430 Version number: 2

Data element type: DATA ELEMENT

Definition: Date on which a treatment episode for alcohol and other drugs commences.

Context: Alcohol and other drug treatment services: Required to identify the commencement of a treatment episode by an alcohol and other drug treatment service.

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid dates

Guide for use: The first date of the treatment episode is the first service contact within the treatment episode when assessment and/or treatment occurs.

Verification rules: Must be earlier than or the same as the 'Date of cessation of treatment episode for alcohol and other drugs'.

Related data: supersedes previous concept Commencement of treatment, version 1

relates to the concept Commencement of treatment episode for alcohol and other drugs, version 2

Administrative attributes

Source organisation: Intergovernmental Committee on Drugs NMDS-WG

National minimum data sets:

Alcohol and other drug treatment services from 01/07/2000

Date of first contact

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000039 Version number: 2

Data element type: DATA ELEMENT

Definition: The date of first contact with the community nursing service for an episode of care, between a staff member and a person or a person's family.

The definition includes:

- visits made to a person in institutional settings such as liaison visits or discharge planning visits, made in a hospital or residential aged care service with the intent of planning for the future delivery of service at home;
- telephone contacts when these are in lieu of a first home or hospital visit for the purpose of preliminary assessment for care at home;
- visits made to the person's home prior to admission for the purpose of assessing the suitability of the home environment for the person's care.

This applies irrespective of whether the person is present or not.

The definition excludes first visits where the visit objective is not met, such as first visit made where no one is home.

Context: To enable analysis of time periods throughout a care episode, especially the pre-admission period and associated activities. This data element enables the capture of the commencement of care irrespective of the setting in which the activities took place.

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid date

Verification rules: This should occur after a previous Date of last contact of a previous care episode and prior to or on the same as Date of first delivery of service.

Collection methods: The Date of first contact can be the same as Date of first delivery of service and apply whether a person is entering care for the first time or any subsequent episode. This date should be recorded when it is the same as the first delivery of service date.

Related data: supersedes Date of first contact, version 1

relates to Date of last contact, version 2

Administrative attributes

Source organisation: Australian Council of Community Nursing Services

Comments: This item is recommended for use in community services which are funded for liaison or discharge planning positions or provide specialist consultancy or assessment services. Further developments in community care, including casemix and coordinated care will require collection of data relating to resource expenditure across the sector.

Date patient presents

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000350 Version number: 2

Data element type: DATA ELEMENT

Definition: The day on which the patient/client presents for the delivery of a service.

Context: Admitted patient care:

Community health care:

Hospital non-admitted patient care:

required to identify commencement of a visit and for calculation of waiting times.

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid dates

Guide for use: For community health care, outreach services and services provided via telephone or telehealth, this may be the date on which the service provider presents to the patient or the telephone/telehealth session commences.

The time of patient presentation at the Emergency Department is the earliest occasion of being registered clerically or triaged.

The date that the patient presents is not necessarily

- the listing date for care (see Listing date for care data element concept), nor
- the date on which care is scheduled to be provided, nor
- the date on which commencement of care actually occurs (for admitted patients see Admission date, for hospital non-admitted patient care and community health care see Date of commencement of service event).

Related data: supersedes previous Date patient presents, version 1

relates to Admission date, version 4

relates to Emergency Department waiting time to service delivery, version 1

relates to Emergency Department waiting time to admission, version 1

relates to concept Patient presentation at Emergency Department, version 1

relates to Time patient presents, version 2

relates to Type of visit to Emergency Department, version 2

relates to Date of triage, version 1

relates to Time of triage, version 1

relates to Triage category, version 1

relates to Date of commencement of service event, version 2

relates to Time of commencement of service event, version 2

Administrative attributes

Source organisation: National Institution Based Ambulatory Model Reference Group; NHDC

National minimum data sets:

Emergency Department waiting times — from 1/07/1999 to

Comments: This data element is required to identify commencement of a visit and for calculation of waiting times. It supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Hospital waiting list

Admin. status: CURRENT 1/07/1995

Identifying and definitional attributes

Knowledgebase ID: 000067 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A register which contains essential details about patients who have been assessed as needing elective hospital care.

Context: Admitted patient care:

Relational and representational attributes

Related data: relates to Patient listing status, version 3

relates to Waiting list category, version 3

Listing date for care

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000082 Version number: 3

Data element type: DATA ELEMENT

Definition: The date on which a hospital or a community health service accepts notification that a patient/client requires care/treatment.

Context: Hospital non-admitted patient care:

Community health care:

Elective surgery (admitted patient care):

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid dates

Guide for use: The acceptance of the notification by the hospital or community health service is conditional upon the provision of adequate information about the patient and the appropriateness of the patient referral.

For elective surgery, the listing date is the date on which the patient is added to an elective surgery waiting list.

Related data: supersedes previous data element Listing date, version 2

is used in conjunction with Patient listing status, version 3

is used in conjunction with Scheduled admission date, version 2

is used in the calculation of Waiting time at a census date, version 1

is used in the calculation of Waiting time at admission, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/1994 to

Comments: The hospital or community health service should only accept a patient onto the waiting list when sufficient information has been provided to fulfil State/Territory, local and national reporting requirements.

Mode of admission

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000385 Version number: 4

Data element type: DATA ELEMENT

Definition: Describes the mechanism by which a person begins an episode of care.

Context: To assist in analyses of intersectoral patient flow and health care planning.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Admitted patient transferred from another hospital

2 Statistical admission—episode type change

3 Other

Guide for use: Code 2—use this code where a new episode of care is commenced within the same hospital stay.

Code 3—use this code for all planned admissions and unplanned admissions (except transfers into the hospital from another hospital).

Related data: supersedes Source of referral to acute hospital or private psychiatric hospital, version 3

supplements the data element Mode of separation, version 3

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Admitted patient palliative care	from 1/07/2000 to

Patient listing status

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000120 Version number: 3

Data element type: DATA ELEMENT

Definition: An indicator of the person's readiness to begin the process leading directly to being admitted to hospital for the awaited procedure. A patient may be 'ready for care' or 'not ready for care'.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Ready for care

2 Not ready for care

Guide for use: Ready for care patients are those who are prepared to be admitted to hospital or to begin the process leading directly to admission. These could include investigations/procedures done on an outpatient basis, such as autologous blood collection, pre-operative diagnostic imaging or blood tests.

Not ready for care patients are those who are not in a position to be admitted to hospital. These patients are either:

- staged patients whose medical condition will not require or be amenable to surgery until some future date; for example, a patient who has had internal fixation of a fractured bone and who will require removal of the fixation device after a suitable time; or
- deferred patients who for personal reasons are not yet prepared to be admitted to hospital; for example, patients with work or other commitments which preclude their being admitted to hospital for a time.

Not ready for care patients could be termed staged and deferred waiting list patients, although currently health authorities may use different terms for the same concepts.

Staged and deferred patients should not be confused with patients whose operation is postponed for reasons other than their own unavailability; for example, surgeon unavailable, operating theatre time unavailable owing to emergency workload. These patients are still 'ready for care'. Periods when patients are not ready for care should be excluded in determining 'Waiting time at admission' and 'Waiting time at a census date'.

Related data: relates to concept Hospital waiting list, version 1

supersedes previous data element Patient listing status, version 2

used in conjunction with Waiting list category, version 3

is a qualifier of Category reassignment date, version 2

Administrative attributes

Source organisation: Hospital Access Program Waiting Lists Working Group/Waiting Times Working Group/National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/1994 to

Comments:

Only patients ready for care are to be included in the National Minimum Data Set—waiting times. The dates when a patient listing status changes need to be recorded. A patient's classification may change if he or she is examined by a clinician during the waiting period, i.e. undergoes clinical review. The need for clinical review varies with the patient's condition and is therefore at the discretion of the treating clinician. The waiting list information system should be able to record dates when the classification is changed (data element Category reassignment date).

At the Waiting Times Working Group meeting on 9 September 1996, it was agreed to separate data elements Patient listing status and Clinical urgency as the combination of these items had led to confusion.

Patient presentation at Emergency Department

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000349 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: The presentation of a patient at an Emergency Department occurs following the arrival of the patient at the Emergency Department and is the earliest occasion of being:

- registered clerically; or
- triaged

Context: Admitted patient care:

Relational and representational attributes

Guide for use: Provided with a service by a treating medical officer or nurse. (In hospital data collection systems, the time and date of the first contact would be selected from the earliest three different recorded times.)

The act of receiving treatment in the Emergency Department is logically preceded by some form of triage event—either formally or informally. For instance, a patient may be so critically ill that they by-pass the formal triage process to receive resuscitative intervention. However, the act of prioritising access to care according to the level of need has still occurred.

Administrative attributes

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Previous specialised treatment

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000139 Version number: 3

Data element type: DATA ELEMENT

Definition: Whether a patient has had a previous admission or service contact for treatment in the specialty area within which treatment is now being provided.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Patient has no previous admission(s) or service contact(s) for the specialised treatment now being provided
2	Patient has previous hospital admission(s) but no service contact(s) for the specialised treatment now being provided
3	Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided
4	Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided
5	Unknown/not stated

Guide for use: For codes 2–4 Includes patients who have been seen at any time in the past within the speciality within which the patient is currently being treated (mental health or palliative care), regardless of whether it was part of the current episode or a previous admission/service contact many years in the past. Use these codes regardless of whether the previous treatment was provided within the service in which the person is now being treated, or another equivalent specialised service (either institutional or community-based).

Admitted patients, whose only prior specialised treatment contact was the service contact that referred the patient for admission should be coded as category 1.

Related data: supersedes previous data element First admission for psychiatric treatment, version 2

relates to concept Service contact, version 1

Administrative attributes

Source organisation: National Health Data Committee/National Mental Health Information Strategy Committee

National minimum data sets:

Admitted patient mental health care	from 1/07/2000 to
Admitted patient palliative care	from 1/07/2000 to

Comments:

This data item was originally developed in the context of mental health admitted patient care data development (originally 'Problem status' and later 'First admission for psychiatric treatment'). More recent data development work, particularly in the area of palliative care, led to the need for this data item to be re-worded in more generic terms for inclusion in other data sets.

For palliative care, the value of this data element is in its use in enabling approximate identification of the number of new palliative care patients receiving specialised treatment. The use of this data element in this way would be improved by the reporting of this data by community-based services.

Reason for removal from elective surgery waiting list

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000142 Version number: 3

Data element type: DATA ELEMENT

Definition: The reason why a patient is removed from the waiting list.

Context: Elective surgery: routine admission for the awaited procedure is only one reason why patients are removed from the waiting list. Each reason for removal provides different information. These data are necessary to augment census and throughput data. For example, after an audit the numbers of patients on a list would be expected to reduce. If an audit were undertaken immediately prior to a census the numbers on the list may appear low and not in keeping with the number of additions to the list and patients admitted from the list.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Admitted as an elective patient for awaited procedure in this hospital
2	Admitted as an emergency patient for awaited procedure in this hospital
3	Could not be contacted (includes patients who have died while waiting whether or not the cause of death was related to the condition requiring treatment)
4	Treated elsewhere for awaited procedure
5	Surgery not required or declined
9	Not known

Guide for use: Patients undergoing the awaited procedure whilst admitted for another reason are to be coded as code 1.

Code 2 identifies patients who were admitted ahead of their normal position in the queue because the condition requiring treatment deteriorated whilst waiting. Admission as an emergency patient could also be due to other causes such as inappropriate urgency rating, delays in the system, or unpredicted biological variation.

Codes 3–5 provide an indication of the amount of clerical audit of the waiting lists. Code 4 gives an indication of patients treated in other hospitals for the awaited procedure. The procedure may have been performed as an emergency or as an elective procedure.

Code 9 identifies patients removed from the waiting list for reasons unknown.

Related data: supersedes previous data element Reason for removal, version 2

Administrative attributes

Source organisation: Hospital Access Program Waiting Lists Working Group/Waiting Times Working Group/National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 01/07/1994 to

Source of referral to alcohol and other drug treatment service

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000444 Version number: 1

Data element type: DATA ELEMENT

Definition: The source from which the person was transferred or referred care to the alcohol and other drug treatment service.

Context: Alcohol and other drug treatment services: Source of referral is important in assisting in the analyses of inter-sectoral patient/client flow and for health care planning.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 2 Layout: NN

Data domain:

1	Self
2	Family member/friend
3	General practitioner
4	Medical specialist
5	Psychiatric hospital
6	Other hospital
7	Residential community mental health care unit
8	Residential alcohol and other drug treatment/care unit
9	Other residential community care unit
10	Non-residential medical and/or allied health care agency
11	Non-residential community mental health care agency or outpatient clinic
12	Non-residential alcohol and other drug treatment agency or outpatient clinic
13	Other non-residential community health care agency or outpatient clinic
14	Other community service agency
15	Community based corrections
16	Police diversion
17	Court diversion
18	Other
99	Not stated/inadequately described

Guide for use:

3	General practitioner includes vocationally registered general practitioners, vocationally registered general practitioner trainees and other primary-care medical practitioners in private practice.
4	Includes specialists in private practice.
5–6	Includes public and private hospitals, hospitals specialising in dental, ophthalmic aids and other specialised medical or surgical care, satellite units managed and staffed by a hospital, Emergency Departments of hospitals, and Mothercraft hospitals. Excludes outpatient clinics (which should be coded to 14–17), Non-residential community health care agencies or outpatient clinics.

Guide for use:

7–9 Includes settings in which persons reside temporarily at an accommodation unit providing support, non-acute care and other services to people with particular personal, social or behavioural problems. Includes mental health care units for people with severe mental illness or severe psychosocial disability and drug and alcohol residential treatment units.

10 Non-residential service centres that operate a range of medical and/or allied health services from a centre-based establishment, including blood donation centres, breast-screening clinics, dental clinics, general medical centres, HIV or AIDS clinics, sexual health clinics; day procedure centres or facilities, Aboriginal medical centres. Excludes any of the above operating from hospital outpatient clinics, which should be coded to 17 Other non-residential community health care agency or outpatient clinic.

11–13 Non-residential centre-based establishments providing a range of community-based health services, including community health centres, family planning centres, maternal and child health centres, migrant women's health centres, multipurpose health centres.

14 Includes Home and Community Care agencies, Aged Care Assessment Teams, agencies providing care or assistance to persons in their own homes, child care centres/pre-schools or kindergartens, community centres, family support services, domestic violence and incest resource centres or services, Aboriginal cooperatives.

Administrative attributes

National minimum data sets:

Alcohol and other drug treatment services — from 1/07/2000 to

Source of referral to public psychiatric hospital

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000150 Version number: 3

Data element type: DATA ELEMENT

Definition: Source from which the person was transferred/referred to the public psychiatric hospital.

Context: To assist in analyses of intersectoral patient flow and health care planning.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain:

01	Private psychiatric practice
02	Other private medical practice
03	Other public psychiatric hospital
04	Other health care establishment
05	Other private hospital
06	Law enforcement agency
07	Other agency
08	Outpatient department
09	Other
10	Unknown

Related data: supersedes previous Source of referral, version 2

supplements Mode of separation, version 3

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Admitted patient mental health care	from 1/07/2000 to

Time patient presents

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000351 Version number: 2

Data element type: DATA ELEMENT

Definition: The time at which the patient presents for the delivery of a service.

Context: Admitted patient care:

Community health care:

Hospital non-admitted patient care:

required to identify commencement of a visit and for calculation of waiting times.

Relational and representational attributes

Datatype: Numeric Field size: Min. 4 Max. 4 Layout: HHMM

Data domain: Expressed as hours and minutes using 24-hour clock

Guide for use: For community health care, outreach services and services provided via telephone or telehealth, this may be the time at which the service provider presents to the patient or the telephone/telehealth session commences.

The time of patient presentation at the Emergency Department is the earliest occasion of being registered clerically or triaged.

The time that the patient presents is not necessarily

- the listing time for care (see Listing date for care data element concept for an analogous concept), nor
- the time at which care is scheduled to be provided, nor
- the time at which commencement of care actually occurs (for admitted patients see Admission time, for hospital non-admitted patient care and community health care see Time of commencement of service event).

Related data: supersedes previous Time patient presents, version 1

relates to Admission time, version 2

relates to Emergency Department waiting time to service delivery, version 1

relates to Emergency Department waiting time to admission, version 1

relates to Date patient presents, version 2

relates to Date of triage, version 1

relates to Time of triage, version 1

relates to Triage category, version 1

relates to Date of commencement of service event, version 2

relates to concept Patient presentation at Emergency Department, version 1

relates to Time of commencement of service event, version 2

Administrative attributes

Source organisation: National Institution Based Ambulatory Model Reference Group; NHDC

National minimum data sets:

Emergency Department waiting times from 1/07/1999 to

Comments: This data element is required to identify commencement of a visit and for calculation of waiting times. It supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Type of residential aged care service admission

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000172 Version number: 1

Data element type: DATA ELEMENT

Definition: Type of admission distinguishes respite/crisis care episodes from other residential aged care services episodes.

Context: Residential aged care service statistics: this item will assist in analyses of demand for institutional services and planning studies.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Respite/crisis care (short-term admission, usually in order to give a carer respite from the provision of care

2 Other (continuing care)

Collection methods: This item is based on the form NH5, which has been replaced.

Administrative attributes

Source organisation: National minimum data set working parties

Type of visit to Emergency Department

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000352 Version number: 2

Data element type: DATA ELEMENT

Definition: The reason the patient presents to the Emergency Department.

Context: Hospital non-admitted patient care: Required for analysis of Emergency Department services.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Emergency presentation: attendance for an actual or suspected condition which is sufficiently serious to require acute unscheduled care.
2	Return visit, planned: presentation is planned and is a result of a previous Emergency Department presentation or return visit.
3	Pre-arranged admission: a patient who presents at the Emergency Department for either clerical, nursing or medical processes to be undertaken, and admission has been pre-arranged by the referring medical officer and a bed allocated.
4	Patient in transit: the Emergency Department is responsible for care and treatment of a patient awaiting transport to another facility.
5	Dead on arrival: a patient who is dead on arrival at the Emergency Department.

Related data: supersedes Type of visit to Emergency Department, version 2

relates to Emergency Department waiting time to service delivery, version 1

relates to Emergency Department waiting time to admission, version 1

relates to concept Patient presentation at Emergency Department, version 1

relates to Triage category, version 1

Administrative attributes

Source organisation: National Institution Based Ambulatory Model Reference Group; NHDC

National minimum data sets:

Emergency Department waiting times from 1/07/1999 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Waiting list category

Admin. status: CURRENT 1/01/1995

Identifying and definitional attributes

Knowledgebase ID: 000176 Version number: 3

Data element type: DATA ELEMENT

Definition: The type of elective hospital care that a patient requires.

Context: Admitted patients: hospitals maintain waiting lists which may include patients awaiting hospital care other than elective surgery—for example, dental surgery and oncology treatments. This item is necessary to distinguish patients awaiting elective surgery (code 1) from those awaiting other types of elective hospital care (code 2).

The waiting period for patients awaiting transplant or obstetric procedures is largely independent of system resource factors.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Elective surgery

2 Other

Guide for use: Elective surgery comprises elective care where the procedures required by patients are listed in the surgical operations section of the Medicare Benefits Schedule, with the exclusion of specific procedures frequently done by non-surgical clinicians.

Elective care is care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least twenty-four hours.

Patients awaiting the following procedures should be classified as Code 2—other:

- organ or tissue transplant procedures
- procedures associated with obstetrics (e.g. elective caesarean section, cervical suture)
- cosmetic surgery, i.e. when the procedure will not attract a Medicare rebate
- biopsy of:
  - kidney (needle only)
  - lung (needle only)
  - liver and gall bladder (needle only)
- bronchoscopy (including fibre-optic bronchoscopy)
- peritoneal renal dialysis; haemodialysis
- colonoscopy
- endoscopic retrograde cholangio-pancreatography (ERCP)
- endoscopy of:
  - biliary tract
  - oesophagus
  - small intestine
  - stomach

Guide for use (continued):

- endovascular interventional procedures
- gastroscopy
- miscellaneous cardiac procedures
- oesophagoscopy
- panendoscopy (except when involving the bladder)
- proctosigmoidoscopy
- sigmoidoscopy
- anoscopy
- urethroscopy and associated procedures
- dental procedures not attracting a Medicare rebate
- other diagnostic and non-surgical procedures.

These procedure terms are also defined by the ICD-10-AM (International Statistical Classification of Diseases and Related Health Problems—Tenth Revision—Australian Modification (2nd edition) National Centre for Classification in Health, Sydney) codes which are listed under Comments below. This coded list is the recommended, but optional, method for determining whether a patient is classified as requiring elective surgery or other care.

All other elective surgery should be included in waiting list Code 1—elective surgery.

Related data: relates to concept Elective care, version 1

supersedes previous data element Waiting list category—ICD-9-CM code, version 2

used in conjunction with Patient listing status, version 3

is supplemented by the data element Indicator procedure, version 3

Administrative attributes

Source document: International Statistical Classification of Diseases and Related Health Problems—Tenth Revision—Australian Modification (2nd edition) National Centre for Classification in Health, Sydney.

Source organisation: Hospital Access Program Waiting Lists Working Group/Waiting Times Working Group/National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/1994 to

Comments: The table of ICD-10-AM procedure codes was prepared by the National Centre for Classification in Health. Some codes were excluded from the list on the basis that they are usually performed by non-surgeon clinicians.

A more extensive and detailed listing of procedure descriptors is under development. This will replace the list in the Guide for use above, to facilitate more readily the identification of the exclusions when the list of codes is not used.

ICD-10-AM CODES FOR THE EXCLUDED PROCEDURES:

Organ or tissue transplant

90172–00 [555] 30204–00 [659] 90204–01 [659] 13706–08 [802] 90172–01 [555] 90324–00 [981] 90205–00 [660] 36503–00 [1057] 13706–00 [802] 13706–06 [802] 13706–07 [802] 13700–00 [801] 36503–01 [1057] 30375–21 [817] 90317–00 [954] 90324–00 [981] 14203–01 [1906]

Comments (continued): Procedures associated with obstetrics

16511–00 [1274] 16512–00 [1274] 90467–00 [1336] 90469–00 [1338] 90469–01 [1338] 90470–00 [1339] 90468–00 [1337] 90468–01 [1337] 90472–00 [1343] 90470–02 [1339] 90470–01 [1339] 90470–04 [1339] 90470–03 [1339] 90468–02 [1337] 90468–04 [1337] 90478–00 [1334] 90477–00 [1343] 90465–03 [1342] 90477–00 [1343] 90466–00 [1335] 90466–01 [1335] 90466–02 [1335] 90466–01 [1335] 90471–01 [1342] 90471–02 [1342] 90471–03 [1342] 16564–00 [1345] 16564–01 [1345] 90465–04 [1334] 90471–05 [1342] 90471–04 [1342] 90468–05 [1337] 90465–00 [1334] 90465–01 [1334] 90465–02 [1334] 90471–06 [1342] 90476–00 [1343] 90471–00 [1342] 90473–00 [1343] 90474–00 [1343] 90475–00 [1343] 90477–00 [1343] 16567–00 [1347] 16520–01 [1340] 16520–02 [1340] 16520–03 [1340] 16520–00 [1340] 16603–00 [1795] 16627–00 [1330] 90461–00 [1330] 16600–00 [1330] 16618–00 [1330] 16609–00 [1330] 16612–00 [1330] 16615–00 [1330] 16624–00 [1331] 90486–00 [1333] 90486–01 [1333] 90486–02 [1333] 90460–00 [1330] 16514–00 [1341] 16514–01 [1341] 16606–00 [1330] 90464–00 [1332] 90482–00 [1345] 90463–00 [1330] 16621–00 [1330] 16571–00 [1344] 90485–00 [1344] 90480–00 [1344] 90480–01 [1344] 90481–00 [1344] 16573–00 [1344] 90483–00 [1347] 16567–00 [1347] 90484–00 [1347] 90484–02 [1347] 90484–01 [1347] 16570–01 [1346] 16570–00 [1346]

Biopsy (needle) of:

Kidney 36561–00 [1046]

Lung 38412–00 [550]

liver and gall bladder 30409–00 [953] 30412–00 [953] 90319–01 [951] 30094–04 [964]

Bronchoscopy

41889–00 [543] 41892–00 [544] 41904–00 [546] 41764–02 [416] 41895–00 [544] 41764–04 [532] 41892–01 [545] 41901–00 [545] 41846–00 [520] 41898–00 [543] 41898–01 [544] 41889–01 [543] 41849–00 [520] 41764–03 [520] 41855–00 [520]

Peritoneal renal dialysis

13100–06 [1060] 13100–07 [1060] 13100–08 [1060] 13100–00 [1059]

Endoscopy of biliary tract, ERCP

30484–00 [957] 30484–01 [957] 30484–02 [974] 30494–00 [971] 30452–00 [971] 30491–00 [958] 30491–01 [963] 30485–00 [958] 30485–01 [963] 30452–01 [963] 30450–00 [958] 30452–02 [959] 30485–01 [959] 90349–00 [975]

Endoscopy of oesophagus

30473–03 [850] 30473–04 [861] 41822–00 [861] 30478–11 [856] 41819–00 [862] 30478–10 [852] 30478–13 [861] 41816–00 [850] 41822–00 [861] 41825–00 [852] 30478–12 [856] 41831–00 [862] 30478–12 [856] 30490–00 [853] 30479–00 [856]

Endoscopy of small intestine

30473–00 [1005] 30473–01 [1008] 32095–00 [891] 30569–00 [894] 30478–04 [1008] 30478–02 [1007] 30478–03 [1007] 30478–00 [1006] 30568–00 [893]

Endoscopy of stomach

30473–00 [1005] 30476–03 [874] 30473–01[1008] 30478–01 [1007] 30478–04 [1008] 30478–02 [1007] 30478–03 [1007] 30478–00 [1006] 30473–02 [1005]

Endoscopy of large intestine, colonoscopy, proctosigmoidoscopy, sigmoidoscopy, anoscopy

32090–00 [905] 32090–01 [911] 90315–00 [943] 90308–00 [908] 32093–00 [911] 32084–00 [905] 32084–01 [911] 30479–02 [908] 32087–00 [911] 30479–01[930] 32075–00 [904] 32075–01 [910] 32078–00 [910] 32081–00 [910] 32072–00 [904] 32072–01 [910] 32171–00 [938]

Comments (continued): Miscellaneous cardiac

38200–00 [667] 38203–00 [667] 38206–00 [667] 38212–00 [665] 38209–00 [665] 38278–00 [648] 38278–01 [648] 38284–00 [648] 38470–00 [649] 38473–00 [649] 38278–02 [654] 38456–07 [654] 90203–00 [654] 38284–00 [654] 38256–00 [647] 38256–01 [647] 38256–02 [647] 90202–00 [649] 90219–00 [663] 38253–00 [652] 38253–01 [650] 38253–02 [650] 38253–03 [650] 38253–04 [650] 38253–05 [650] 38253–06 [650] 38253–07 [651] 38253–08 [651] 38253–09 [651] 38253–10 [651] 38253–11 [655] 38253–12 [655] 35315–00 [758] 35315–01 [758] 35324–00 [740] 38603–00 [642] 38600–00 [642]

Endovascular interventional

35304–01 [670] 35305–00 [670] 35310–00 [971] 35310–01 [671] 35310–03 [671] 35310–04 [671] 35310–02 [671] 35310–05 [671] 34524–00 [694] 90220–00 [738] 35304–00 [670] 32500–01 [722] 32500–00 [722]

Urethroscopy

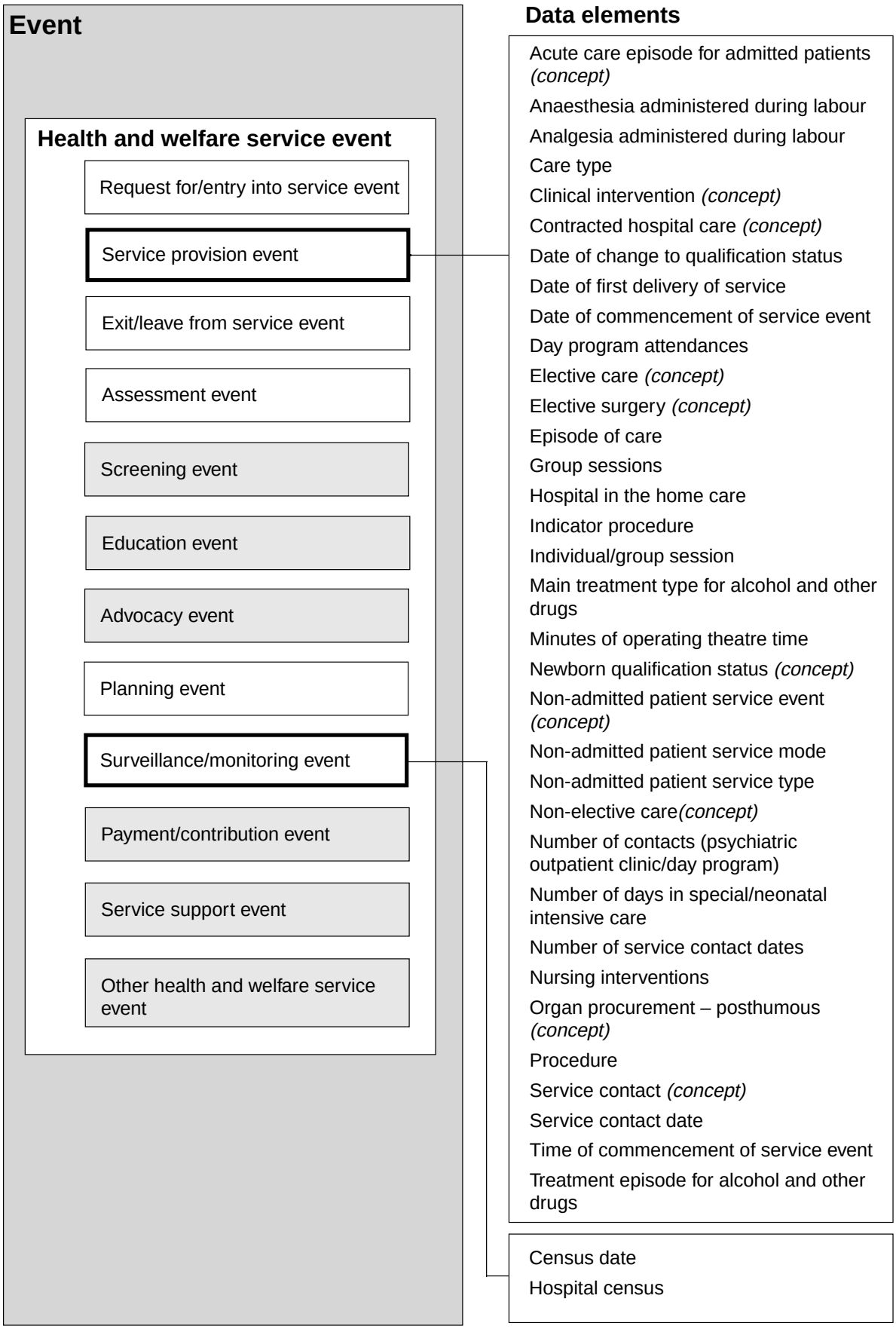
36800–00 [1089] 36800–01 [1089] 37011–00 [1092] 37008–01 [1092] 37008–00 [1092] 37315–00 [1111] 37315–01 [1115] 37318–01 [1115] 36815–01 [1115] 37854–00 [1115] 37318–04 [1116] 35527–00 [1115]

Dental–Blocks [450] to [490]

Other diagnostic and non–surgical

90347–01 [983] 90760–00 [1780] 90767–00 [1780] 13915–00 [1780] 13918–00 [1780] 13921–00 [1780] 13927–00 [1780] 13939–00 [1780] 13942–00 [1780] 90768–00 [1780] Blocks [1820] to 1939], [1940] to [2016]

National Health Information Model entity



Acute care episode for admitted patients

Admin. status: CURRENT 1/07/1995

Identifying and definitional attributes

Knowledgebase ID: 000004 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: An episode of acute care for an admitted patient is one in which the principal clinical intent is to do one or more of the following:

- manage labour (obstetric);
- cure illness or provide definitive treatment of injury;
- perform surgery;
- relieve symptoms of illness or injury (excluding palliative care);
- reduce severity of illness or injury;
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions;
- perform diagnostic or therapeutic procedures.

Context: Admitted patient care:

Relational and representational attributes

Related data: relates to Care type, version 4

Administrative attributes

Source organisation: National Health Data Committee

Anaesthesia administered during labour

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000013 Version number: 1

Data element type: DATA ELEMENT

Definition: Anaesthesia administered for the operative delivery of the baby (caesarean, forceps or vacuum extraction).

Context: Perinatal: anaesthetic use may influence the duration of labour, may affect the health status of the baby at birth and is an indicator of obstetric intervention.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	None
2	Local anaesthetic to perineum
3	Pudendal
4	Epidural or caudal
5	Spinal
6	General
8	Other
9	Not stated

Guide for use: If more than one agent is used, select the largest number (excluding 8 or 9) as this is how the data are tabulated.

Related data: used in conjunction with Method of birth, version 1

used in conjunction with Apgar score, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Analgesia administered during labour

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000014 Version number: 1

Data element type: DATA ELEMENT

Definition: Agents administered to the mother by injection or inhalation to relieve pain during labour and delivery.

Context: Perinatal: analgesia use may influence the duration of labour, may affect the health status of the baby at birth and is an indicator of obstetric intervention.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	None
2	Nitrous oxide
3	Intra-muscular narcotics
4	Epidural/caudal
5	Spinal
8	Other
9	Not stated

Guide for use: If more than one agent is used, select the largest number (excluding 8 or 9) as this is how the data will be tabulated.

Related data: used in conjunction with Method of birth, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Care type

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000168 Version number: 4

Data element type: DATA ELEMENT

Definition: The care type defines the overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (other care).

Context: Admitted patient care: and hospital activity. For admitted patients, the type of care received will determine the appropriate casemix classification employed to classify the episode of care.

Relational and representational attributes

Datatype: Numeric Field size: Min. 3 Max. Layout: (N)N.N

Data domain:

Admitted care:

1.0 Acute care
2.0 Rehabilitation care
2.1 Rehabilitation care delivered in a designated unit (optional)
2.2 Rehabilitation care according to a designated program (optional)
2.3 Rehabilitation care is the principal clinical intent (optional)
3.0 Palliative care
3.1 Palliative care delivered in a designated unit (optional)
3.2 Palliative care according to a designated program (optional)
3.3 Palliative care is the principal clinical intent (optional)
4.0 Geriatric evaluation and management
5.0 Psychogeriatric care
6.0 Maintenance care
7.0 Newborn care
8.0 Other admitted patient care

Other care:

9.0 Organ procurement—posthumous
10.0 Hospital boarder

Guide for use: Persons with mental illness may receive any one of the care types (except newborn and organ procurement). Classification depends on the principal clinical intent of the care received. Admitted care can be one of the following:

1.0 Acute care is care in which the clinical intent or treatment goal is to:

- manage labour (obstetric);
- cure illness or provide definitive treatment of injury;
- perform surgery;
- relieve symptoms of illness or injury (excluding palliative care);
- reduce severity of an illness or injury;

Guide for use (continued):

- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function; and/or
- perform diagnostic or therapeutic procedures.

2.0 Rehabilitation care is care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap. It is usually evidenced by a multi-disciplinary rehabilitation plan comprising negotiated goals and indicative time frames which are evaluated by a periodic assessment using a recognised functional assessment measure. It includes care provided:

- in a designated rehabilitation unit (code 2.1), or
- in a designated rehabilitation program, or in a psychiatric rehabilitation program as designated by the state health authority for public patients in a recognised hospital, for private patients in a public or private hospital as approved by a registered health benefits organisation (code 2.2), or
- under the principal clinical management of a rehabilitation physician or, in the opinion of the treating doctor, when the principal clinical intent of care is rehabilitation (code 2.3).

Optional categories

2.1 A designated rehabilitation care unit (code 2.1) is a dedicated ward or unit (and can be a stand-alone unit) that receives identified funding for rehabilitation care and/or primarily delivers rehabilitation care.

2.2 In a designated rehabilitation care program (code 2.2), care is delivered by a specialised team of staff who provide rehabilitation care to patients in beds that may or may not be dedicated to rehabilitation care. The program may, or may not be funded through identified rehabilitation care funding. Code 2.1 should be used instead of code 2.2 if care is being delivered in a designated rehabilitation care program and a designated rehabilitation care unit.

2.3 Rehabilitation as principal clinical intent (code 2.3) occurs when the patient is primarily managed by a medical practitioner who is a specialist in rehabilitation care or when, in the opinion of the treating medical practitioner, the care provided is rehabilitation care even if the doctor is not a rehabilitation care specialist. The exception to this is when the medical practitioner is providing care within a designated unit or a designated program, in which case code 2.1 or 2.2 should be used, respectively.

3.0 Palliative care is care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and a grief and bereavement support service for the patient and their carers/family. It includes care provided:

- in a palliative care unit (code 3.1); or
- in a designated palliative care program (code 3.2); or
- under the principal clinical management of a palliative care physician or, in the opinion of the treating doctor, when the principal clinical intent of care is palliation (code 3.3).

Optional categories

3.1 A designated palliative care unit (code 3.1) is a dedicated ward or unit (and can be a stand-alone unit) that receives identified funding for palliative care and/or primarily delivers palliative care.

3.2 In a designated palliative care program (code 3.2), care is delivered by a specialised team of staff who provide palliative care to patients in beds that may or may not be dedicated to palliative care. The program may, or may not be funded through identified palliative care funding. Code 3.1 should be used instead of code 3.2 if care is being delivered in a designated palliative care program and a designated palliative care unit.

Guide for use (continued):

3.3 Palliative care as principal clinical intent (code 3.3) occurs when the patient is primarily managed by a medical practitioner who is a specialist in palliative care or when, in the opinion of the treating medical practitioner, the care provided is palliative care even if the doctor is not a palliative care specialist. The exception to this is when the medical practitioner is providing care within a designated unit or a designated program, in which case code 3.1 or 3.2 should be used, respectively. For example, code 3.3 would apply to a patient dying of cancer who was being treated in a geriatric ward without specialist input by palliative care staff.

4.0 Geriatric evaluation and management is care in which the clinical intent or treatment goal is to maximise health status and/or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, who is usually (but not always) an older patient. This may also include younger adults with clinical conditions generally associated with old age. This care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. Geriatric evaluation and management includes care provided:

- in a geriatric evaluation and management unit; or
- in a designated geriatric evaluation and management program; or
- under the principal clinical management of a geriatric evaluation and management physician or, in the opinion of the treating doctor, when the principal clinical intent of care is geriatric evaluation and management.

5.0 Psychogeriatric care is care in which the clinical intent or treatment goal is improvement in health, modification of symptoms and enhancement in function, behaviour and/or quality of life for a patient with an age-related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance. The care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. It includes care provided:

- in a psychogeriatric care unit;
- in a designated psychogeriatric care program; or
- under the principal clinical management of a psychogeriatric physician or, in the opinion of the treating doctor, when the principal clinical intent of care is psychogeriatric care.

6.0 Maintenance care is care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment. Following assessment or treatment the patient does not require further complex assessment or stabilisation, and requires care over an indefinite period. This care includes that provided to a patient who would normally receive care in another setting e.g. at home, or in a residential aged care service, by a relative or carer, that is unavailable in the short term.

7.0 Newborn care is initiated when the patient is born in hospital or is nine days old or less at the time of admission. Newborn care continues until the care type changes or the patient is separated:

- patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders;
- patients who turn 10 days of age and require clinical care continue in a newborn episode of care until separated.
- patients aged less than 10 days and not admitted at birth (e.g. transferred from another hospital) are admitted with newborn care type;
- patients aged greater than 9 days not previously admitted (e.g. transferred from another hospital) are either boarders or admitted with an acute care type;

Guide for use (continued):

- within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day.
- a newborn is qualified when it meets at least one of the criteria detailed in Newborn qualification status.

Within a newborn episode of care, each day after the baby turns 10 days of age is counted as a qualified patient day.

Newborn qualified days are equivalent to acute days and may be denoted as such.

8.0 Other admitted patient care is care where the principal clinical intent does not meet the criteria for any of the above.

Other care can be one of the following:

(a) Organ procurement—posthumous is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead.

Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, should be recorded in accordance with the relevant ICD-10-AM Australian Coding Standards. These patients are not admitted to the hospital but are registered by the hospital.

(b) Hospital boarder is a person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.

Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

Related data: supersedes previous data element Type of episode of care, version 3

used in conjunction with Newborn qualification status, version 2

used in conjunction with Number of qualified) days for newborns, version 2

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Admitted patient mental health care	from 1/07/2000 to
Admitted patient palliative care	from 1/07/2000 to

Comments: Unqualified newborn days (and separations consisting entirely of unqualified newborn days are not to be counted under the Australian Health Care Agreements and they are ineligible for health insurance benefit purposes.

Clinical intervention

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000399 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: An intervention carried out to improve, maintain or assess the health of a person, in a clinical situation.

Clinical interventions include invasive and non-invasive procedures, and cognitive interventions.

Invasive:

(a) Therapeutic interventions where there is a disruption of the epithelial lining generally, but not exclusively, with an implied closure of an incision (e.g. operations such as cholecystectomy or administration of a chemotherapeutic drug through a vascular access device);

(b) Diagnostic interventions where an incision is required and/or a body cavity is entered (e.g. laparoscopy with/without biopsy, bone marrow aspiration).

Non-invasive:

Therapeutic or diagnostic interventions undertaken without disruption of an epithelial lining (e.g. lithotripsy, hyperbaric oxygenation; allied health interventions such as hydrotherapy; diagnostic interventions not requiring an incision or entry into a body part such as pelvic ultrasound, diagnostic imaging).

Cognitive:

An intervention which requires cognitive skills such as evaluating, advising, planning (e.g. dietary education, physiotherapy assessment, crisis intervention, bereavement counselling).

Context: Health services: Information about the surgical and non-surgical interventions provides the basis for analysis of health service usage, especially in relation to specialised resources, for example theatres and equipment or human resources.

Administrative attributes

Source organisation: National Health Data Committee

Comments: Classification and coding systems for procedures include the International Statistical Classification of Diseases and Related Health Problems—Tenth Revision—Australian Modification (2nd edition), (ICD-10-AM) and the International Classification of Primary Care (1987).

Contracted hospital care

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000337 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: Contracted hospital care is provided to a patient under an agreement between a purchaser of hospital care (contracting hospital or external purchaser) and a provider of an admitted or non-admitted service (contracted hospital).

Context: Admitted patient care:

Relational and representational attributes

Data domain: Valid dates

Guide for use: Related contracted hospital care data items should only be completed where services are provided which represent some, but not all of the contracted hospital's total services. It is not necessary to complete contracted hospital care data items where all of the hospital services are contracted by a health authority, e.g. privately owned and/or operated public hospitals.

Contracted hospital care must involve all of the following:

- a purchaser, which can be a public or private hospital, or a health authority (Department or Region) or another external purchaser; and
- a contracted hospital, which can be a public or private hospital or day procedure centre; and
- the purchaser paying the contracted hospital for the contracted service. Thus, services provided to a patient in a separate facility during their episode of care, where the patient is directly responsible for payment of this additional service, are not considered contracted services for reporting purposes; and
- the patient being physically present in the contracted hospital for the provision of the contracted service.

Thus, pathology or other investigations performed at another location on specimens gathered at the contracting hospital would not be considered contracted services for reporting purposes.

Allocation of diagnosis and procedure codes should not be affected by the contract status of an episode: the Australian Coding Standards should be applied when coding all episodes. In particular, procedures which would not otherwise be coded should not be coded solely because they were performed at another hospital under contract.

Procedures performed by a health care service (i.e. not a recognised hospital) should be coded if appropriate but are not considered to be contracted hospital procedures.

Any DRG derived for episodes involving contracted hospital care, should reflect the total treatment provided (all patient days and procedures), even where part of the treatment was provided under contract by another hospital.

Related data: relates to Contract type, version 1
relates to Contract role, version 1
relates to Contract establishment identifier, version 3
relates to Contracted care commencement date, version 1
relates to Contracted care completion date, version 1
relates to Total contract patient days, version 1
relates to Contract procedure flag, version 1

Administrative attributes

Source organisation: National Health Data Committee

Date of change to qualification status

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000342 Version number: 1

Data element type: DATA ELEMENT

Definition: The date, within a newborn episode of care, on which the newborn's Qualification status changes from acute (qualified) to unqualified or vice versa.

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid date

Guide for use: Record the date or dates on which the newborn's Qualification Status changes from acute (qualified) to unqualified or vice versa.

If more than one change of qualification status occurs on a single day, the day is counted against the final qualification status.

Verification rules: Must be greater than or equal to admission date

Related data: used in conjunction with Admitted patient, version 3

used in conjunction with Care type, version 4

used in conjunction with Newborn qualification status, version 2

is used in the calculation of Number of qualified days for newborns, version 2

Date of first delivery of service

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000038 Version number: 2

Data element type: DATA ELEMENT

Definition: The date of first delivery of service to a person in a non-institutional setting.

The definition excludes:

- visits made to persons in institutional settings such as liaison visits or discharge planning visits, made in a hospital or residential aged care service, with the intent of planning for the future delivery of community-based services;
- first visits where there is no contact with the person, such as a first visit where no-one is at home.
- telephone, letter or other such contacts made with the person prior to the first home visit.

In situations where the first delivery of service determines that no future visit needs to be made, the Date of first Delivery of service and the Date of last delivery of service will be the same.

Context: The Date of first delivery of service is used for the analysis of time periods within a care episode and to locate that episode in time. The date relates to the first delivery of formal services within the community setting.

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid dates

Verification rules: This date may occur on the same day or prior to the Date of last delivery of service, but must never occur after that date within the current episode of care. The date may be the same as the Date of first contact.

Collection methods: As long as contact is made with the person in a non-institutional setting, the Date of first delivery of service must be recorded. Normally this will be the first home or clinic visit and is the date most often referred to in a service agency as the admission. This date applies whether a person is being admitted for the first time, or is being re-admitted for care.

Related data: supersedes previous Date of first community nursing visit, version 1

relates to Date of first delivery of service, version 2

Administrative attributes

Source organisation: Australian Council of Community Nursing Services

Comments: This date marks the most standard event, which occurs at the beginning of an episode of care in community setting. It should not be confused with the Date of first contact with a community nursing service; although they could be the same, the dates for both items must be recorded. Agencies providing hospital in the Home services should develop their own method of distinguishing between the period the person remains a formal patient of the hospital, with funding to receive services at home, and the discharge of the person into the care of the community service.

Date of commencement of service event

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000356 Version number: 2

Data element type: DATA ELEMENT

Definition: The day on which the delivery of a service commences. The service is defined as commencing when a health care professional first takes responsibility for the patient/client's care.

Context: Hospital non—Admitted patient care:

Community health care.

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid dates

Guide for use: For the Emergency Department the date of triage is recorded separately. In an Emergency Department the service event commences when the medical officer (or, if no medical officer is on duty in the Emergency Department, a treating nurse) provides treatment or diagnostic service. The commencement of a service event does not include contact associated with triage.

Related data: supersedes Date of service event, version 1

relates to Emergency Department waiting time to service delivery, version 1

relates to Emergency Department waiting time to admission, version 1

relates to concept Patient presentation at Emergency Department, version 1

relates to Time of commencement of service event, version 2

relates to Date of triage, version 1

relates to Time of triage, version 1

relates to Date patient presents, version 2

relates to Time patient presents, version 2

Administrative attributes

Source organisation: National Institution Based Ambulatory Model Reference Group; NHDC

National minimum data sets:

Emergency Department waiting times from 1/07/1999 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Day program attendances

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000211 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: A count of the number of patient/client visits to day centres. Each individual is to be counted once for each time they attend a day centre. Where an individual is referred to another section of the hospital/centre and returns to the day centre after treatment only one visit is to be recorded.

Context: Required to measure adequately non-admitted patient services in psychiatric hospitals and alcohol and drug hospitals.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 5 Layout: NNNNN

Data domain: Number of attendances

Administrative attributes

Source organisation: National minimum data set working parties

Comments: Difficulties were envisaged in using the proposed definitions of an individual or group occasion of service for clients attending psychiatric day care centres. These individuals may receive both types of services during a visit to a centre.

This data element is derived from data elements that are not currently specified in the National Health Data Dictionary, but which are recorded in various ways by hospitals and/or outpatient departments. Examples include identifiers of individual consultations/visits, diagnostic tests, etc. Further specification/development of these data elements is expected as part of the National Institution Based Ambulatory Care Modelling (NIBAM) Project.

Elective care

Admin. status: CURRENT 1/07/1995

Identifying and definitional attributes

Knowledgebase ID: 000348 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: Care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least twenty-four hours.

Context: Admitted patient care:

Relational and representational attributes

Related data: relates to Waiting list category, version 3

Administrative attributes

Source organisation: Hospital Access Program Waiting List Working Group/National Health Data Committee

Elective surgery

Admin. status: CURRENT 1/07/1995

Identifying and definitional attributes

Knowledgebase ID: 000046 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: Elective care where the procedures required by patients are listed in the surgical operations section of the Medicare benefits schedule book, with the exclusion of specific procedures frequently done by non-surgical clinicians.

Context: Admitted patient care:

Relational and representational attributes

Related data: relates to Waiting list category, version 3

Administrative attributes

Source organisation: Hospital Access Program Waiting List Working Group/National Health Data Committee

Episode of care

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000445 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: The period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type.

Context: Admitted patient care:

Relational and representational attributes

Guide for use: This treatment and/or care provided to a patient during an episode of care can occur in hospital and/or in the person's home (for hospital-in-the-home patients).

Related data: relates to Care type, version 4

relates to concept Admitted patient, version 3

relates to Separation date, version 5

relates to concept Admission date, version 4

relates to concept Admission, version 3

relates to concept Separation, version 3

Administrative attributes

Source organisation: National Health Data Committee

Group sessions

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000210 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: The number of groups of patients/clients receiving services. Each group is to count once, irrespective of size or the number of staff providing services.

Context: The resources required to provide services to groups of patients are different from those required to provide services to an equivalent number of individuals. Hence services to groups of non-admitted patients or outreach clients should be counted separately from services to individuals.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 6 Layout: NNNNNN

Data domain: Number of groups receiving services

Collection methods: At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Administrative attributes

Source organisation: National minimum data set working parties

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Comments: This data element is derived from data elements that are not currently specified in the National Health Data Dictionary, but which are recorded in various ways by hospitals and/or outpatient departments. Examples include identifiers of individual consultations/visits, diagnostic tests, etc.

Hospital in the home care

Admin. status: DRAFT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000633 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: Provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary.

Context: Admitted patient care:

Relational and representational attributes

Guide for use: The criteria for inclusion as hospital in the home include but are not limited to:

- without hospital in the home care being available patients would be accommodated in the hospital;
- the treatment forms all or part of an episode of care for an admitted patient (as defined in the Admitted patient data element concept);
- the hospital medical record is maintained for the patient; and
- there is adequate provision for crisis care.

Selection criteria for the assessment of suitable patients include but are not limited to:

- the hospital deems the patient requires health care professionals funded by the hospital to take an active part in their treatment;
- the patient does not require continuous 24 hour assessment, treatment or observation;
- the patient agrees to this form of treatment;
- the patient's place of residence is safe and has carer support available;
- the patient's place of residence is accessible for crisis care; and
- the patient's place of residence has adequate communication facilities and access to transportation.

Related data: relates to concept Admitted patient, version 3

relates to concept Episode of care, version 1

Administrative attributes

Source organisation: National Health Data Committee

Indicator procedure

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000073 Version number: 3

Data elemvent type: DATA ELEMENT

Definition: An indicator procedure is a procedure which is of high volume, and is often associated with long waiting periods.

Context: Waiting list statistics for indicator procedures give a specific indication of performance in particular areas of elective care provision.

It is not always possible to code all elective surgery procedures at the time of addition to the waiting list. Reasons for this include that the surgeon may be uncertain of the exact procedure to be performed, and that the large number of procedures possible and lack of consistent nomenclature would make coding errors likely. Furthermore, the increase in workload for clerical staff may not be acceptable. However, a relatively small number of procedures account for the bulk of the elective surgery workload. Therefore, a list of common procedures with a tendency to long waiting times is useful.

Waiting time statistics by procedure are useful to patients and referring doctors. In addition, waiting time data by procedure assists in planning and resource allocation, audit and performance monitoring.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain:

01	Cataract extraction (includes: Intracapsular crystalline lens extraction, Extracapsular crystalline lens extraction by aspiration alone, Extracapsular crystalline lens extraction by phacoemulsification, Extracapsular crystalline lens extraction by mechanical phacofragmentation, Other extracapsular crystalline lens extraction, Other extraction of crystalline lens, Removal of juvenile cataract, Other application, insertion or removal procedures on lens)
02	Cholecystecomy (includes: Laparoscopic cholecystectomy, Cholecystectomy with choledochotomy, Cholecystectomy with choledochotomy and biliary intestinal anastomosis)
03	Coronary artery bypass graft
04	Cystoscopy (includes: Cystoscopy through artificial stoma, Endoscopic biopsy of bladder)
05	Haemorrhoidectomy (includes: Sclerotherapy for haemorrhoids, Rubber band ligation of haemorrhoids, Destruction of haemorrhoids, haemorrhoidectomy
06	Hysterectomy (includes: Abdominal hysterectomy, Vaginal Hysterectomy, Pelvic exenteration)
07	Inguinal herniorrhaphy (includes: Repair of inguinal hernia, Repair of incarcerated, obstructed or strangulated hernia)
08	Myringoplasty
09	Myringotomy (includes: Myringotomy with insertion of tube)

Data domain (continued):	10	Prostatectomy (includes: Transurethral prostatectomy, Other closed prostatectomy, Open prostatectomy, Endoscopic destruction of prostatic lesion, Endoscopic resection of prostatic lesion)
	11	Septoplasty (includes: Septoplasty, Septoplasty with submucous resection of nasal septum)
	12	Tonsillectomy (includes: Tonsillectomy without adenoidectomy, Tonsillectomy with adenoidectomy)
	13	Total hip replacement (includes: Total arthroplasty of hip (unilateral/bilateral), Revision of total arthroplasty of hip, Revision of total arthroplasty of hip with bone graft or allograft)
	14	Total knee replacement (includes: Total arthroplasty of knee (unilateral/bilateral), Total arthroplasty of knee with bone graft to femur or tibia, Revision of total arthroplasty of knee)
	15	Varicose veins stripping and ligation (includes: Interruption of sapheno-femoral or sapheno-popliteal junction varicose veins, Other destruction procedures on veins)
	16	Not applicable

Guide for use: The procedure terms are described using descriptive terms (above) and ICD-10-AM procedure codes (as listed in the Comments below). Either list may be used to determine if a procedure is an indicator procedure.

Where a patient is awaiting more than one indicator procedure, all codes should be listed. This is because the intention is to count procedures rather than patients in this instance. These are planned procedures for the waiting list, not what is actually performed during hospitalisation.

Verification rules: Zero filled, right justified.

Related data: supersedes previous Indicator procedure—ICD-9-CM code, version 2

supplements Waiting list category, version 3

is used in conjunction with Procedure, version 5

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 01/07/1994 to

Comments: The list of indicator procedures may be reviewed from time to time. Some health authorities already code a larger number of waiting list procedures.

The following is a list of ICD-10-AM codes, for the indicator procedures:

Cataract extraction:

42698–00 [195] 42702–00 [195] 42702–01 [195] 42698–01 [196] 42702–02 [196] 42702–03 [196] 42698–02 [197] 42702–04 [197] 42702–05 [197] 42698–03 [198] 42702–06 [198] 42702–07 [198] 42698–04 [199] 42702–08 [199] 42702–09 [199] 42731–01 [200] 42698–05 [200] 42702–10 [200] 42734–00 [201] 42788–00 [201] 42719–00 [201] 42731–00 [201] 42719–02 [201] 42791–02 [201] 42716–00 [202] 42702–11 [200] 42719–00 [201] 42722–00 [201]

Cholecystectomy

30443–00 [965] 30454–01 [965] 30455–00 [965] 30445–00 [965] 30446–00 [965] 30448–00 [965] 30449–00 [965]

Comments (continued): Coronary Artery Bypass Graft

38497–00 [672] 38497–01 [672] 39497–02 [672] 38497–03 [672] 38497–04 [673] 38497–05 [673] 38497–06 [673] 39497–07 [673] 38500–00 [674] 38503–00 [674] 38500–01 [675] 38503–01 [675] 38500–02 [676] 38503–02 [676] 38500–03 [677] 38503–03 [677] 38500–04 [678] 38503–04 [678] 90201–00 [679] 90201–01 [679] 90201–02 [679] 90201–03 [679]

Cystoscopy

36812–00 [1088] 36812–01 [1088] 36836–00 [1097]

Haemorrhoidectomy

32138–00 [949] 32132–00 [949] 32135–00 [949] 32135–01 [949]

Hysterectomy

35653–00 [1268] 35653–01 [1268] 35653–02 [1268] 35653–03 [1268] 35661–00 [1268] 35670–00 [1268] 35667–00 [1268] 35664–00 [1268] 35657–00 [1269] 35750–00 [1269] 35756–00 [1269] 35673–00 [1269] 35673–01 [1269] 35753–00 [1269] 35753–01 [1269] 35756–01 [1269] 35756–02 [1269] 35667–01 [1269] 35664–01 [1269] 90450–00 [989] 90450–01 [989] 90450–02 [989]

Inguinal herniorrhaphy

30614–03 [990] 30615–00 [997] 30609–03 [990] 30614–02 [990 30609–02 [990]

Myringoplasty

41527–00 [313] 41530–00 [313] 41533–01 [313] 41542–00 [315] 41635–10 [313]

Myringotomy

41626–00 [309] 31626–01 [309] 41632–00 [309] 41632–01 [309]

Prostatectomy

37203–00 [1165] 37203–01 [1165] 37203–02 [1165] 37207–00 [1166] 37207–01 [1166] 37200–00 [1166] 37200–01 [1166] 37203–05 [1166] 37203–06 [1166] 37200–03[1167] 37200–04 [1167] 37209–00 [1167] 37200–05 [1167] 90407–00 [1168] 36839–03 [1162] 36869–01 [1162]

Septoplasty

41672–02 [379] 41679–03 [379]

Tonsillectomy

41789–00 [412] 41789–01 [412]

Total hip replacement

49318–00 [1489] 49319–00 [1489] 49324–00 [1492] 49327–00 [1492] 49330–00 [1492] 49333–00 [1492] 49345–00 [1492]

Total knee replacement

49518–00 [1518] 49519–00 [1518] 49521–00 [1519] 49521–01 [1519] 49521–02 [1519] 49521–03 [1519] 49524–00 [1519] 49524–01 [1519] 49527–00 [1524] 49530–00 [1523] 49530–01 [1523] 49533–00 [1523] 49554–00 [1523] 49534–00 [1519]

Varicose Veins Stripping and Ligation

32508–00 [727] 32508–01 [727] 32511–00 [727] 32504–01 [728] 32505–00 [728] 32514–00 [737]

Individual/group session

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000235 Version number: 1

Data element type: DATA ELEMENT

Definition: A group is defined as two or more patients receiving services at the same time from the same hospital staff. However, this excludes the situation where individuals all belong to the same family. In such cases the service is being provided to the family unit and as a result the session should be counted as a single occasion of service to an individual.

Context: Required to distinguish between those occasions of service on an individual patient basis and those servicing groups of patients. This distinction has resource implications.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 5 Max. 5 Layout: ANNN.N

Data domain: A12.1 Individual sessions

A12.2 Group sessions

Administrative attributes

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Main treatment type for alcohol and other drugs

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000639 Version number: 1

Data element type: DATA ELEMENT

Definition: The main activity determined at assessment by the treatment provider to treat the client's alcohol and/or drug problem for the principal drug of concern.

Context: Alcohol and other drug treatment services: Information about treatment provided is of fundamental importance to service delivery and planning.

Relational and representational attributes

Datatype: Numeric Field size: Min 1 Max. 1 Layout: N

Data domain:

1 Withdrawal management (detoxification)
2 Counselling
3 Rehabilitation
4 Pharmacotherapy
5 Support and case management only
6 Information and education only
7 Assessment only
8 Other

Guide for use: To be completed at assessment or commencement of treatment.

The main treatment type is the principal activity as judged by the treatment provider that is necessary for the completion of the treatment plan for the principal drug of concern. The 'main treatment type for alcohol and other drugs' is the principal focus of a single treatment episode. Consequently, each treatment episode will only have one main treatment type.

For brief interventions, the main treatment type may apply to as few as one contact between the client and agency staff.

Code 1 refers to any form of withdrawal management, including medicated and non-medicated, in any delivery setting.

Code 2 refers to any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency. This code excludes counselling activity that is part of a rehabilitation program as defined in code 3.

Code 3 refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and tends towards a medium to longer- term duration. Rehabilitation activities can occur in residential or non/residential settings.

Code 4 refers to pharmacotherapies that include those used as maintenance therapies (e.g. naltrexone, buprenorphine, LAAM and specialist methadone treatment). Use code 1 (withdrawal management) where a pharmacotherapy is used solely for withdrawal.

Guide for use (continued):	Code 5	refers to support and case management offered to clients (e.g. treatment provided through youth alcohol and drug outreach services). This choice only applies where support and case management treatment is recorded as individual client data and the treatment activity is not included in any other category.
	Code 6	refers to when there is no treatment provided to the client other than information and education. It is noted that, in general, service contacts would include a component of information and education.
	Code 7	refers to when there is no treatment provided to the client other than assessment. It is noted that, in general, service contacts would include an assessment component.

Collection methods: Only one code to be selected.

Related data: Related to Other treatment type for alcohol and other drugs, version 1

Administrative attributes

Source organisation: Intergovernmental Committee on Drugs NMDS-WG

National minimum data sets:

Alcohol and other drug treatment services from 1/07/2001

Minutes of operating theatre time

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000094 Version number: 1

Data element type: DATA ELEMENT

Definition: Total time spent by a patient in operating theatres during current episode of hospitalisation.

Context: Admitted patient care:

Relational and representational attributes

Datatype: Numeric Field size: Min. 4 Max. 4 Layout: HHMM

Data domain: Time in hours and minutes

Verification rules: Right justified, zero filled.

Administrative attributes

Source organisation: National Health Data Committee

Comments: This item was recommended for inclusion in the National health data dictionary by Hindle (1988a, 1988b) to assist with Diagnosis Related Group costing studies in Australia.

This data element has not been accepted for inclusion in the National minimum data set—admitted patient care.

Newborn qualification status

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000343 Version number: 2

Data element type: DATA ELEMENT CONCEPT

Definition: Qualification status indicates whether the patient day within a newborn episode of care is either qualified or unqualified.

Context: Admitted patient care: To provide accurate information on care provided in newborn episodes of care through exclusion of unqualified patient days.

Relational and representational attributes

Guide for use: A newborn qualification status is assigned to each patient day within a newborn episode of care.

A newborn patient day is qualified if the infant meets at least one of the following criteria:

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient;
- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care;
- is admitted to, or remains in hospital without its mother.

A newborn patient day is unqualified if the infant does not meet any of the above criteria.

The day on which a change in qualification status occurs is counted as a day of the new qualification status.

If there is more than one qualification status in a single day, the day is counted as a day of the final qualification status for that day.

Related data: supersedes previous data element Qualification status, version 1

used in conjunction with Admitted patient, version 3

used in conjunction with Care type, version 4

is used in the calculation of Date of change to qualification status, version 1

is used in the calculation of Number of qualified days for newborns, version 2

Administrative attributes

Comments: All babies born in hospital are admitted patients.

The newborn baby's qualified days are eligible for health insurance benefits purposes and the patient day count under the Australian Health Care Agreements. In this context, newborn qualified days are equivalent to acute days and may be denoted as such.

The days when a newborn baby does not meet these criteria are classified as unqualified (if they are nine days old or less) and should not be counted as patient days under the Australian Health Care Agreements and are not eligible for health insurance benefit purposes.

Non-admitted patient service event

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000438 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: An interaction between one or more health care professionals with one or more non-admitted patients, for assessment, consultation and/or treatment intended to be unbroken in time. A service event means that a dated entry is made in the patient/client's medical record.

Context: Hospital non-admitted patient care: This definition applies to non-admitted hospital patients and is not intended to apply to community based services.

Relational and representational attributes

Guide for use: The period of interaction can be broken but still regarded as one service event if it was intended to be unbroken in time. This covers those circumstances in which treatment during a service event is temporarily interrupted for unexpected reasons, for example, a clinician is called to assess another patient who requires more urgent care.

Service events can occur in an outpatient, emergency, radiology, pathology and/or pharmacy department or, by a hospital-based outreach service, in a location that is not part of the hospital campus.

Service events may or may not be pre-arranged (except for telephone calls).

Imaging, pathology and/or pharmacy services that are ASSOCIATED with a service event in an outpatient clinic, Emergency Department or outreach service are NOT regarded as service events themselves.

Imaging, pathology or pharmacy services provided INDEPENDENT of a service event in an outpatient clinic, Emergency Department or outreach service are regarded as individual service events.

Service events delivered via a telephone call are included if

- they are a substitute for a face-to-face service event, and
- they are pre-arranged, and
- a record of the service event is included in the patient's medical record.

Service events include when the patient is participating via a video link (telemedicine). A service event can be counted at each site participating via the video link.

If a carer/relative accompanies a patient during a service event, this is not considered to be a service event for the carer/relative, provided that the carer/relative is not a patient in their own right for the service contact.

Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.

A service event is regarded as having occurred when a consultation occurs between their carer/relative and a service provider at an appointment when the patient is not present, provided that the carer/relative is not a patient in their own right for the service contact. Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.

Guide for use (continued): A service event is regarded as having occurred for each patient who attends a group session such as an antenatal class.

Outpatient department services provided to admitted patients are not regarded as service events.

Work-related services provided in clinics for staff are not service events.

Definitions:

An Emergency Department provides triage, assessment, care and/or treatment for patients suffering from medical condition/s and/or injury.

Hospital based outreach services events relate to treatment of patients by hospital staff in a location that is not part of the hospital campus (such as in the patient's home or place of work).

Related data: used in conjunction with Non-admitted patient service event count, version 1

used in conjunction with Multi-disciplinary team status, version 1

used in conjunction with Non-admitted patient service type, version 1

used in conjunction with Non-admitted patient service mode, version 1

used in conjunction with Non-admitted patient service event—patient present status, version 1

used in conjunction with Individual/group session, version 1

Administrative attributes

Source organisation: National Health Data Committee

Non-admitted patient service mode

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000439 Version number: 1

Data element type: DATA ELEMENT

Definition: Relative physical location of the patient, provider and the hospital campus of the provider of a non-admitted patient service event.

Context: Hospital non-admitted patient care:

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Patient and provider in the same physical location
1.1	On the hospital campus of the provider
1.2	Not on the hospital campus of the provider
2	Patient and provider not in the same physical location, and communicating via:
2.1	Telephone
2.2	Telemedicine

Guide for use: Patient and provider in the same physical location refers to face to face contacts. If this occurs at the hospital campus of the provider, use code 1.1. If the service event does not occur on the hospital campus of the provider (hospital-based outreach services), use code 1.2. Hospital-based outreach service events occur when the patient is treated by hospital staff in a location that is not part of the hospital campus (such as in the patient's home or place of work).

Patient and provider not in the same physical location refers to service events delivered via a telephone call or video link (telemedicine). The provider may or may not be physically present on their hospital campus.

A service event delivered via a telephone call is included if

- it is a substitute for a face-to-face service event, and
- it is pre-arranged, and
- a record of the service event is included in the patient's medical record.

A service event can be counted at each site participating via a video link.

Related data: used in conjunction with Non-admitted patient service event count, version 1

used in conjunction with Non-admitted patient service event, version 1

used in conjunction with Non-admitted patient service type, version 1

used in conjunction with Multi-disciplinary team status, version 1

used in conjunction with Individual/group session, version 1

Administrative attributes

Source organisation: National Health Data Committee

Non-admitted patient service type

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000440 Version number: 1

Data element type: DATA ELEMENT

Definition: The type of clinical service provided to a non-admitted patient in a non-admitted patient service event.

Context: Hospital non-admitted patient care: This definition applies to non-admitted hospital patients and is not intended to apply to community based services.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 5 Layout: NN.NN

Data domain:

1	Allied health and/or clinical nurse specialist
2	Dental
3	Imaging
4	Medical
5	Obstetrics and gynaecology
6	Paediatrics
7	Pathology
8	Pharmacy
9	Psychiatric
10	Surgical
11	Emergency department

Guide for use: The following provides a guide to types of clinical services that are included in each of the categories in the data domain. Clinical services that are not specifically identified in this Guide for use should be classified as one of the groups in the data domain on the basis of the type of clinical professional staff involved in providing the service event.

In paediatric hospitals, the full range of service types should be used. That is, paediatric medical should be reported as medical and paediatric surgical should be reported as surgical.

Clinical service type	Clinical service examples
Allied Health and/or clinical nurse specialist	Audiology Clinical pharmacy Diabetes education Neuropsychology Nutrition/dietetics Occupational therapy Optometry Orthoptics Orthotics Physiotherapy Podiatry Prosthetics Psychology

Guide for use (continued):

	Social work
	Speech pathology
	Stomal therapy
	Wound management
Dental	Dental
Imaging	Medical imaging
Medical	Aged Care
	Alcohol and other drug
	Allergy
	Anti-coagulant
	Asthma
	Cardiology
	Clinical measurement
	Dermatology
	Dementia
	Developmental disabilities
	Diabetes
	Endocrine
	Epilepsy
	Falls
	Gastroenterology
	General internal medicine
	Genetic
	Haematology
	Hepatobiliary
	Hypertension
	Hyperbaric medicine
	Immunology
	Infectious diseases
	Medical oncology
	Metabolic bone
	Nephrology
	Neurology
	Occupational medicine
	Palliative care
	Pain management
	Pulmonary
	Radiation oncology
	Rehabilitation
	Respiratory
	Rheumatology
	Spinal
	Transplants
Obstetrics and gynaecology	Family planning
	Gynaecology
	Gynaecology oncology
	Obstetrics
	Assisted Reproductive Technology
Pathology	Pathology
Paediatrics	Adolescent health
	Neonatal
	Paediatric medicine
	Paediatric surgery
Pharmacy	Dispensing pharmacy
Psychiatric	Psychiatry

Guide for use (continued):

Surgical	Breast Burns Cardiac surgery Colorectal Craniofacial Ear, nose and throat Fracture General surgery Neurosurgery Ophthalmology Orthopaedics Plastic surgery Pre-admission Pre-anaesthesia Thoracic surgery Urology Vascular surgery
Emergency department	Emergency department

An Emergency Department provides triage, assessment, care and/or treatment for patients suffering from medical condition/s and/or injury.

Related data:

used in conjunction with Non-admitted patient service event count, version 1

used in conjunction with Non-admitted patient service event, version 1

used in conjunction with Multi-disciplinary team status, version 1

(used in conjunction with New/repeat status, version 1, if required)

used in conjunction with Individual/group session, version 1

Administrative attributes

Source organisation: National Health Data Committee

Non-elective care

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000105 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: Care that, in the opinion of the treating clinician, is necessary and admission for which cannot be delayed for more than 24 hours.

Context: Admitted patient care:

Administrative attributes

Source organisation: Hospital Access Program Waiting Lists Working Group/National Health Data Committee

Number of contacts (psychiatric outpatient clinic/day program)

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000141 Version number: 1

Data element type: DATA ELEMENT

Definition: Number of days that a patient attended a psychiatric outpatient clinic or a day program during the relevant financial year.

Context: Mental health statistics: this data element gives a measure of the level of service provided.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 3 Layout: NNN

Data domain: Count in number of days

Collection methods: All States and Territories where there are public psychiatric hospitals also collect date of contact, and number of contacts during the financial year can be derived from this. (Collection status for New South Wales is unknown at time of writing.)

Related data: is an alternative to Number of service contact dates, version 2

Administrative attributes

Source organisation: National minimum data set working parties

Number of days in special/neonatal intensive care

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000009 Version number: 2

Data element type: DATA ELEMENT

Definition: Number of days spent by a neonate in a special care or neonatal intensive care nursery (in the hospital of birth).

Context: Admitted patient care: and Perinatal: an indicator of the requirements for hospital care of high-risk babies in specialised nurseries that add to costs because of extra staffing and facilities.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 3 Layout: NNN

Data domain: Number, representing the number of days spent in the special/intensive care nursery.

Guide for use: The number of days is calculated from the date the baby left the special/neonatal intensive care unit minus the date the baby was admitted to the special/neonatal intensive care unit.

Collection methods: This item is to be completed if baby has been treated in an intensive care unit or a special care nursery.

Special care nurseries (SCN) are staffed and equipped to provide a full range of neonatal services for the majority of complicated neonatal problems, including short-term assisted ventilation and intravenous therapy.

Neonatal intensive care nurseries (NICN) are staffed and equipped to treat critically ill newborn babies including those requiring prolonged assisted respiratory support, intravenous therapy, and alimentation and treatment of serious infections. Full supportive services are readily available throughout the hospital. These NICNs also provide consultative services to other hospitals.

Related data: supersedes previous data element Admission to special/neonatal intensive care, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Number of service contact dates

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000141 Version number: 2

Data element type: DERIVED DATA ELEMENT

Definition: The number of dates where a service contact was recorded for the patient/client.

Context: Community-based mental health care: This data element gives a measure of the level of service provided to a patient/client.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 3 Layout: NNN

Data domain: Count of dates

Guide for use: This data element is a count of service contact dates recorded on a patient or client record. Where multiple service contacts occur on the same date, the date is counted only once.

Collection methods: For collection from community based (ambulatory and non-residential) agencies. Includes mental health day programs and psychiatric outpatients.

Related data: is an alternative to Number of contact (psychiatric outpatient clinic/day program), version 1

relates to concept Service contact, version 1

is derived from Service contact date, version 1

Administrative attributes

Source organisation: National Mental Health Information Strategy Committee

Nursing interventions

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000112 Version number: 2

Data element type: DATA ELEMENT

Definition: The nursing action/s intended to relieve or alter a person's responses to actual or potential health problems.

Context: To enable analysis of the interventions within an episode of care, in relation to the outcome of this care, especially when linked with information on the diagnosis and goals. The recording of Nursing interventions is critical information for health service monitoring and planning. It is a major descriptor of the care provided throughout an episode.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Coordination and collaboration of care
2 Supporting informal carers
3 General nursing care
4 Technical nursing treatment or procedure
5 Counselling and emotional support
6 Teaching/education
7 Monitoring and surveillance
8 Formal case management
9 Service needs assessment only

Guide for use: For the purposes of the CNMDSA, the interventions are not necessarily linked to each nursing problem, nor are they specific tasks, but rather, broader-level intervention categories focusing on the major areas of a person's need. These summary categories subsume a range of specific actions or tasks.

The following definitions are to assist in coding:

1 COORDINATION AND COLLABORATION OF CARE

occurs when there are multiple care deliverers. The goal of coordination and collaboration is the efficient, appropriate integrated delivery of care to the person. Tasks which may be involved include: liaison, advocacy, planning, referral, information and supportive discussion and/or education. Although similar in nature to formal case management this intervention is not the one formally recognised by specific funding (see Code 8).

2 SUPPORTING INFORMATION CARERS

includes activities, which the nurse undertakes to assist the carer in the delivery of the carer's role. This does not include care given directly to the person. Examples of tasks involved in supporting the carer include: counselling, teaching, informing, advocacy, coordinating, and grief or bereavement support.

Guide for use (continued):

3 GENERAL NURSING CARE

includes a broad range of activities, which the nurse performs to directly assist the person; in many cases, this assistance will focus on activities of daily living. This assistance will help a person whose health status, level of dependency, and/or therapeutic needs are such that nursing skills are required. Examples of tasks include: assistance with washing, grooming and maintaining hygiene, dressing, pressure area care, assistance with toileting, bladder and bowel care, assistance with mobility and therapeutic exercise, attention to physical comfort and maintaining a therapeutic environment.

4 TECHNICAL NURSING TREATMENT OR PROCEDURE

refers to technical tasks and procedures for which nurses receive specific training and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. Some examples of technical care activities are: medication administration (including injections), dressings and other procedures, venipuncture, monitoring of dialysis, and implementation of pain management technology.

5 COUNSELLING AND EMOTIONAL SUPPORT

focuses on non-physical care given to the person, which aims to address the affective, psychological and/or social needs. Examples of these include: bereavement, well being, decision-making support and values-clarification.

6 TEACHING/EDUCATION

refers to providing information and/or instruction about a specific body of knowledge and/or procedure, which is relevant to the person's situation. Examples of teaching areas include: disease process, technical procedure, health maintenance, health promotion and techniques for coping with a disability.

7 MONITORING AND SURVEILLANCE

refers to any action by which the nurse evaluates and monitors physical, behavioural, social and emotional responses to disease, injury, and nursing or medical interventions.

8 FORMAL CASE MANAGEMENT

refers to the specific formal service, which is funded to provide case management for a person. Note that coordination and collaboration of care (Code 1) is not the same as Formal Case Management.

9 SERVICE NEEDS ASSESSMENT ONLY

is assessment of the person when this is the only activity carried out and no further nursing care is given; for example, assessment for ongoing care and/or inappropriate referrals. Selection of this option means that no other intervention may be nominated. Thus, if an assessment for the Domiciliary Care Benefit is the reason for a visit, but other interventions such as, counselling and support; coordination/collaboration of care are carried out, then the Assessment only is not an appropriate code.

Verification rules: Up to eight codes may be selected. If Code 9 is selected no other nursing interventions are collected. If Code 9 is selected then code 7 in Goal of care must also be selected.

Collection methods: Collect on continuing basis throughout the episode in the event of data collection that occurs prior to discharge. Up to eight codes may be collected. Within a computerised information system the detailed activities can be mapped to the CNMDSA interventions enabling the option of a rich level of detail of activities or summarised information.

Related data: relates to Nursing goal, version 1
supersedes previous data element Nursing interventions, version 1
relates to Nursing diagnosis, version 2

Administrative attributes

Source organisation: Australian Council of Community Nursing Services

Comments: The CNMDSA Nursing interventions are summary information overlying the detailed nursing activity usually included in an agency data collection. They are not intended as a description of nursing activities in the CNMDSA. For instance, Technical nursing treatment or Procedure is the generic term for a broad range of nursing activities such as: medication administration and wound care management.

Collection of this information at discharge carries with it the expectation that nursing records will lend themselves to this level of summarisation of the care episode. The selection of eight interventions if more are specified is a potentially subjective task unless the nursing record is structured and clear enough to enable such a selection against the reasons for admission to care, and the major focus of care delivery. Clearly, the task is easier if ongoing automated recording of interventions within an agency information system enables discharge reporting of all interventions and their frequency, over a care episode.

Those agencies providing allied health services may wish to use the Physiotherapy and Occupational Therapy Interventions developed in conjunction with the National Centre for Classification in Health in addition to the CNMDSA Nursing interventions or other more relevant code sets.

Organ procurement—posthumous

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000441 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: Organ procurement—posthumous is an activity undertaken by hospitals in which human tissue is procured for the purpose of transplantation from a donor who has been declared brain dead.

Context: Hospital activity:

Relational and representational attributes

Guide for use: This activity is not regarded as care or treatment of an admitted patient, but is registered by the hospital. Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, are recorded in accordance with the Australian Coding Standards.

Declarations of brain death are made in accordance with relevant State/Territory legislation.

Procedure

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000137 Version number: 5

Data element type: DATA ELEMENT

Definition: A clinical intervention that:

- is surgical in nature; and/or
- carries a procedural risk; and/or
- carries an anaesthetic risk; and/or
- requires specialised training; and/or
- requires special facilities or equipment only available in an acute care setting.

Context: This item gives an indication of the extent to which specialised resources, for example, human resources, theatres and equipment, are used. It also provides an estimate of the numbers of surgical operations performed and the extent to which particular procedures are used to resolve medical problems. It is used for classification of episodes of acute care for admitted patients into Australian Refined Diagnosis Related Groups.

Relational and representational attributes

Datatype: Numeric Field size: Min. 7 Max. 7 Layout: NNNNN–NN

Data domain: Valid ICD-10 code

Guide for use: Admitted patients: record all procedures undertaken during an episode of care in accordance with the ICD-10-AM (2nd edition) Australian Coding Standards.

The order of codes should be determined using the following hierarchy:

- procedure performed for treatment of the principal diagnosis
- procedure performed for the treatment of an additional diagnosis
- diagnostic/exploratory procedure related to the principal diagnosis; or
- diagnostic/exploratory procedure related to an additional diagnosis for the episode of care.

The first edition of ICD-10-AM, the Australian modification of ICD-10, was published by the National Centre for Classification in Health and implemented from July 1998. The 2nd edition was published for use from July 2000.

Verification rules: As a minimum requirement procedure codes must be valid codes from ICD-10-AM procedure codes and validated against the nationally agreed age and sex edits. More extensive edit checking of codes may be utilised within individual hospitals and State and Territory information systems. Record and code all procedures undertaken during the episode of care in accordance with the ICD-10-AM (2nd edition) Australian Coding.

Collection methods: Standards. An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected. Procedures are derived from and must be substantiated by clinical documentation.

Related data: supersedes previous Principal procedure—ICD-9-CM code, version 3
supersedes previous Additional procedures—ICD-9-CM code, version 3
used in conjunction with Indicator procedure, version 3
is qualified by Principal diagnosis, version 3
is qualified by Additional diagnosis, version 4
supersedes previous Principal procedure—ICD-10-AM code, version 4
supersedes previous Additional procedures—ICD-10-AM code, version 4

Administrative attributes

Source document: International Statistical Classification of Diseases and Related Health Problems—Tenth Revision—Australian Modification (2nd edition); National Centre for Classification in Health, Sydney.

Source organisation: National Centre for Classification in Health, National Health Data Committee

National minimum data sets:

Admitted patient care — from 1/07/1999 to

Comments: The National Centre for Classification in Health advises the National Health Data Committee of relevant changes to the ICD-10-AM.

Service contact

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000401 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A contact between a patient/client and an ambulatory care health unit (including outpatient and community health units) which results in a dated entry being made in the patient/client record.

Context: Identifies service delivery at the patient level for mental health services (including consultation/liaison, mobile and outreach services).

A service contact can include either face-to-face, telephone or video link service delivery modes. Service contacts would either be with a client, carer or family member or another professional or mental health worker involved in providing care and do not include contacts of an administrative nature (e.g. telephone contact to schedule an appointment) except where a matter would need to be noted on a patient's record.

Service contacts may be differentiated from administrative and other types of contacts by the need to record data in the client record. However, there may be instances where notes are made in the client record that have not been prompted by a service contact with a patient/client (e.g. noting receipt of test results that require no further action). These instances would not be regarded as a service contact.

Relational and representational attributes

Related data: relates to Number of service contact dates, version 2

relates to Number of service contacts within a treatment episode for alcohol and other drugs, version 1

relates to Service contact date, version 1

Administrative attributes

Comments: The proposed definition is not able to measure case complexity or level of resource usage with each service contact alone. This limitation also applies to the concept of occasions of service (in admitted patient care) and hospital separations.

Some overlap with the data element Occasions of service is acknowledged by the National Health Data Committee.

The National Health Data Committee also acknowledges that information about group sessions or activities that do not result in a dated entry being made in each individual participant's patient/client record is not currently covered by this data element concept.

Service contact date

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000402 Version number: 1

Data element type: DATA ELEMENT

Definition: The date of each service contact between a health service provider and patient/client.

Context: Community-based mental health care: Collection of the date of each service contact with health service providers allows a description or profile of service utilisation by a person or persons during an episode of care.

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid date

Guide for use: Requires services to record the date of each service contact, including the same date where multiple visits are made on one day (except where the visits may be regarded as a continuation of the one service contact).

Where an individual patient/client participates in a group activity a service contact date is recorded if the person's participation in the group activity results in a dated entry being made in the patient's/client's record.

Collection methods: For collection from community based (ambulatory and non-residential) agencies.

Related data: is used in the derivation of Number of service contact dates, version 2

relates to concept Service contact, version 1

Administrative attributes

National minimum data sets:

Community mental health care from 1/07/2000 to

Comments: The National Health Data Committee acknowledges that information about group sessions or activities that do not result in a dated entry being made in each individual participant's patient/client record is not obtained via this data element.

Time of commencement of service event

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000357 Version number: 2

Data element type: DATA ELEMENT

Definition: The time at which the delivery of a service commences. The service is defined as commencing when a health care professional first takes responsibility for the patient/client's care.

Context: Community health care:

Hospital non-admitted patient care:

Relational and representational attributes

Datatype: Numeric Field size: Min. 4 Max. 4 Layout: HHMM

Data domain: Expressed as hours and minutes using 24-hour clock

Related data: supersedes Time of service event, version 1

relates to Emergency Department waiting time to service delivery, version 1

relates to Emergency Department waiting time to admission, version 1

relates to concept Patient presentation at Emergency Department, version 1

relates to Date of commencement of service event, version 2

relates to Date patient presents, version 2

relates to Time patient presents, version 2

relates to Date of triage, version 1

relates to Time of triage, version 1

Administrative attributes

Source organisation: National Institution Based Ambulatory Model Reference Group; NHDC

National minimum data sets:

Emergency Department waiting times from 1/07/1999 to

Treatment episode for alcohol and other drugs

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000647 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: The period of contact, with defined dates of commencement and cessation, between a client and a treatment provider or team of providers that occurs in one setting and in which there is no change in the main treatment type or principal drug of concern, and there has not been a non-planned absence of contact for greater than 3 months.

Context: Alcohol and drug treatment services: This concept is required to provide the basis for a standard approach to recording and monitoring patterns of service utilisation by clients.

Relational and representational attributes

Guide for use: A treatment episode can have only one 'main treatment type for alcohol and other drugs' and only one 'principal drug of concern'.

A treatment episode must have a defined 'date of commencement of treatment episode for alcohol and other drugs' and a 'date of cessation of treatment episode for alcohol and other drugs'.

A treatment episode is only delivered within one setting. Where an agency operates in more than one treatment delivery setting, for any client receiving treatment in multiple settings, a separate treatment episode is required for each setting. Consequently, more than one treatment episode may be in progress for a client at the same time, and it is possible for each of these episodes to have different dates of commencement and cessation.

Collection methods: Is taken as the period starting from the date of commencement of treatment and ending at the date of cessation of treatment episode.

Related data: Relates to Main treatment type for alcohol and other drugs, version 1

Relates to Treatment delivery setting for alcohol and other drugs, version 1

Relates to Date of commencement of treatment episode for alcohol and other drugs, version 2

Relates to Date of cessation of treatment episode for a alcohol and other drugs, version 2

Relates to the concept Commencement of treatment episode for alcohol and other drugs, version 2

Relates to the concept Cessation of treatment episode for alcohol and other drugs, version 2

Administrative attributes

Source organisation: Intergovernmental Committee on Drugs NMDS-WG

Census date

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000174 Version number: 2

Data element type: DATA ELEMENT

Definition: Date on which the hospital takes a point in time (census) count of and characterisation of patients on the waiting list.

Context: Elective surgery: this data element is necessary for the calculation of the waiting time until a census.

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Guide for use: This date is recorded when a census is done of the patients on a waiting list.

Related data: supersedes previous data element Census date, version 1

is used in the calculation of Waiting time at a census date, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/1994 to

Hospital census

Admin. status: CURRENT 1/01/1995

Identifying and definitional attributes

Knowledgebase ID: 000066 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A point in time count by a hospital of all its admitted patients and/or patients currently on a waiting list.

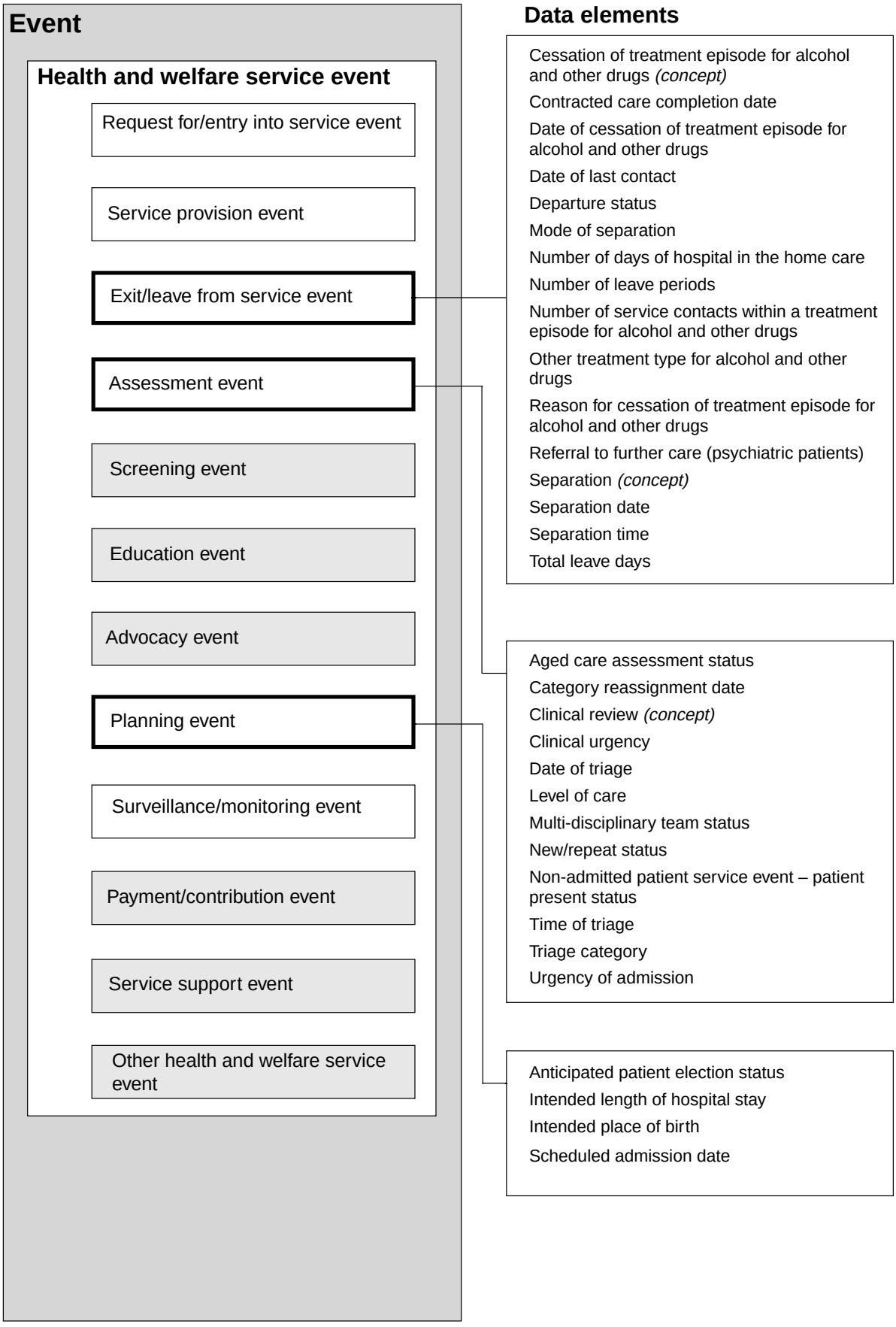
Context: Admitted patient care:

Relational and representational attributes

Related data: relates to Census date, version 2

relates to Waiting time at a census date, version 1

National Health Information Model entity



Cessation of treatment episode for alcohol and other drugs

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000422 Version number: 2

Data element type: DATA ELEMENT CONCEPT

Definition: Cessation of a treatment episode occurs when treatment is completed or discontinued; or there has been a change in the principal drug of concern, the main treatment type, or the treatment delivery setting.

Context: Alcohol and other drug treatment services:

Relational and representational attributes

Guide for use: A client is identified as ceasing a treatment episode if one or more of the following apply:

- their treatment plan is completed;
- they have had no contact with the treatment provider for a period of three months, nor is there a plan in place for further contact;
- their 'principal drug of concern for alcohol and other drugs' has changed;
- their 'main treatment type for alcohol and other drugs' has changed;
- their 'treatment delivery setting for alcohol and other drugs' has changed;
- their treatment has ceased for other reasons (e.g. imprisoned, ceased treatment against advice, transferred to another service provider, died etc)

Related data: supersedes previous concept Cessation of treatment, version 1

relates to Reason for cessation of treatment episode for alcohol and other drugs, version 2

relates to Date of cessation of treatment episode for alcohol and other drugs, version 2

Administrative attributes

Source organisation: Intergovernmental Committee on Drugs NMDS-WG

Contracted care completion date

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000428 Version number: 1

Data element type: DATA ELEMENT

Definition: The date the period of contracted care commenced.

Context: Admitted patient care:

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid dates

Guide for use: This item is to be used by the contracting hospital to record the commencement date of the contracted hospital care and will be the admission date for the contracted hospital.

Related data: relates to concept Contracted hospital care, version 1

relates to Contract type, version 1

relates to Contract role, version 1

relates to Contract establishment identifier, version 3

relates to Contracted care completion date, version 1

relates to Total contract patient days, version 1

relates to Contract procedure flag, version 1

Administrative attributes

Source organisation: National Health Data Committee

Date of cessation of treatment episode for alcohol and other drugs

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000424 Version number: 2

Data element type: DATA ELEMENT

Definition: Date on which a treatment episode for alcohol and other drugs ceases.

Context: Alcohol and other drug treatment services: Required to identify the cessation of a treatment episode by an alcohol and other drug treatment service.

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid dates

Guide for use: Refers to the date of the last service contact in a treatment episode between the client and staff of the treatment provider. In situations where the client has had no contact with the treatment provider for three months, nor is there a plan in place for further contact, the date of last service contact should be used.

Refer to data element concept 'Cessation of treatment episode for alcohol and other drugs' to determine when a treatment episode ceases.

Verification rules: Must be later than or the same as the 'Date of commencement of treatment for alcohol and other drugs'.

Related data: supersedes previous data element Date of cessation of treatment, version 1

relates to Reason for cessation of treatment episode for alcohol and other drugs, version 2

relates to the concept Cessation of treatment episode for alcohol and other drugs, version 2

Administrative attributes

Source organisation: Intergovernmental Committee on Drugs NMDS-WG

National minimum data sets:

Alcohol and other drug treatment services from 01/07/2000

Date of last contact

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000040 Version number: 2

Data element type: DATA ELEMENT

Definition: Date of the last contact between a staff member of the community service and a person in any setting.

The definition includes:

- visits made to persons in institutional settings for the purpose of handing over or otherwise completing a care episode;
- bereavement visits in any setting;
- visits made to the person's home to complete the service, including the collection of equipment.

The definition excludes visits made by liaison/discharge planning staff of a community service for the purpose of assessment of need related to a subsequent episode of care.

Context: To enable analysis of time periods throughout a care episode, especially the bereavement period. This date has been included in order to capture the end of a care episode in terms of involvement of the community nursing service.

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid dates

Guide for use: This could be the same as the date of discharge.

Verification rules: May occur after or on the same day as Date of last delivery of service

Related data: supersedes Date of last community service contact with client/family, version 1

relates to Date of first contact, version 2

Administrative attributes

Source organisation: Australian Council of Community Nursing Services

Comments: Although the data item has Recommended status only, if service agencies are committed to monitoring all resource utilisation associated with an episode of care, this post-discharge date and the corresponding pre-admission item Date of first contact, have a place within an agency information system. This is particularly true for those agencies providing discharge planning service or specialist consultancy or assessment services.

Departure status

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000359 Version number: 1

Data element type: DATA ELEMENT

Definition: The status of the patient on departure from the Emergency Department.

Context: Admitted patient care: Required for analysis of client care.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Admitted to ward or other admitted patient unit (includes patients who may have been in observation area in Emergency Department prior to admission).
2	Emergency department service event completed, departed under own care.
3	Transferred to another hospital for admission.
4	Did not wait to be attended (by medical officer).
5	Left at own risk, after medical officer assumed responsibility for the patient but before Emergency Department service event was completed.
6	Died in Emergency Department.
7	Dead on arrival, not treated in Emergency Department.

Related data:

relates to Admission date, version 3
relates to Emergency Department waiting time to service delivery, version 1
relates to Emergency Department waiting time to admission, version 1
relates to concept Patient presentation at Emergency Department, version 1
relates to Date patient presents, version 2
relates to Time patient presents, version 2
relates to Type of visit to Emergency Department, version 2
relates to Date of triage, version 1
relates to Time of triage, version 1
relates to Triage category, version 1
relates to Date of commencement of service event, version 2
relates to Time of commencement of service event, version 2
relates to Admission time, version 1

Administrative attributes

Source organisation: National Institution Based Ambulatory Model Reference Group; NHDC

National minimum data sets:

Emergency Department waiting times from 1/07/1999 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Mode of separation

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000096 Version number: 3

Data element type: DATA ELEMENT

Definition: Status at separation of person (discharge/transfer/death) and place to which person is released (where applicable).

Context: Required for outcome analyses: for analyses of intersectoral patient flows and to assist in the continuity of care and classification of episodes into Diagnosis Related Groups.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Discharge/transfer to an(other) acute hospital
2	Discharge/transfer to a Residential Aged Care Service, unless this is the usual place of residence
3	Discharge/transfer to an(other) psychiatric hospital
4	Discharge/transfer to other health care accommodation (includes mothercraft hospitals)
5	Statistical discharge-type change
6	Left against medical advice/discharge at own risk
7	Statistical discharge from leave
8	Died
9	Other (includes discharge to usual residence/own accommodation/welfare institution (includes prisons, hostels and group homes providing primarily welfare services))

Guide for use: For Code 4—In jurisdictions where mothercraft facilities are considered to be acute hospitals, patients separated to a mothercraft facility should have a mode of separation of Code 1. If the residential aged care service is the patient's place of usual residence then they should have a mode of separation of Code 9.

Related data: is supplemented by Source of referral to public psychiatric hospital, version 3

is supplemented by Source of referral to acute hospital or private psychiatric hospital, version 3

supersedes Mode of separation, version 2

is used in the derivation of Diagnosis related group, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Admitted patient mental health care	from 1/07/2000 to
Admitted patient palliative care	from 1/07/2000 to

Comments: During 2000, the National Mental Health Information Strategy Committee is reviewing a draft data element 'Referral to further care' which will involve a review of the data element Mode of separation.

Number of days of hospital in the home care

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000640 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: The number of hospital in the home days occurring within an episode of care for an admitted patient.

Context: Admitted patient care:

Relational and representational attributes

Datatype: Numeric Field size: Min. 0 Max. 3 Layout: NNN

Data domain: Integer count of number of days

Guide for use: The rules for calculating the number of hospital in the home days are outlined below:

- The number of hospital in the home days is calculated with reference to the date of admission, date of separation, leave days and any date(s) of change between hospital and home accommodation;
- The date of admission is counted if the patient was at home at the end of the day;
- The date of change between hospital and home accommodation is counted if the patient was at home at the end of the day;
- The date of separation is not counted, even if the patient was at home at the end of the day;
- The normal rules for calculation of patient days apply, for example in relation to leave and same day patients.

Related data: relates to the concept Hospital in the home care, version 1

relates to the concept Admitted patient, version 3

relates to the concept Episode of care, version 1

relates to Admission date, version 4

relates to Separation date, version 5

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient care	from 1/07/2001 to
Admitted patient mental health care	from 1/07/2001 to
Admitted patient palliative care	from 1/07/2001 to

Comments: Data will be collected from all states and territories except Western Australia from 1 July 2001. Western Australia will begin to collect data from a later date.

Number of leave periods

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000107 Version number: 3

Data element type: DATA ELEMENT

Definition: Number of leave periods in a hospital stay (excluding one-day leave periods for admitted patients).

Leave period is a temporary absence from hospital, with medical approval for a period no greater than seven consecutive days.

Context: Recording of leave periods allows for the calculation of patient days excluding leave. This is important for analysis of costs per patient and for planning. The maximum limit allowed for leave affects admission and separation rates, particularly for long-stay patients who may have several leave periods.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 2 Layout: NN

Data domain: Number of leave periods

Guide for use: If the period of leave is greater than seven days or of the patient fails to return from leave, the patient is discharged.

Related data: is used in the derivation of Length of stay, version 3

supersedes Number of leave periods, version 2

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient care from 1/07/2000 to

Comments: This data element was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients at the instigation of the National Mental Health Strategy Committee.

Number of service contacts within a treatment episode for alcohol and other drugs

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000641 Version number: 1

Data element type: DATA ELEMENT

Definition: Number of service contacts made with a client for the purpose of providing alcohol and other drug treatment during a treatment episode.

Context: Alcohol and drug treatment services: This data element provides a measure of the frequency of client contact and service utilisation within a treatment episode.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 3 Layout: NNN

Data domain: Valid integer

Guide for use: This data element is a count of therapeutic contacts recorded on a client record. Any client contact that does not constitute part of a treatment should not be considered a 'service contact'. Contact with the client for administrative purposes, such as arranging an appointment, should not be included.

This data element is not collected for residential clients.

Where multiple service provider staff have contact with the client on the same occasion of service, the contact is counted only once. Where the client has multiple contacts on a single day, contact is counted only once.

Collection methods: To be collated at the close of an episode. The total number of contacts are calculated or counted for the closed episode.

Related data: Relates to the concept Service contact, version 1

Relates to the concept Treatment episode for alcohol and other drugs, version 1.

Administrative attributes

Source organisation: Intergovernmental Committee on Drugs NMDS-WG

National minimum data sets:

Alcohol and other drug treatment services from 01/07/2001

Other treatment type for alcohol and other drugs

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000642 Version number: 1

Data element type: DATA ELEMENT

Definition: All other forms of treatment provided to the client in addition to the 'main treatment type for alcohol and other drugs'.

Context: Alcohol and other drug treatment services: Information about treatment provided is of fundamental importance to service delivery and planning.

Relational and representational attributes

Datatype: Numeric Field size: Min 1 Max. 1 Layout: N

Data domain:

1 Withdrawal management (detoxification)

2 Counselling

3 Rehabilitation

4 Pharmacotherapy

5 Other

Guide for use: To be completed at cessation of treatment episode.

Only report treatment recorded in the client's file that is in addition to, and not a component of, the 'main treatment type for alcohol and other drugs'. Treatment activity reported here is not necessarily for 'principal drug of concern' in that it may be treatment for a 'other drug of concern'.

Code 1 refers to any form of withdrawal management, including medicated and non-medicated.

Code 2 refers to any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency. This selection excludes counselling activity that is part of a rehabilitation program as defined in code 3.

Code 3 refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and tends towards a medium to longer- term duration. Rehabilitation activities can occur in residential or non/residential settings.

Code 4 refers to pharmacotherapies that include those used as maintenance therapies (e.g. naltrexone, buprenorphine, LAAM and specialist methadone treatment). Use code 1 (withdrawal management) where a pharmacotherapy is used solely for withdrawal.

Collection methods: More than one code may be selected. This field should be left blank if there are no other treatment types for the episode.

Related data: Related to Main treatment type for alcohol and other drugs, version 1

Administrative attributes

Source organisation: Intergovernmental Committee on Drugs NMDS-WG

National minimum data sets:

Alcohol and other drug treatment services from 1/07/2001

Reason for cessation of treatment episode for alcohol and other drugs

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000423 Version number: 2

Data element type: DATA ELEMENT

Definition: The reason for the client ceasing to receive a treatment episode from an alcohol and other drug treatment service.

Context: Alcohol and other drug treatment services: Given the levels of attrition within alcohol and other drug treatment programs, it is important to identify the range of different reasons for ceasing treatment with a service.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 2 Layout: NN

Data domain:

1	Treatment completed
2	Change in main treatment type
3	Change in the delivery setting
4	Change in the principal drug of concern
5	Transferred to another service provider
6	Ceased to participate against advice
7	Ceased to participate without notice
8	Ceased to participate involuntary (non-compliance)
9	Ceased to participate at expiation
10	Ceased to participate by mutual agreement
11	Drug court and/or sanctioned by court diversion service
12	Imprisoned, other than drug court sanctioned
13	Died
98	Other
99	Not stated/inadequately described

Guide for use:

Code 1	is to be used when all of the immediate goals of the treatment plan have been fulfilled
Code 2	a treatment episode will end if there is a change in the 'Main treatment type for alcohol and other drugs'
Code 3	a treatment episode will end if there is a change in the 'Treatment delivery setting for alcohol and other drugs'
Code 4	a treatment episode will end if there is a change in the 'Principal drug of concern'.
Code 5	includes situations where the service provider is no longer the most appropriate and the client is transferred/referred to another service. For example, transfers could occur for clients between non-residential and residential services or between residential services and a hospital.

Guide for use (continued):	Code 6	refers to situations where the service provider is aware of the client's intention to stop participating in treatment, and the client ceases despite advice from staff that such action is against the client's best interest.
	Code 7	refers to situations where the client ceased to receive treatment without notifying the service provider of their intention to no longer participate.
	Code 8	refers to situations where the client's participation has been ceased by the service provider due to non-compliance with the rules or conditions of the program.
	Code 9	refers to situations where the client has fulfilled their obligation to satisfy expiation requirements (e.g. participate in a treatment program to avoid having a criminal conviction being recorded against them) as part of a police or court diversion scheme and chooses not to continue with the treatment program.
	Code 10	refers to situations where the client ceases participation by mutual agreement with the service provider even though the treatment plan has not been completed. This may include situations where the client has moved out of the area. To be used when codes 2, 3 or 4 is not applicable.
	Code 11	applies to drug court and/or court diversion service clients who are sanctioned back into jail for non-compliance with the program.
	Code 12	applies to clients who are imprisoned for reasons other than code 11.

Collection methods: To be collected on cessation of a treatment episode.

Related data: supersedes previous Reason for cessation of treatment, version 1

relates to the concept Cessation of treatment episode for alcohol and other drugs, version 2

relates to Date of cessation of treatment episode for alcohol and other drugs, version 2

Administrative attributes

Source organisation: Intergovernmental Committee on Drugs NMDS-WG

National minimum data sets:

Alcohol and other drug treatment services — from 01/07/2000

Referral to further care (psychiatric patients)

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000143 Version number: 1

Data element type: DATA ELEMENT

Definition: Referral to further care by health service agencies/facilities.

Context: Mental health care: many psychiatric inpatients have continuing needs for post-discharge care. Continuity of care across the hospital-community interface is a key policy theme emerging in the various States and Territories. Inclusion of this item allows the opportunity to monitor interagency linkages and is complementary to the data element Source of referral.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Not referred
2	Private psychiatrist
3	Other private medical practitioner
4	Mental health/alcohol and drug in-patient facility
5	Mental health/alcohol and drug non in-patient facility
6	Acute hospital
7	Other

Administrative attributes

Source organisation: National minimum data set working parties

National minimum data sets

Admitted patient mental health care from 01/07/1997 to

Separation

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000148 Version number: 3

Data element type: DATA ELEMENT CONCEPT

Definition: Separation is the process by which an episode of care for an admitted patient ceases.

A separation may be formal or statistical.

Formal separation: the administrative process by which a hospital records the cessation of treatment and/or care and/or accommodation of a patient.

Statistical separation: the administrative process by which a hospital records the cessation of an episode of care for a patient within the one hospital stay.

Context: Admitted patient care:

Relational and representational attributes

Guide for use: This treatment and/or care provided to a patient prior to separation occurs over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).

Related data: supersedes previous data element Separation, version 2

relates to Care type, version 4

relates to concept Admitted patient, version 3

relates to Separation date, version 5

relates to concept Admission, version 3

Administrative attributes

Source organisation: National Health Data Committee

Comments: While this concept is also applicable to non-admitted patient care and welfare services, different terminology to 'separation' is often used in these other care settings.

Separation date

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000043 Version number: 5

Data element type: DATA ELEMENT

Definition: Date on which an admitted patient completes an episode of care.

Context: 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 Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid dates

Verification rules: For the provision of State and Territory hospital data to Commonwealth agencies this field must:

- be ≤ last day of financial year
- be ≥ first day of financial year
- be ≥ Admission date

Related data: supersedes previous data element Discharge date, version 4

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient care	from 1/07/1999 to
Admitted patient mental health care	from 1/07/2000 to
Admitted patient palliative care	from 1/07/2000 to

Comments: There may be variations amongst jurisdictions with respect to the recording of separation date. This most often occurs for patients who are statistically separated after a period of leave (and who do not return for further hospital care). In this case, some jurisdictions may record the separation date as the date of statistical separation (and record intervening days as leave days) while other jurisdictions may retrospectively separate patients on the first day of leave. Despite the variations in recording of separation date for this group of patients, the current practices provide for the accurate recording of length of stay.

Separation time

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000644 Version number: 1

Data element type: DATA ELEMENT

Definition: Time at which an admitted patient completes an episode of care.

Context: Admitted patient care:

Relational and representational attributes

Datatype: Numeric Field size: Min. 4 Max. 4 Layout: HHMM

Data domain: Expressed as hours and minutes using 24-hour clock

Related data: relates to the data element concept Admitted patient, version 3
relates to the data element concept Admission, version 3
is used in conjunction with Admission date, version 4
is used in conjunction with Admission time, version 2
is used in conjunction with Separation date, version 5

Administrative attributes

Comments: Required to identify the time of completion of the episode or hospital stay, for calculation of length of stay.

Total leave days

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000163 Version number: 3

Data element type: DATA ELEMENT

Definition: Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.

Context: Recording of leave days allows for exclusion of these from the calculation of patient days. This is important for analysis of costs per patient and for planning. The maximum limit allowed for leave affects admission and separation rates, particularly for long-stay patients who may have several leave periods.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 3 Layout: NNN

Data domain: Count is number of days

Guide for use: A day is measured from midnight to midnight.

The following rules apply in the calculation of leave days for both overnight and same-day patients:

- The day the patient goes on leave is counted as a leave day.
- The day the patient is on leave is counted as a leave day.
- The day the patient returns from leave is counted as a patient day.
- If the patient is admitted and goes on leave on the same day, this is counted as a patient day, not a leave day.
- If the patient returns from leave and then goes on leave again on the same day, this is counted as a leave day.
- If the patient returns from leave and is separated on the same day, the day should not be counted as either a patient day or a leave day.

Verification rules: For the provision of State and Territory hospital data to Commonwealth agencies (Date of separation minus Date of admission) minus Total leave days must be ≥0 days.

Related data: supersedes previous data element Total leave days, version 2

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Admitted patient mental health care	from 1/07/2000 to

Comments: It should be noted that for private patients in public and private hospitals, s.3 (12) of the Health Insurance Act 1973 (Cwlth) currently applies a different leave day count, Commonwealth Department of Human Services and Health HBF Circular 354 (31 March 1994).

This item was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients.

Aged care assessment status

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000017 Version number: 1

Data element type: DATA ELEMENT

Definition: The assessment status of a person in terms of whether or not he or she has been assessed by a regional aged care assessment team and, if so, which one.

Context: Aged care assessment: useful variable when comparing resident population across systems.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Assessed by approved aged care assessment team
2	Assessed by non-approved aged care assessment team
3	Assessed by Commonwealth medical officer
4	Not assessed
5	Unknown

Collection methods: This item is based on the form NH5, which has been replaced.

Administrative attributes

Source organisation: Commonwealth Department of Health and Aged Care

Category reassignment date

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000391 Version number: 2

Data element type: DATA ELEMENT

Definition: The date on which a patient awaiting elective hospital care is assigned to a different urgency category as a result of clinical review for the awaited procedure, or is assigned to a different patient listing status category ('ready for care' or 'not ready for care').

Context: Elective surgery: this date is necessary for the calculation of Waiting time at admission and Waiting time at a census date.

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid date

Guide for use: The date needs to be recorded each time a patient's urgency classification or listing status changes.

Related data: relates to Clinical review, version 1

used in conjunction with Patient listing status, version 3

used in conjunction with Clinical urgency, version 2

supersedes previous data element Urgency reassignment date, version 1

is used in the calculation of Waiting time at a census date, version 1

is used in the calculation of Waiting time at admission, version 1

Administrative attributes

Source organisation: AIHW, National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/1994 to

Clinical review

Admin. status: CURRENT 1/07/1995

Identifying and definitional attributes

Knowledgebase ID: 000024 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: The examination of a patient by a clinician after the patient has been added to the waiting list. This examination may result in the patient being assigned a different urgency rating from the initial classification. The need for clinical review varies with a patient's condition and is therefore at the discretion of the treating clinician.

Context: Admitted patient care:

Relational and representational attributes

Related data: relates to Clinical urgency, version 1

relates to Clinical urgency, version 2

Administrative attributes

Source organisation: Hospital Access Program Waiting List Working Group/National Health Data Committee

Clinical urgency

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000025 Version number: 2

Data element type: DATA ELEMENT

Definition: A clinical assessment of the urgency with which a patient requires elective hospital care.

Context: Elective surgery: categorisation of waiting list patients by clinical urgency assists hospital management and clinicians in the prioritisation of their workloads. It gives health consumers a reasonable estimate of the maximum time they should expect to wait for care.

Clinical urgency classification allows a meaningful measure of system performance to be calculated, namely the number or proportion of patients who wait for times in excess of the maximum desirable time for their urgency category (data element 'Overdue patient').

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency.
2	Admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency.
3	Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency.

Guide for use: The classification employs a system of urgency categorisation based on factors such as the degree of pain, dysfunction and disability caused by the condition and its potential to deteriorate quickly into an emergency. All patients ready for care must be assigned to one of the urgency categories, regardless of how long it is estimated they will need to wait for surgery.

Related data: relates to concept Clinical review, version 1

supersedes the data element Patient listing status, version 2

used in conjunction with Patient listing status, version 3

used in conjunction with Category reassignment date, version 2

is a qualifier of Overdue patient, version 3

is a qualifier of Extended wait patient, version 1

is a qualifier of Waiting time at a census date, version 1

is a qualifier of Waiting time at admission, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/1994 to

Comments: A patient's classification may change if he or she undergoes clinical review during the waiting period. The need for clinical review varies with the patient's condition and is therefore at the discretion of the treating clinician. The waiting list information system should be able to record dates when the classification is changed (data element Category reassignment date).

Date of triage

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000353 Version number: 1

Data element type: DATA ELEMENT

Definition: The day on which the patient is triaged.

Context: Admitted patient care: Required to identify the commencement of the service and calculation of waiting times.

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid dates

Related data: relates to Emergency Department waiting time to service delivery, version 1

relates to concept Patient presentation at Emergency Department, version 1

relates to Time of triage, version 1

Administrative attributes

Source organisation: National Institution Based Ambulatory Model Reference Group; NHDC

National minimum data sets:

Emergency Department waiting times from 1/07/1999 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Level of care

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000294 Version number: 1

Data element type: DATA ELEMENT

Definition: The level of care needed by a patient/resident as assessed by the summation of scores on questions contained in the Resident Classification Instrument and subsequent classification into one of five major categories.

Context: Residential aged care services: the level of resources and associated costs of providing care to residential aged care service residents depends on the levels of dependency of the residents. This field is an attempt to measure the levels of care required by individual residents in order that an overall profile of the residential aged care service population can be obtained. Such a profile is necessary to help explain cost variations both between residential aged care services and over time.

At present there is no method of determining the underlying population demand for residential aged care service beds. changes on the level of care required on admission to a residential aged care service may also provide a useful indication of changes in demand.

This data element also provides a summary profile of dependency of resident population, as a basis for monitoring changes in resident profile as a consequence of assessment and other measures being introduced.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Very high need
2	High need
3	Medium need
4	Low need
5	Very low need
6	Ordinary care (non-RCI)
7	Extensive care (non-RCI)

Guide for use: For State residential aged care services not using Resident Classification Instrument, the level of care as measured by resident classification into ordinary of extensive care.

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Administrative attributes

Source organisation: National minimum data set working parties

Multi-disciplinary team status

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000434 Version number: 1

Data element type: DATA ELEMENT

Definition: A non-admitted multi-disciplinary team patient service event is one for which there is at most one appointment and the patient is assessed and/or treated by more than one medical practitioner, allied health practitioner and/or specialist nurse practitioner.

Context: Hospital non-admitted patient care:

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Non-admitted multi-disciplinary team patient service event

2 Other non-admitted patient service event

Related data: used in conjunction with Non-admitted patient service event count, version 1

used in conjunction with Non-admitted patient service event, version 1

used in conjunction with Non-admitted patient service type, version 1

used in conjunction with New/repeat status, version 1, if required

used in conjunction with Individual/group session, version 1

New/repeat status

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000435 Version number: 1

Data element type: DATA ELEMENT

Definition: A new non-admitted patient service event is one for a problem not previously addressed at the same clinical service.

All other non-admitted patient service events are repeat service events.

Context: Hospital non-admitted patient care:

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 New non-admitted patient service event

2 Repeat non-admitted patient service event

Guide for use: New service events occur as each type of clinical service makes their full assessment consultation with the patient.

Repeat visits include completion of an ambulatory procedure, e.g. removal of sutures and removal of plaster casts.

Examples of clinical services are included in the Guide for use for Non-admitted patient service type.

Related data: used in conjunction with Non-admitted patient service event, version 1

used in conjunction with Non-admitted patient service type, version 1

used in conjunction with Non-admitted patient service mode, version 1

used in conjunction with Non-admitted patient service event—patient present status, version 1

used in conjunction with Multi-disciplinary team status, version 1

used in conjunction with Individual/group session, version 1

Non-admitted patient service event—patient present status

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000436 Version number: 1

Data element type: DATA ELEMENT

Definition: The presence or absence of a patient at a non-admitted patient service event.

Context: Hospital non-admitted patient care:

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Patient present with or without carer(s)/relative(s)

2 Carer(s)/relative(s) of the patient only

Guide for use: A service event is regarded as having occurred when a consultation occurs between their carer/relative and a service provider at an appointment when the patient is not present, provided that the carer/relative is not a patient in their own right for the service contact. Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.

Related data:

used in conjunction with Non-admitted patient service event count, version 1

used in conjunction with Non-admitted patient service event, version 1

used in conjunction with Non-admitted patient service type, version 1

used in conjunction with Non-admitted patient service mode, version 1

used in conjunction with Multi-disciplinary team status, version 1

used in conjunction with Individual/group session, version 1

Time of triage

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000354 Version number: 1

Data element type: DATA ELEMENT

Definition: The time at which the patient is triaged.

Context: Admitted patient care: Required to identify the commencement of the service and calculation of waiting times.

Relational and representational attributes

Datatype: Numeric Field size: Min. 4 Max. 4 Layout: HHMM

Data domain: Valid value

Related data: relates to Admission date, version 3
relates to Emergency Department waiting time to service delivery, version 1
relates to Emergency Department waiting time to admission, version 1
relates to concept Patient presentation at Emergency Department, version 1
relates to Date patient presents, version 2
relates to Time patient presents, version 2
relates to Type of visit to Emergency Department, version 2
relates to Date of triage, version 1
relates to Triage category, version 1
relates to Date of commencement of service event, version 2
relates to Time of commencement of service event, version 2
relates to Admission time, version 1

Administrative attributes

Source organisation: National Institution Based Ambulatory Model Reference Group; NHDC

National minimum data sets:

Emergency Department waiting times from 1/07/1999 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Triage category

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000355 Version number: 1

Data element type: DATA ELEMENT

Definition: The urgency of the patient's need for medical and nursing care.

Context: Admitted patient healthcare: Required to provide data for analysis of Emergency Department processes.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Resuscitation: Immediate (within seconds)
2	Emergency: Within 10 minutes
3	Urgent: Within 30 minutes
4	Semi-urgent: Within 60 minutes
5	Non-urgent: Within 120 minutes

Collection methods: This triage classification is to be used in the Emergency Departments of hospitals. Patients will be triaged into one of five categories on the National Triage Scale according to the triageur's response to the question: 'This patient should wait for medical care no longer than…?'.

The triage category is allocated by an experienced registered nurse or medical practitioner. If the triage category changes, record the more urgent category.

Related data:

relates to Non-admitted patient, version 1

relates to Admission date, version 3

supersedes previous data element Triage category (trial), version 1

relates to Emergency Department waiting time to service delivery, version 1

relates to Emergency Department waiting time to admission, version 1

relates to concept Patient presentation at Emergency Department, version 1

relates to Date patient presents, version 2

relates to Time patient presents, version 2

relates to Type of visit to Emergency Department, version 2

relates to Date of triage, version 1

relates to Time of triage, version 1

relates to Date of commencement of service event, version 2

relates to Time of commencement of service event, version 2

relates to Admission time, version 1

relates to Departure status, version 1

Administrative attributes

Source document: National Triage Scale, Australasian College for Emergency Medicine (ACEM)

National minimum data sets:

Emergency Department waiting times from 1/07/1999 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Urgency of admission

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000425 Version number: 1

Data element type: DATA ELEMENT

Definition: Whether the admission has an urgency status assigned and, if so, whether admission occurred on an emergency basis.

An emergency admission is an admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which should occur within 24 hours.

An elective admission is an admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours.

Admissions for which an urgency status is usually not assigned are:

- admissions for normal delivery (obstetric);
- admissions which begin with the birth of the patient, or when it was intended that the birth occur in the hospital, commence shortly after the birth of the patient;
- statistical admissions; and
- planned re-admissions for the patient to receive limited care or treatment for a current condition, for example dialysis or chemotherapy.

Context: Admitted patient care:

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 3 Layout: N(.N)

Data domain:

1 Urgency status assigned—emergency

2 Urgency status assigned—elective

3 Urgency status not assigned

9 Not known/not reported

Guide for use: Emergency admission

The following guidelines may be used by health professionals, hospitals and health insurers in determining whether an emergency admission has occurred. These guidelines should not be considered definitive.

An emergency admission occurs if one or more of the following clinical conditions are applicable such that the patient required admission within 24 hours.

Such a patient would be:

- at risk of serious morbidity or mortality and requiring urgent assessment and/or resuscitation; or
- suffering from suspected acute organ or system failure; or
- suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or
- suffering from a drug overdoes, toxic substance or toxin effect; or

Guide for use (continued):

- experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or
- suffering severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
- suffering acute significant haemorrhage and requiring urgent assessment and treatment; or
- suffering gynaecological or obstetric complications; or
- suffering an acute condition which represents a significant threat to the patient's physical or psychological wellbeing; or
- suffering a condition which represents a significant threat to public health.

If an admission meets the definition of emergency above, it is categorised as emergency, regardless of whether the admission occurred within 24 hours of such a categorisation being made, or after 24 hours or more.

Elective admissions

If an admission meets the definition of elective above, it is categorised as elective, regardless of whether the admission actually occurred after 24 hours or more, or it occurred within 24 hours. The distinguishing characteristic is that the admission could be delayed by at least 24 hours.

Scheduled admissions

A patient who expects to have an elective admission will often have that admission scheduled in advance. Whether or not the admission has been scheduled does not affect the categorisation of the admission as emergency or elective, which depends only on whether it meets the definitions above. That is, patients both with and without a scheduled admission can be admitted on either an emergency or elective basis.

Admissions from elective surgery waiting lists

Patients on waiting lists for elective surgery are assigned a Clinical urgency status which indicates the clinical assessment of the urgency with which a patient requires elective hospital care. On admission, they will also be assigned an Urgency of admission category, which may or may not be elective.

Patients who are removed from elective surgery waiting lists on admission as an elective patient for the procedure for which they were waiting (see data domain value 1 in Reason for removal) will be assigned an Urgency of admission of 'Urgency status assigned—elective'. In that case, their Clinical urgency category could be regarded as further detail on how urgent their admission was.

Patients who are removed from elective surgery waiting lists on admission as an emergency patient for the procedure for which they were waiting (see data domain value 2 in Reason for removal), will be assigned an Urgency of admission of 'Urgency status assigned—emergency'.

Admissions for which an urgency status is usually not assigned

An urgency status can be assigned for admissions of the types listed above for which an urgency status is not usually assigned. For example, a patient who is to have an obstetric admission may have one or more of the clinical conditions listed above and be admitted on an emergency basis.

Guide for use (continued):

Use of data domain 9

The not known/not reported category is to be used when it is not known whether or not an urgency status has been assigned, or when an urgency status has been assigned but is not known.

Administrative attributes

Source organisation: Emergency Definition Working Party, NHDC

National minimum data sets:

Admitted patient care	from 1/07/2000 to

Anticipated patient election status

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000631 Version number: 1

Data element type: DATA ELEMENT

Definition: Accommodation chargeable status nominated by the patient when placed on an elective surgery waiting list.

Context: Elective surgery waiting times.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Public

2 Private

Guide for use: The election status nominated by the patient at the time of being placed on an elective surgery waiting list, to be treated as either:

- a public patient; or
- a private patient

This item is independent of patient's hospital insurance status. The definitions of a public and private patient are those in the 1998–2003 Australian Health Care Agreements:

1. Public patient: an eligible person who receives or elects to receive a public hospital service free of charge.

2. Private patient: an eligible person who elects to be treated as a private; and elects to be responsible for paying fees of the type referred to in clause 57 (clause 58 of the Northern Territory Agreement) of the Australian Health Care Agreements.

Clause 57 states that "Private patients and ineligible persons may be charged an amount for public hospital services as determined by the State."

Patients whose charges are to be met by the Department of Veteran's Affairs are regarded as private patients.

Administrative attributes

Comments: Anticipated election status may be used for the management of elective surgery waiting lists, but the term is not defined under the 1998–2003 Australian Health Care Agreements. Under the Agreements patients are required to elect to be treated as a public or private patient, at the time of, or as soon as practicable after admission. Therefore, the anticipated patient election status is not binding on the patient and may vary from the election the patient makes on admission.

Intended length of hospital stay

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000076 Version number: 2

Data element type: DATA ELEMENT

Definition: The intention of the responsible clinician at the time of the patient's admission to hospital or at the time the patient is placed on an elective surgery waiting list, to discharge the patient either on the day of admission or a subsequent date.

Context: Admitted patient care: to assist in the identification and casemix analysis of planned same-day patients, that is those patients who are admitted with the intention of discharge on the same day. This is also a key indicator for quality assurance activities.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Intended same-day

2 Intended overnight

Collection methods: The intended length of stay should be ascertained for all admitted patients at the time the patient is admitted to hospital.

Related data: Is used in the derivation of Diagnosis related group, version 1

supersedes Intended length of hospital stay, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Admitted patient care	from 1/07/2001 to
Admitted patient mental health care	from 1/07/2001 to

Comments: Information comparing the intended length of the episode of care and the actual length of the episode of care is considered useful for quality assurance and utilisation review purposes.

Intended place of birth

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000077 Version number: 1

Data element type: DATA ELEMENT

Definition: The intended place of birth at the onset of labour.

Context: Perinatal: women who plan to give birth in birth centres or at home usually have different risk factors for outcome compared to those who plan to give birth in hospitals. Women who are transferred to hospital after the onset of labour have increased risks of intervention and adverse outcomes.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Hospital, excluding birth centre
2	Birth centre, attached to hospital
3	Birth centre, free standing
4	Home
8	Other
9	Not stated

Guide for use:

1	Hospital—includes for women who have elective caesarean sections
4	Home—should be restricted to the home of the woman or a relative or friend.
8	Other—includes community (health) centres.

Related data: is qualified by Actual place of birth, version 1

is qualified by Onset of labour, version 2

is qualified by Method of birth, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Comments: The development of a definition of a birth centre is currently under consideration by the Commonwealth in conjunction with the States and Territories.

Scheduled admission date

Admin. status: CURRENT 1/01/1995

Identifying and definitional attributes

Knowledgebase ID: 000147 Version number: 2

Data element type: DATA ELEMENT

Definition: The date on which it is proposed that a patient on the waiting list will be admitted for an episode of care.

Context: This item is required for the purposes of hospital management—allocation of beds, operating theatre time and other resources.

Relational and representational attributes

Datatype: Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

Data domain: Valid dates

Related data: supersedes previous data element Scheduled admission date, version 1

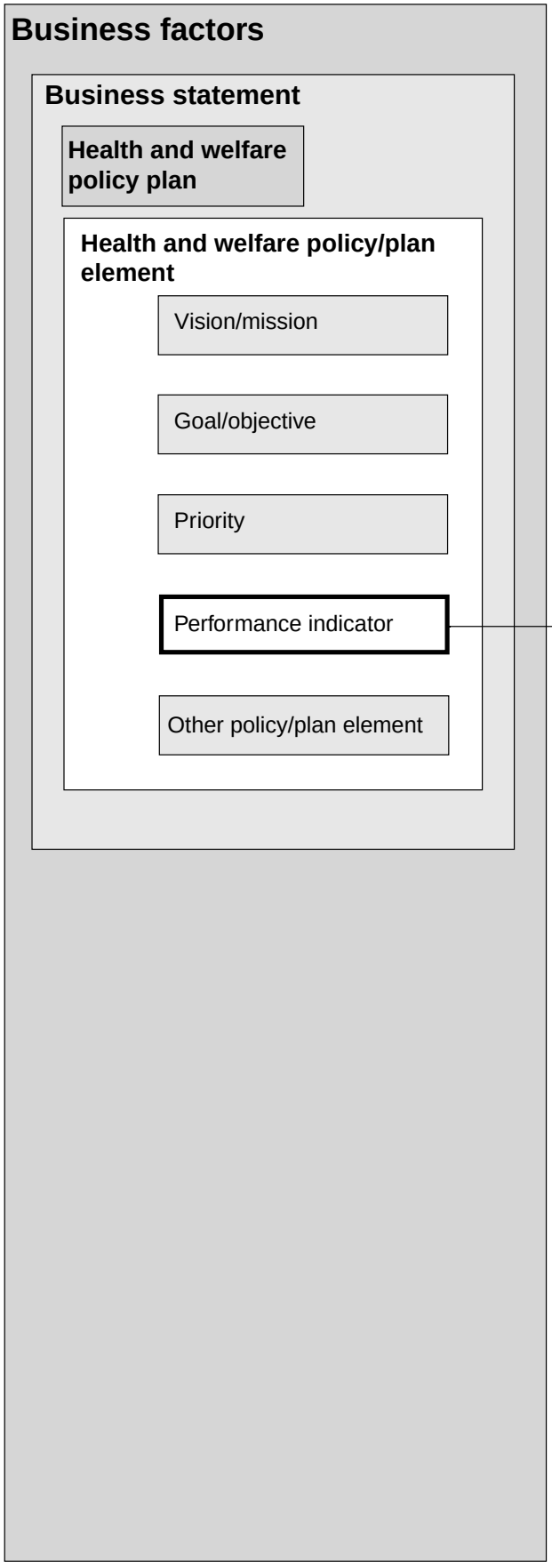
used in conjunction with Listing date for care, version 3

Administrative attributes

Source organisation: National Health Data Committee

Comments: If this data element were to be used to compare different hospitals or geographical locations, it would be necessary to specify when the scheduled date is to be allocated (for example, on addition to the waiting list).

National Health Information Model entity



Data elements

- Emergency Department waiting time to admission
- Emergency Department waiting time to service delivery
- Extended wait patient
- Length of stay
- Length of stay (antenatal)
- Length of stay (including leave days)
- Length of stay (postnatal)
- Non-admitted patient service event count
- Number of qualified days for newborns
- Occasions of service
- Overdue patient
- Patient days
- Patients in residence at year end
- Separations
- Total contract patient days
- Total psychiatric care days
- Type of non-admitted patient care
- Type of non-admitted patient care (residential aged care services)
- Type of non-admitted patient care (public psychiatric, alcohol and drug)
- Waiting time at a census date
- Waiting time at admission

Emergency Department waiting time to admission

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000397 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: The time elapsed for each patient from presentation to the Emergency Department to admission to hospital.

Context: Emergency care: this is a critical waiting times data item. This item is used to examine the length of waiting time, for performance indicators and benchmarking. Information based on this data item will have many uses including to assist in the planning and management of hospitals and in health care research.

Relational and representational attributes

Datatype: Numeric Field size: Min. 4 Max. 4 Layout: HHMM

Data domain: Count in numbers of hours and minutes

Guide for use: Calculated from admission date and time minus date and time patient presents for those Emergency Department patients who are admitted.

Collection methods: To be collected on patients presenting to Emergency Department for unplanned care in public hospitals with Emergency Department and private hospitals providing contracted services for the public sector.

Related data: is calculated using Admission date, version 4

relates to concept Patient presentation at Emergency Department, version 1

is calculated using Date patient presents, version 2

is calculated using Time patient presents, version 2

is calculated using Admission time, version 1

is calculated using Departure status, version 1

Administrative attributes

Source organisation: National Health Data Committee

Emergency Department waiting time to service delivery

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000347 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: The time elapsed for each patient from presentation to the Emergency Department to commencement of service by a treating medical officer or nurse.

Context: Emergency care: this is a critical waiting times data item. This item is used to examine the length of waiting time, for performance indicators and benchmarking. Information based on this data item will have many uses including to assist management of Emergency Departments, the planning and management of hospitals and in health care related research.

Relational and representational attributes

Datatype: Numeric Field size: Min. 4 Max. 4 Layout: HHMM

Data domain: Count in numbers of hours and minutes

Guide for use: Calculated from date and time of service event minus date and time patient presents. Although triage category 1 is measured in seconds, it is recognised that the data will not be collected with this precision.

Waiting time may be zero if triage and treatment are coincident.

Collection methods: To be collected on patients presenting to Emergency Department for unplanned care in public hospitals with Emergency Department and private hospitals providing contracted services for the public sector.

Related data: is used in the calculation of Triage category (trial), version 1

is calculated using Date patient presents, version 2

is calculated using Time patient presents, version 2

is calculated using Date of commencement of service event, version 2

is calculated using Time of commencement of service event, version 2

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Emergency Department waiting times from 1/07/1999 to

Comments: It is recognised that at times of extreme urgency or multiple synchronous presentations, or if no medical officer is on duty in the Emergency Department, this service may be provided by a nurse.

This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department waiting times National Minimum Data Set.

Extended wait patient

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000400 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: A patient with the lowest level of clinical urgency for an awaited procedure who has been on the waiting list for elective surgery for more than one year.

Context: Elective surgery: the numbers and proportions of patients with extended waits are measures of hospital performance in relation to patient access to elective hospital care.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Extended wait patient

2 Other patient

Guide for use: A patient is classified as an extended wait patient if the patient is in clinical urgency category 3 at the time of admission or at a census time and has been waiting for the elective surgery for more than one year.

Related data: is qualified by Clinical urgency, version 2

is derived from Waiting time at a census date, version 1

is derived from Waiting time at admission, version 1

Administrative attributes

Source organisation: AIHW, National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/1999 to

Comments: This data item is used to identify clinical urgency category 3 patients who had waited longer than one year at admission or have waited longer than one year at the time of a census. An extended wait patient is not an 'Overdue patient' as there is no maximum desirable waiting time specified for patients in clinical urgency category 3 as they have been assessed as not having a clinically urgent need for the awaited procedure.

Length of stay

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000119 Version number: 3

Data element type: DERIVED DATA ELEMENT

Definition: The length of stay of a patient measured in patient days. A same-day patient should be allocated a length of stay of one patient day. The length of stay of an overnight stay patient is calculated by subtracting the date the patient is admitted from the date of separation and deducting total leave days. Total contracted patient days are included in the length of stay.

Context: Admitted patient care:

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 3 Layout: NNN

Data domain: Count number of patient days

Related data: supersedes previous Length of stay, version 2
is calculated using Admission date, version 4
is calculated using Total leave days, version 3
is calculated using Separation date, version 5

Administrative attributes

Source organisation: National Health Data Committee

Comments Perinatal length of stay data elements include leave days and so are not included in this data element.

Length of stay (antenatal)

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000635 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: The length of stay of a patient measured in days calculated from the admission date of mother to the date of birth of the baby. Total contracted days are included in the length of stay. Leave days are included.

Context: Perinatal:

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 3 Layout: NNN

Data domain: Integer count number of patient days

Guide for use: Antenatal length of stay refers only to the admission associated with the birth.

This data element is calculated by subtracting the Date of birth of the baby from the mother's Admission date. The calculation is inclusive of the day of admission of the mother and the day of birth of the baby.

Related data: is related to the concept Perinatal period version 1

is related to Length of stay (including leave days) version 1

is calculated using Admission date, version 4

is calculated using Date of birth, version 3

Administrative attributes

Source organisation: National Health Data Committee

Length of stay (including leave days)

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000636 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: The length of stay of a patient measured in days. A same-day patient should be allocated a length of stay of one day. Total contracted days are included in the length of stay. All leave days are included in length of stay calculation.

Context: Perinatal: and other situations where it is required to know the total length of a stay in hospital.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 3 Layout: NNN

Data domain: Integer count number of patient days

Guide for use: This data element is calculated by subtracting the mother's Admission date from the mother's Separation date. The calculation is inclusive of admission and separation dates.

Related data: is related to Perinatal period version 1

is related to length of stay (ante-natal) version 1

is related to length of stay (post-natal) version 1

is calculated using Admission date, version 4

is calculated using Separation date, version 5

Administrative attributes

Source organisation: National Health Data Committee

Length of stay (postnatal)

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000637 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: The length of stay of a patient measured in days calculated from the Date of birth of baby to Separation date of mother. Total contracted days are included in the length of stay. Leave days are included.

Context: Perinatal:

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 3 Layout: NNN

Data domain: Count number of patient days from day of birth of baby(s)

Guide for use: Excludes transfers, home births and other non-hospital births.

For the mother, this data element is calculated by subtracting the mother's Separation date from the Date of birth of the baby. The calculation is inclusive of those dates.

For the baby, this data element is calculated by subtracting the baby's Separation date from the Date of birth of the baby. The calculation is inclusive of those dates.

Related data: is related to Perinatal period version 1

is related to Length of stay (including leave days) version 1

is calculated using Date of birth, version 3

is calculated using Separation date, version 5

Administrative attributes

Source organisation: National Health Data Committee

Non-admitted patient service event count

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000437 Version number: 1

Data element type: DATA ELEMENT

Definition: The number of service events provided to non-admitted patients in the reference period, for each of the clinical service types in the hospital.

Context: Hospital non-admitted patient care—public patients only.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 7 Layout: NNNNNNN

Data domain: Count of non-admitted patient service events for each of the clinical service types listed in the data domain of the data element Non-admitted patient service type.

Guide for use: For each non-admitted patient service event count, specify the:

- Service type
- Multi-disciplinary team status
- Individual/group session status
- Patient present status
- Service mode

Related data: used in conjunction with Multi-disciplinary team status, version 1

used in conjunction with Non-admitted patient service event, version 1

used in conjunction with Non-admitted patient service type, version 1

used in conjunction with Non-admitted patient service mode, version 1

used in conjunction with Non-admitted patient service event - patient present status, version 1

used in conjunction with Individual/group session, version 1

Administrative attributes

Source organisation: National Health Data Committee

Comments: Public patients are defined in accordance with the 1998–2003 Australian Health Care Agreements.

Number of qualified days for newborns

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000346 Version number: 2

Data element type: DATA ELEMENT

Definition: The number of qualified newborn days occurring within a newborn episode of care.

Context: Admitted patient care—newborn episodes of care only.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 5 Layout: NNNNN

Data domain: Count of the number of days

Guide for use: The rules for calculating the number of qualified newborn days are outlined below. The number of qualified days is calculated with reference to the date of admission, date of separation and any date(s) of change to qualification status:

- the date of admission is counted if the patient was qualified at the end of the day
- the date of change to qualification status is counted if the patient was qualified at the end of the day
- the date of separation is not counted, even if the patient was qualified on that day
- the normal rules for calculation of patient days apply, for example in relation to leave and same day patients

The length of stay for a newborn episode of care is equal to the sum of the qualified and unqualified days.

Related data: supersedes previous data element Number of acute (qualified)/unqualified days for newborns), version 1

is used in the calculation of Patient days, version 3

used in conjunction with Date of change to qualification status, version 1

used in conjunction with Newborn qualification status, version 2

Occasions of service

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000209 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: The number of occasions of examination, consultation, treatment or other service provided to a patient in each functional unit of a health service establishment. Each diagnostic test or simultaneous set of related diagnostic tests for the one patient referred to a hospital pathology department consists of one occasion of service.

Context: Occasions of service are required as a measure of non-admitted patient service provision.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 7 Layout: NNNNNNN

Data domain: Number of occasions of service

Collection methods: The definition does not distinguish case complexity for non-admitted patients. For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average Diagnosis Related Group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition. For admitted patients the concept of a separation is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Administrative attributes

Source organisation: National minimum data set working parties

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Overdue patient

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000085 Version number: 3

Data element type: DERIVED DATA ELEMENT

Definition: An overdue patient is one whose wait has exceeded the time that has been determined as clinically desirable in relation to the urgency category to which they have been assigned.

Context: Elective surgery: the numbers and proportions of overdue patients represent a measure of the hospital's performance in provision of elective hospital care.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1 Overdue patient

2 Other

Guide for use: This data element is only required for patients in clinical urgency categories with specified maximum desirable waiting times. Overdue patients are those for whom the hospital system has failed to provide timely care and whose wait may have an adverse effect on the outcome of their care. They are identified by a comparison of 'Waiting time at admission' or 'Waiting time at a census date' and the maximum desirable time limit for the 'Clinical urgency' classification.

A patient is classified as overdue if ready for care and 'Waiting time at admission' or 'Waiting time at a census date' is longer than 30 days for patients in Clinical urgency category 1 or 90 days for patients in Clinical urgency category 2.

Related data: supersedes previous data element Overdue patient, version 2

is qualified by Clinical urgency, version 2

is derived from Waiting time at a census date, version 1

is derived from Waiting time at admission, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/1994 to

Comments: This data item is not used for patients in Clinical urgency category 3 as there is no specified timeframe within which it is desirable that they are admitted.The data element Extended wait patient identifies patients in Clinical urgency category 3 who have waited longer than one year at admission or at the time of a census.

Patient days

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000206 Version number: 3

Data element type: DERIVED DATA ELEMENT

Definition: The number of patient days is the total number of days for all patients who were admitted for an episode of care and who separated during a specified reference period.

Context: Admitted patient care: needed as the basic count of the number of services provided by an establishment.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 8 Layout: NNNNNNNN

Data domain: Total patient days for the period

Guide for use: A day is measured from midnight to 2359 hours.

The following basic rules are used to calculate the number of patient days for overnight stay patients:

- The day the patient is admitted is a patient day.
- If the patient remains in hospital from midnight to 2359 hours count as a patient day.
- The day a patient goes on leave is counted as a leave day.
- If the patient is on leave from midnight to 2359 hours count as a leave day.
- The day the patient returns from leave is counted as a patient day.
- The day the patient is separated is not counted as a patient day.
- The following additional rules cover special circumstances and in such cases, override the basic rules:
- Patients admitted and separated on the same date (same-day patients) are to be given a count of one patient day.
- If the patient is admitted and goes on leave on the same day, count as a patient day.
- If the patient returns from leave and goes on leave on the same date, count as a leave day.
- If the patient returns from leave and is separated, it is not counted as either a patient day or a leave day.
- If a patient goes on leave the day they are admitted and does not return from leave until the day they are discharged, count as one patient day (the day of admission is counted as a patient day, the day of separation is not counted as a patient day).

Guide for use (continued): When calculating total patient days for a specified period:

- Count the total patient days of those patients separated during the specified period including those admitted before the specified period
- Do not count the patient days of those patients admitted during the specified period who did not separate until the following reference period.
- Contract patient days are included in the count of total patient days. If it is a requirement to distinguish contract patient days from other patient days, they can be calculated by using the rules contained in the data element: total contract patient days.

Collection methods: For the national minimum data set—Admitted patient care the reference period for data collection is a financial year i.e. 1 July to 30 June inclusive.

Related data: supersedes previous data element Patient days, version 2

relates to Admission date, version 4

relates to Total leave days, version 3

relates to Total contract patient days, version 1

relates to Discharge date, version 4

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments from 1/07/1989 to

Patients in residence at year-end

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000208 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: A headcount of all formally admitted patients/clients in residence in long-stay facilities (public psychiatric hospitals, alcohol and drug hospitals, residential aged care services) at midnight, to be done on 30 June.

Context: The number of separations and bed days for individual long-stay establishments is often a poor indication of the services provided. This is because of the relatively small number of separations in a given institution. Experience has shown that the number of patients/clients in residence can often give a more reliable picture of the levels of services being provided.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 4 Layout: NNNN

Data domain: Number of admitted patients/clients in residence

Collection methods: For public psychiatric hospitals and alcohol and drug hospitals, all States have either an annual census or admission tracking that would enable a statistical census. The Commonwealth Department of Health and Family Service is able to carry out a statistical census from its residential aged care services databases. No system is presently in place for hostels.

A headcount snapshot could be achieved either by census or by the admission/discharge derivation approach.

There are difficulties with the snapshot in view of both seasonal and day of the week fluctuations. Most of the traffic occurs in a small number of beds.

Any headcount should avoid the problems associated with using 31 December or 1 January. The end of the normal financial year is probably more sensible (the Wednesday before the end of the financial year was suggested, but probably not necessary). This should be qualified by indicating that the data does not form a time series in its own right.

Administrative attributes

Source organisation: Morbidity Working Party

Separations

Admin. status: CURRENT 1/07/1994

Identifying and definitional attributes

Knowledgebase ID: 000205 Version number: 2

Data element type: DERIVED DATA ELEMENT

Definition: The total number of separations occurring during the reference period. This includes both formal and statistical separations.

Context: Admitted patient care: needed as the basic count of the number of separations from care for an establishment.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 6 Layout: NNNNNN

Data domain: A number, representing the number of completed episodes of care

Guide for use: The sum of the number of separations where the Discharge date has a value:

≥ the beginning of the reference period (typically a financial year); and

≤ the end of the reference period.

This sum may be calculated at:

- individual establishment level; or
- system (i.e. State/Territory) level i.e. the sum of the number of establishments.

Collection methods: For the national minimum data set—admitted patient care the reference period for data collection is a financial year i.e. 1 July to 30 June inclusive.

Related data: relates to concept Separation, version 3

supersedes previous derived data element Separations, version 1

is derived from Separation date, version 5

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments	from 1/07/2000 to
Community mental health establishments	from 1/07/1998 to

Total contract patient days

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000429 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: Sum of the number of contract patient days (Contracted care completion date minus Contracted care commencement date) for all periods within the hospital stay.

Context: Admitted patient care:

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 3 Layout: NNN

Data domain: Count number of days

Guide for use: A day is measured from midnight to 2359 hours.

Contract patient days are included in the total count of patient days. If necessary, Contract patient days can be distinguished from other patient days by using the following rules:

The day the contract commences is counted as a contract patient day.

If the patient is on contract from midnight to 2359 count as a contract patient day.

The day a contract is completed is not counted as a contract patient day.

If the patient is admitted and commences a contract on the same day, this is not counted as a contract patient day

If a contract is completed and the patient is separated on the same day, the day should not be counted as a contract or other patient day.

Related data: relates to Contracted hospital care, version 1

relates to Contract type, version 1

relates to Contract role, version 1

relates to Contract establishment identifier, version 3

relates to Contracted care commencement date, version 1

relates to Contracted care completion date, version 1

relates to Contract procedure flag, version 1

relates to Patient days, version 3

Administrative attributes

Source organisation: National Health Data Committee

Total psychiatric care days

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000164 Version number: 2

Data element type: DERIVED DATA ELEMENT

Definition: The sum of the number of days or part days of stay that the person received care as an admitted patient or resident within a designated psychiatric unit, minus the sum of leave days occurring during the stay within the designated unit.

Context: Admitted patient and residential mental health care: this data element is required to identify the characteristics of patients treated in specialist psychiatric units located within acute care hospitals or 24-hour staffed community-based residential services and to analyse the activities of these units and services. Community mental health care: this data element is required to identify the characteristics of patients treated in specialist psychiatric 24-hour staffed community-based residential services and to analyse the activities of these units. The data element is necessary to describe and evaluate the progress of mainstreaming of mental health services.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 5 Layout: NNNNN

Data domain: Count in number of days

Guide for use: Designated psychiatric units are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder. The unit may or may not be recognised under relevant State and Territory legislation to treat patients on an involuntary basis. Patients are admitted patients in the acute and psychiatric hospitals and residents in community based residences.

Public acute care hospitals

Designated psychiatric units in public acute care hospitals are normally recognised by the State/Territory health authority in the funding arrangements applying to those hospitals.

Private acute care hospitals

Designated psychiatric units in private acute care hospitals normally require license or approval by the State/Territory health authority in order to receive benefits from health funds for the provision of psychiatric care.

Psychiatric hospitals

Total psychiatric care days in stand-alone psychiatric hospitals are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.

Psychiatric hospitals are establishments devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. Private hospitals formerly approved by the Commonwealth Department of Health under the Health Insurance Act 1973 (Cwlth) (now licensed/approved by each State/Territory health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Guide for use (continued):

Community-based residential services

Designated psychiatric units refers to 24-hour staffed community-based residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. Special psychiatric units for the elderly are covered by this category, including psychogeriatric hostels or psychogeriatric residential aged care services. Note that residences occupied by admitted patients located on hospital grounds, whether on the campus of a general or stand-alone psychiatric hospital, should be counted in the category of admitted patient services and not as community-based residential services.

Counting of patient days and leave days in designated psychiatric units should follow the standard definitions applying to these items.

- For each period of care in a designated psychiatric unit, total days is calculated by subtracting the date on which care commenced within the unit from the date on which the specialist unit care was completed, less any leave days that occurred during the period.

Total psychiatric care days in 24-hour community-based residential care are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.

Admitted patients in acute care: Commencement of care within a designated psychiatric unit may be the same as the date the patient was admitted to the hospital, or occur subsequently, following transfer of the patient from another hospital ward. Where commencement of psychiatric care occurs by transfer from another ward, a new episode of care may be recorded, depending on whether the care type has changed (see data element 'Care type'). Completion of care within a designated psychiatric unit may be the same as the date the patient was discharged from the hospital, or occur prior to this on transfer of the patient to another hospital ward. Where completion of psychiatric care is followed by transfer to another hospital ward, a new episode of care may be recorded, depending on whether the care type has changed (see data element 'Care type'). Total psychiatric care days may cover one or more periods in a designated psychiatric unit within the overall hospital stay.

Accurate counting of total days in psychiatric care requires periods in designated psychiatric units to be identified in the person-level data collected by State or Territory health authorities. Several mechanisms exist for this data field to be implemented.

Ideally, the new data field should be collected locally by hospitals and added to the unit record data provided to the relevant State/Territory health authority.

Acute care hospitals in most States and Territories include details of the wards in which the patient was accommodated in the unit record data provided to the health authority.

Local knowledge should be used to identify designated psychiatric units within each hospital's ward codes to allow total psychiatric care days to be calculated for each episode of care.

Acute care hospitals and 24-hour staffed community-based residential services should be identified separately at the level of the establishment.

Verification rules:

Total days in psychiatric care must be:

- ≥ zero; and
- ≤ length of stay

Related data: is derived from Admission date, version 3
is derived from Total leave days, version 3
supersedes previous data element Total psychiatric care days, version 1
is derived from Establishment type, version 1
is derived from Care type, version 4
is derived from Separation date, version 5

Administrative attributes

Source organisation: National Mental Health Information Strategy Committee

National minimum data sets:

Admitted patient care	from 1/07/2000 to
Admitted patient mental health care	from 1/07/2000 to
Community mental health care	from 1/07/2000 to

Comments: This data element was originally designed to monitor trends in the delivery of psychiatric admitted patient care in acute care hospitals. It has been modified to enable collection of data in the community-based residential care sector. The data element is intended to improve understanding in this area and contribute to the ongoing evaluation of changes occurring in mental health services.

Type of non-admitted patient care

Admin. status: CURRENT 1/07/1994

Identifying and definitional attributes

Knowledgebase ID: 000231 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: This data element concept identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

Context: Required to describe the broad types of services provided to non-admitted patients, community patients and outreach clients.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 7 Layout: NNNNNNN

Data domain: Count number of non-admitted patient occasions of service.

Guide for use: Categories are as follows (definitions of each are given below):

Emergency department and emergency services

A9.1 emergency services

Outpatient services

A9.2 dialysis

A9.3 pathology

A9.4 radiology and organ imaging

A9.5 endoscopy and related procedures

A9.6 other medical/surgical/diagnostic

A9.7 mental health

A9.8 drug and alcohol

A9.9 dental

A9.10 pharmacy

A9.11 allied health services

*Other non-admitted service*s

A9.12 community health services

A9.13 district nursing services

A9.14 other outreach services

Definitions:

A9.1 Emergency services: Services to patients who are not admitted and who receive treatment that was either unplanned or carried out in designated Emergency Departments within a hospital. Unplanned patients are patients who have not been booked into the hospital before receiving treatment.In general it would be expected that most patients would receive surgical or medical treatment. However, where patients receive other types of treatment that are provided in Emergency Departments these are to be included. The exceptions are for dialysis and endoscopy and related procedures which have been recommended for separate counting.

Guide for use (continued):

A9.2 Dialysis: This represents all non-admitted patients receiving dialysis within the establishment. Where patients receive treatment in a ward or clinic classified elsewhere (for example, an Emergency Department), those patients are to be counted as dialysis patients and to be excluded from the other category. All forms of dialysis which are undertaken as a treatment necessary for renal failure are to be included.

A9.3 Pathology: This includes all occasions of service to non-admitted patients from designated pathology laboratories. Occasions of service to all patients from other establishments should be counted separately.

A9.4 Radiology and organ imaging: This includes all occasions of service to non-admitted patients undertaken in radiology (X-ray) departments as well as in specialised organ imaging clinics carrying out ultrasound, computerised tomography (CT) and magnetic resonance imaging.

A9.5 Endoscopy and related procedures: This should include all occasions of service to non-admitted patients for endoscopy including:

- cystoscopy
- gastroscopy
- oesophagoscopy
- duodenoscopy
- colonoscopy
- bronchoscopy
- laryngoscopy

Where one of these procedures is carried out in a ward or clinic classified elsewhere, for example in the Emergency Department, the occasion is to be included under endoscopy and related procedures, and to be excluded from the other category. Care must be taken to ensure procedures or admitted patients are excluded from this category.

A9.6 Other medical/surgical/diagnostic: Any occasion of service to a non-admitted patient given at a designated unit primarily responsible for the provision of medical/surgical or diagnostic services which has not been covered in the above. These include ECG, obstetrics, nuclear medicine, general medicine, general surgery, fertility and so on.

A9.7 Mental health: All occasions of service to non-admitted patients attending designated psychiatric or mental health units within hospitals.

A9.8 Alcohol and drug: All occasions of service to non-admitted patients attending designated drug and alcohol units within hospitals.

A9.9 Dental: All occasions of service to non-admitted patients attending designated dental units within hospitals.

A9.10 Pharmacy: This item includes all occasions of service to non-admitted patients from pharmacy departments. Those drugs dispensed/administered in other departments such as the Emergency Department, or outpatient departments, are to be counted by the respective departments.

Guide for use (continued):

A9.11 Allied health services: This includes all occasions of service to non-admitted patients where services are provided at units/clinics providing treatment/counselling to patients. These include units primarily concerned with physiotherapy, speech therapy, family planning, dietary advice, optometry, occupational therapy and so on.

A9.12 Community health services: Occasions of service to non-admitted patients provided by designated community health units within the establishment. Community health units include:

- baby clinics
- immunisation units
- aged care assessment teams
- other

A9.13 District nursing service: Occasions of service to non-admitted patients which:

- are for medical/surgical/psychiatric care
- are provided by a nurse, paramedic or medical officer
- involve travel by the service provider*
- are not provided by staff from a unit classified in the community health category above.

A9.14 Other outreach services: Occasions of service to non-admitted patients which:

- involve travel by the service provider*
- are not classified in allied health or community health services above

*Travel does not include movement within an establishment, movement between sites in a multi-campus establishment or between establishments. Such cases should be classified under the appropriate non-admitted patient category.

It is intended that these activities should represent non-medical/surgical/psychiatric services. Activities such as home cleaning, meals on wheels, home maintenance and so on should be included.

A patient who first contacts the hospital and receives non-admitted care, for example through Emergency Departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted, should be identified as a subset of the total occasions of service.

Collection methods: The list of categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Administrative attributes

Source organisation: National minimum data set working parties

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Comments:

Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients.

This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary.

For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

Type of non-admitted patient care (residential aged care services)

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000234 Version number: 1

Data element type: DATA ELEMENT

Definition: Outpatients are patients who receive non-admitted care. Non-admitted care is care provided to a patient who is not formally admitted but receives direct care from a designated clinic within the residential aged care service.

For outreach/community patients, care is delivered by residential aged care service employees to the patient in the home, place of work or other non-establishment site.

Context: Required to adequately describe the services provided to non-admitted patients.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 3 Layout: NNN

Data domain: A11.1 Occasions of service to outpatients

A11.2 Occasions of service to outreach/community patients

Administrative attributes

Source organisation: National minimum data set working parties

Comments: Apart from acute hospitals, establishments generally provide a much more limited range of services for non-admitted patients and outreach/community patients/clients. Therefore disaggregation by type of episode is not as necessary as in acute hospitals.

Type of non-admitted patient care (public psychiatric, alcohol and drug)

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000233 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: Emergency and outpatients are patients who receive non-admitted care. Non-admitted care is care provided to a patient who receives direct care within the Emergency Department or other designated clinics within the hospital and who is not formally admitted at the time when the care is provided. A patient who first contacts the hospital and receives non-admitted care, for example through the Emergency Department, and is subsequently admitted should have both components of care enumerated separately.

For outreach/community patients, care delivered by hospital employees to the patient in the home, place of work or other non-hospital site.

A group is defined as two or more patients receiving a service together, where all individuals are not members of the same family. Family services are to be treated as occasions of service to an individual.

Context: Required to adequately describe the services provided to non-admitted patients in public psychiatric hospitals and alcohol and drug hospitals.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 7 Layout: NNNNNNN

Data domain: Count occasions of service for the following categories:

Guide for use: Emergency and outpatient occasions of service

1 Individual patients

2 Groups

Outreach/community occasions of service

3 Individual patients

4 Groups

Collection methods: The working party discussed the need to distinguish different types of psychiatric outpatient services in psychiatric hospitals. South Australia outlined its categories of psychiatric outpatients:

- day patients (not admitted but are day program patients);
- outpatients (typically 20 minutes consultation); community/outreach (outreach services provided by staff off the hospital site, including community health service provided off-site and domiciliary care); and casualty patients (designated casualty area, mirroring usual hospital set up).

These categories also applied to mental health clinics in South Australia. The working party agreed that the South Australian categories were useful, but that outpatient and casualty categories should be collapsed as there was a boundary problem between these two categories.

Collection methods (continued):

The working party initially recommended the following categories for activity data for outpatient services at establishment level:

- day program patients
- emergency and other outpatients
- outreach/community

The first two of the above categories cover all outpatients treated on the hospital site, the latter covers outreach services provided by the staff off the hospital site. It includes community health services provided by hospital staff off-site.

The working party then discussed the unit of counting for activity data. The Psychiatric Working Party reviewed the recommendation of the In-patient/Non-in-patient Working Party that occasions of service should be the appropriate unit of counting. The following points were raised:

- The method of counting the number of group sessions in a psychiatric setting was difficult because a day patient is always a group patient. Also, groups would have a mixture of in-patients and outpatients.
- Counting occasions of service for a day patient was difficult because a patient could have up to eight treatment encounters in one day.
- From a client perspective, groups should be ignored and information should be collected on every individual.
- Queensland counted the number of days on which contact is made, irrespective of intensity of service.
- It was suggested that occasions of service (or individuals) be counted but that the information should be divided into one-on-one sessions or group sessions, for resource implications.
- Some members thought that, in terms of resources, groups of staff and type of provider were more important than number of clients.
- Victoria proposed a bare bones approach, and recommended that only occasions of service be counted. All the other points raised were important dimensions, but Victoria felt that to do justice to them, it would be necessary to include community services, phone consultations and so on, which was not feasible at this stage.

The Psychiatric Working Party foreshadowed the need to categorise outpatients further into child, adult and other. It was generally agreed that while this aspect would be worthwhile flagging in a policy statement, it was not necessary to consider it at this stage.

The Psychiatric Working Party also agreed that occasions of service was the preferred counting unit for non-admitted patient activity data. It was noted that the acute sector had opted for this unit.

The Psychiatric Working Party recommended that a family was to be counted as one occasion of service (individual session) not as a group, and that a family unit was to be determined as a group of people which identified themselves as such.

The Psychiatric Working Party agreed that the unit of counting of services should be as follows:

- day program attendances
- other outpatient occasions of service
- outreach occasions of service.

Day program patients should be counted as number of attendances to a day program (patient days). Day program patient occasions of service with other staff should be counted separately as other outpatient occasions of service.

Administrative attributes

Source organisation: National minimum data set working parties

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Comments: In general, establishments other than acute hospitals provide a much more limited range of services for non-admitted patients and outreach/community patients/clients. Therefore, disaggregation by type of non-admitted patient care is not relevant to psychiatric and alcohol/drug hospitals.

Waiting time at a census date

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000412 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: The time elapsed for a patient on the elective surgery waiting list from the date they were added to the waiting list for the procedure to a designated census date.

Context: Elective surgery: this is a critical elective surgery waiting times data element. It is used to determine whether patients are overdue, or had extended waits at a census date. It is used to assist doctors and patients in making decisions about hospital referral, to assist in the planning and management of hospitals and in health care related research.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 4 Layout: NNNN

Data domain: Count in number of days

Guide for use: The number of days is calculated by subtracting the Listing Date from the Census date, minus any days when the patient was 'not ready for care', and also minus any days the patient was waiting with a less urgent clinical urgency category than their clinical urgency category at the Census date.

Days when the patient was not ready for care is calculated by subtracting the date(s) the person was recorded as 'not ready for care' from the date(s) the person was subsequently recorded as again being 'ready for care'

If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a less urgent clinical urgency category than the category at the Census date, then the number of days waited at the less urgent clinical urgency category should be subtracted from the total number of days waited.

In cases where there has been only one category reassignment (i.e. to the more urgent category attached to the patient at Census date) the number of days at the less urgent clinical urgency category should be calculated by subtracting the Listing date from the Category reassignment date. If the patient's clinical urgency was reclassified more than once, days spent in each period of less urgent clinical urgency than the one applying at the Census date should be calculated by subtracting one Category reassignment date from the subsequent Category reassignment date, and then added together.

When a patient is admitted from an elective surgery waiting list but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue. Therefore at the Census date the patient's waiting time includes the number of days waited on an elective surgery waiting list, both before and after any cancelled surgery admission. The time waited before the cancelled surgery should be counted as part of the total time waited by the patient.

Related data: is calculated using Listing date for care, version 3
is calculated using Census date, version 2
is calculated using Patient listing status, version 3
is qualified by Clinical urgency, version 2
is calculated using Category reassignment date, version 2
is used in the derivation of Overdue patient, version 3
is used in the derivation of Extended wait patient, version 1

Administrative attributes

Source organisation: Australian Institute of Health and Welfare, National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 01/07/1999 to

Comments: Elective surgery waiting times data collections include measures of waiting times at admission and at designated census dates. This data element is used to measure waiting times at a designated census date whereas the data element Waiting time at admission measures waiting times at admission.

In the future the intention is that when a patient is transferred from one hospital's elective surgery waiting list to that of another, the amount of time waited on the initial list should follow the patient to the next. Therefore, at the Census date a patient's waiting time includes the number of days waited on all lists.

Waiting time at admission

Admin. status: CURRENT 1/07/1999

Identifying and definitional attributes

Knowledgebase ID: 000413 Version number: 1

Data element type: DERIVED DATA ELEMENT

Definition: The time elapsed for a patient on the elective surgery waiting list from the date they were added to the waiting list for the procedure to the date they were admitted to hospital for the procedure.

Context: Elective surgery: this is a critical elective surgery waiting times data element. It is used to determine whether patients are overdue, or had extended waits at admission. It is used to assist doctors and patients in making decisions about hospital referral, to assist in the planning and management of hospitals and in health care related research.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 4 Layout: NNNN

Data domain: Count in number of days

Guide for use: The number of days is calculated by subtracting the Listing Date from the Admission date, minus any days when the patient was 'not ready for care', and also minus any days the patient was waiting with a less urgent clinical urgency category than their clinical urgency category at admission.

Days when the patient was not ready for care is calculated by subtracting the date(s) the person was recorded as 'not ready for care' from the date(s) the person was subsequently recorded as again being 'ready for care'.

If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a less urgent clinical urgency category than the category at admission, then the number of days waited at the less urgent clinical urgency category should be subtracted from the total number of days waited.

In cases where there has been only one category reassignment (i.e. to the more urgent category attached to the patient at admission) the number of days at the less urgent clinical urgency category should be calculated by subtracting the Listing date from the Category reassignment date. If the patient's clinical urgency was reclassified more than once, days spent in each period of less urgent clinical urgency than the one applying at admission should be calculated by subtracting one Category reassignment date from the subsequent Category reassignment date, and then added together.

When a patient is admitted from an elective surgery waiting list but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue. Therefore at the admission date the patient's waiting time includes the number of days waited on an elective surgery waiting list, both before and after any cancelled surgery admission. The time waited before the cancelled surgery should be counted as part of the total time waited by the patient.

Related data: is calculated using Listing date for care, version 3

is calculated using Patient listing status, version 3

is qualified by Clinical urgency, version 2 is calculated using Category reassignment date, version 2

is used in the derivation of Overdue patient, version 3

is used in the derivation of Extended wait patient, version 1

is calculated using Admission date, version 4

Administrative attributes

Source organisation: Australian Institute of Health and Welfare, National Health Data Committee

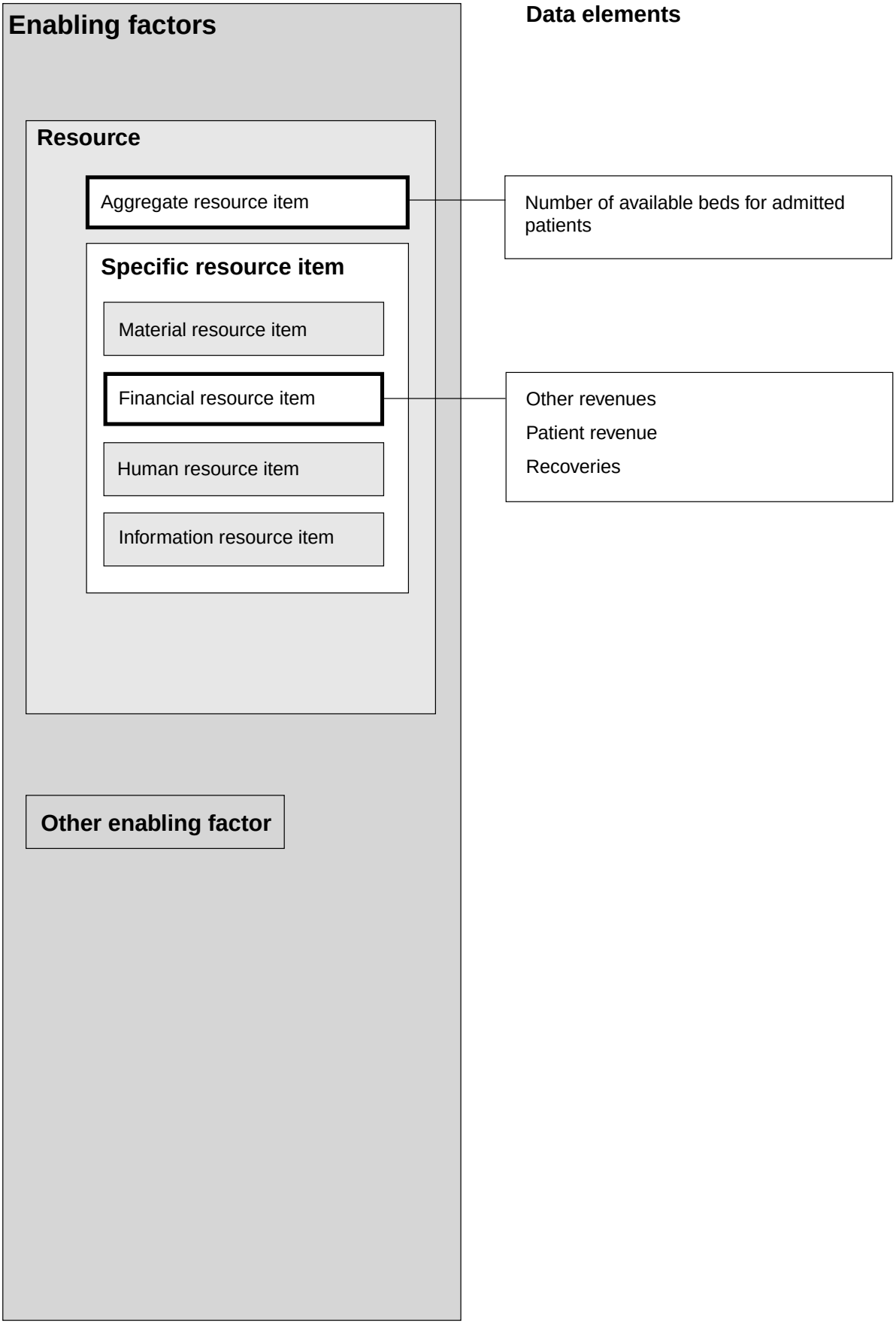
National minimum data sets:

Elective surgery waiting times from 01/07/1999 to

Comments: Elective surgery waiting times data collections include measures of waiting times at admission and at designated census dates. This data element is used to measure waiting times at admission whereas the data element Waiting time at Census Date measures waiting times at a designated census date.

In the future it is the intention that when a patient is transferred from one hospital's elective surgery waiting list to that of another, the amount of time waited on the list should follow the patient to the next. Therefore when the patient is admitted, their waiting time includes the number of days on all lists.

National Health Information Model entity



Number of available beds for admitted patients

Admin. status: CURRENT 1/07/1997

Identifying and definitional attributes

Knowledgebase ID: 000255 Version number: 2

Data element type: DATA ELEMENT

Definition: An available bed is a bed which is immediately available to be used by an admitted patient or resident if required. A bed is immediately available for use if it is located in a suitable place for care with nursing and auxiliary staff available within a reasonable period.

Inclusions: both occupied and unoccupied beds are included. For residential aged care services, the number of approved beds includes beds approved for respite care.

Exclusions: surgical tables, recovery trolleys, delivery beds, cots for normal neonates, emergency stretchers/beds not normally authorised or funded and beds designated for same-day non-admitted patient care are excluded. Beds in wards which were closed for any reason (except weekend closures for beds/ wards staffed and available on weekdays only) are also excluded.

Context: Necessary to provide an indicator of the availability and type of service for an establishment.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 4 Layout: NNNN

Data domain: Average available beds, rounded to the nearest whole number

Guide for use: The average bed is to be calculated from monthly figures.

Related data: relates to concept Admitted patient, version 3

supersedes previous data element Number of available beds for admitted patients, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments	from 1/07/2000 to
Community mental health establishments	from 1/07/1998 to

Comments: This National Health Data Dictionary entry was amended during 1996–97. Until then, both average and end of year counts of available beds were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate characterisation of establishments and comparisons.

Other revenues

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000323 Version number: 1

Data element type: DATA ELEMENT

Definition: All other revenue received by the establishment that is not included under patient revenue or recoveries (but not including revenue payments received from State or Territory governments). This would include revenue such as investment income from temporarily surplus funds and income from charities, bequests and accommodation provided to visitors.

See text relating to offsetting practices. Gross revenue should be reported (except in relation to payments for inter-hospital transfers of goods and services).

Context: Health services: in aggregate, other revenues as defined above constitute a significant source of income for many establishments and are necessary to complete the revenue picture for health financing studies or analyses at the national level.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain: Dollar value

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Related data: relates to Establishment type, version 1

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Patient revenue

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000296 Version number: 1

Data element type: DATA ELEMENT

Definition: Patient revenue comprises all revenue received by, and due to, an establishment in respect of individual patient liability for accommodation and other establishment charges. All patient revenue is to be grouped together regardless of source of payment (Commonwealth, health fund, insurance company, direct from patient) or status of patient (whether in-patient or non-in-patient, private or compensable). Gross revenue should be reported.

Note: The Commonwealth contribution in respect of residential aged care service patients should be included under patient revenue.

Context: Health expenditure: patient revenue is a significant source of income for most establishments. For some establishments (principally the private sector) it is the major source of income. Patient revenue data is important for any health financing analyses or studies at the national level.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain: Dollar value

Related data: relates to Establishment type, version 1

Administrative attributes

Source organisation: National minimum data set working parties

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Comments: The Resources Working Party considered a split of patient revenue into various categories including an in-patient/non-in-patient split and a private/compensable/ineligible split but decided against this level of detail. In part, this reflected sensitivities to too detailed a disclosure of sources of revenue and also a feeling that total patient revenue was adequate for analysis at a national level. However, for residential aged care service patient revenue, the Commonwealth Department of Community Services and Health nursing home experts said they would like to see a limited split up of patient revenue perhaps along the following lines:

Residential aged care services

- Commonwealth benefit
- residents payment
- resident recurrent funding
- resident capital funding

Recoveries

Admin. status: CURRENT 1/07/1989

Identifying and definitional attributes

Knowledgebase ID: 000295 Version number: 1

Data element type: DATA ELEMENT

Definition: All revenue received that is in the nature of a recovery of expenditure incurred. This would include:

- income received from the provision of meals and accommodation to members of staff of the hospital (assuming it is possible to separate this from income from the provision of meals and accommodation to visitors;
- income received from the use of hospital facilities by salaried medical officers exercising their rights of private practice and by private practitioners treating private patients in hospital; and
- other recoveries such as those relating to inter-hospital services where the revenue relates to a range of different costs and cannot be clearly offset against any particular cost.

Generally, gross revenues should be reported but, where inter-hospital payments for transfers of goods and services are made, offsetting practices are acceptable to avoid double counting. Where a range of inter-hospital transfers of goods and services is involved and it is not possible to allocate the offsetting revenue against particular expenditure categories, then it is acceptable to bring that revenue in through recoveries.

Context: Health expenditure: recoveries represent a significant source of income for many establishments and, as well as assisting in completing the picture in any health financing studies or analysis at the national level, are relevant in relation to the determination of net costs and output costs.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 9 Layout: $$$,$$$,$$$

Data domain: Dollar value

Guide for use: This data element relates to all revenue received by establishments except for general revenue payments received from State or Territory governments.

Related data: relates to Establishment type, version 1

Administrative attributes

National minimum data sets:

Public hospital establishments from 1/07/2000 to

Comments: The Resources Working Party had considered splitting recoveries into staff meals and accommodation, and use of hospital facilities (private practice) and other recoveries.

Some States had felt that use of facilities was too sensitive as a separate identifiable item in a national minimum data set. Additionally, it was considered that total recoveries was an adequate category for health financing analysis purposes at the national level.

Appendix A: The National Health Data Committee membership

The National Health Data Committee membership as at February 2001 was:

Member	Organisation	Telephone	Facsimile	Email
Mr Geoff Sims (Chair)	Head Health Division Australian Institute of Health and Welfare GPO Box 570 CANBERRA ACT 2601	(02) 6244 1168	(02) 6244 1166	geoff.sims@aihw.gov.au
Mr Michael Bassingthwaighte	(Private health insurance industry representative) Lysaght's Hospital and Medical Club PO Box 77 PORT KEMBLA NSW 2505	(02) 9460 3897	(02) 9460 3897	michaeljbass@ozemail.com.au
Mr Paul Basso	Manager Enterprise Information Services Information Management Services Department of Human Services (SA) PO Box 287, Rundle Mall ADELAIDE SA 5001	(08) 8226 7329	(08) 8226 7341	paul.basso@dhs.sa.gov.au
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Mr Peter Callanan	Director Private Health Services Reform Section Department of Health and Aged Care GPO Box 9848 CANBERRA ACT 2601	(02) 6289 8530	(02) 6289 8750	peter.callanan@health.gov.au
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Mr Mark Gill	Manager Health Data Standards and Systems Unit Acute Health Division Department of Human Services GPO Box 4057 MELBOURNE VIC 3001	(03) 9616 7456	(03) 9616 8523	mark.gill@dhs.vic.gov.au
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Member	Organisation	Telephone	Facsimile	Email
Mr David Hunter	Director Classifications and Data Standards Australian Bureau of Statistics PO Box 10 BELCONNEN ACT 2616	(02) 6252 6300	(02) 6252 5281	david.hunter@abs.gov.au
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Mr Gary Kennedy	Data Management Unit Department of Health, Housing and Community Care GPO Box 825 CANBERRA ACT 2601	(02) 6205 1373	(02) 6205 0842	gary.kennedy@act.gov.au
Ms Amanda Lanagan	Business Information Analyst Business Information Management Territory Health Services PO Box 40596 CASUARINA NT 0811	(08) 8999 2520	(08) 8999 2618	amanda.lanagan@nt.gov.au
Mr Terry Lennard	Manager Health Information Planning Unit Health Department of Western Australia PO Box 8172, Stirling Street PERTH WA 6849	(08) 9222 4228	(08) 9222 4236	terry.lennard@health.wa.gov.au
Mr Geoffrey Moore	Assistant Director Hospital Deeds and Arrangements Department of Veterans' Affairs PO Box 21 WODEN ACT 2606	(02) 6289 4896	(02) 6289 4727	geoffrey.moore@dva.gov.au
Mr George Neale	(Australian Private Hospital Association Representative) PO Box 291 Erindale Centre ACT 2903	0411 104 379	(02) 6291 4466	George.neale@bigpond.com
Mr Steve Neilsen	Director Corporate Information Health Insurance Commission 134 Reed Street TUGGERANONG ACT 2900	(02) 6124 6533	(02) 6124 6006	steve.neilsen@hic.gov.au
Ms Sue Walker	Associate Director National Centre for Classification in Health School of Public Health Queensland University of Technology Victoria Park Road KELVIN GROVE QLD 4059	(07) 3864 5873	(07) 3864 5515	s.walker@qut.edu.au

Appendix B: Format for data element definitions— ISO/IEC 11179-based standards

All data element definitions included in the *National Health Data Dictionary* are presented in a format based on ISO/IEC Standard 11179 *Specification and Standardization of Data Elements* – the international standard for defining data elements issued by the International Organization for Standardization and the International Electrotechnical Commission. Collectively, the format describes a set of attributes for data definitions.

Starting from Version 10 of the Dictionary, when a data element does not contain information for a given attribute, that attribute heading will not be displayed.

The set of attributes for data definitions used in the *National Health Data Dictionary* are described below.

Administrative status: The operational status (e.g. CURRENT, SUPERSEDED) of the data element or data element concept and the date from which this status is effective. For example, in the Dictionary the latest revision of 'area of usual residence' effective from 1 July 1997 has a 'CURRENT' status, replacing the previous version of this data element operational from 1 July 1995 until 30 June 1997, which now has a 'SUPERSEDED' status. No SUPERSEDED data elements are included in this hard copy publication of the Dictionary. However, all data elements, including SUPERSEDED data elements, are included on the Knowledgebase.

Knowledgebase ID: A six-digit number used to identify the data element on the Knowledgebase (previously known as the National Health Information Knowledgebase or NHIK). In the Knowledgebase this number is preceded by an acronym that identifies the Registration Authority for each data element. The National Health Information Management Group (NHIMG) is the Registration Authority for all data elements included in the Dictionary. The combination of Registration Authority, Knowledgebase (or NHIK) ID and version number (see below) uniquely identifies each data element in the Knowledgebase.

Version number: A version number for each data element, beginning with 1 for the initial version of the data element, and 2, 3 etc. for each subsequent revision. This meets the ISO/IEC Standard 11179 requirement for 'identification of a data element specification in a series of evolving data element specifications within a registration authority'. A new version number is allocated to a data element/concept when changes have been made to one or more of the following attributes of the definition:

- name
- definition
- data domain.

Identifying and definitional attributes

Name: A single or multi-word designation assigned to a data element. This appears in the heading for each unique data definition in the Dictionary.

Data element type: A data element may be either:

a. a DATA ELEMENT CONCEPT—a concept which can be represented in the form of a data element, described independently of any particular representation. For example, hospital 'admission' is a process, which does not have any particular representation of its own, except through data elements such as 'admission date', 'mode of admission' etc.

b. a DATA ELEMENT—a unit of data for which the definition, identification, representation and permissible values are specified by means of a set of attributes. For example, a hospital 'admission date' is a unit of data for which the definition, identification, representation and permissible values are specified.

c. a DERIVED DATA ELEMENT—a data element whose values are derived by calculation from the values of other data elements. For example, the data element 'length of stay' is derived by calculating the number of days from 'admission date' to 'separation date' less any 'total leave days'.

d. a COMPOSITE DATA ELEMENT—a data element whose values represent a grouping of the values of other data elements in a specified order. For example, the data element 'establishment identifier' is a grouping of the data elements 'state identifier', 'establishment type', 'region' and 'establishment number' in that order.

Definition: A statement that expresses the essential nature of a data element and its differentiation from all other data elements.

Context: A designation or description of the application environment or discipline in which a name is applied or from which it originates. For example, the context for 'admission date' is 'admitted patients', while the context for 'capital expenditure—gross' is 'health expenditure'. For the Dictionary this attribute may also include the justification for collecting the items and uses of the information.

Relational and representational attributes

Data type: The type of symbol, character or other designation used to represent a data element. Examples include integer, numeric, alphanumeric etc. For example, the data type for 'intended place of birth' is a numeric drawn from a domain or codeset in which numeric characters such as 1 = hospital, 4 = home are used to denote a data domain value (see Data domain below).

Field size (minimum and maximum): The minimum and maximum number, respectively, of storage units (of the corresponding data type) to represent the data element value. For example, a data element value expressed in dollars may require a minimum field size of one character (1) up to a maximum field size of nine characters (999,999,999). Field size does not generally include characters used to mark logical separations of values, e.g. commas, hyphens or slashes.

Layout: The ***representational layout*** of characters in data element values expressed by a character string representation. Examples include 'DDMMYYYY' for calendar date, 'N' for a one-digit numeric field, and '$$$,$$$,$$$' for data elements about expenditure.

Data domain: The set of representations of permissible instances of the data element, according to the representation form, layout, data type and maximum size specified in the corresponding attributes. The set can be specified by name (including an existing classification/code scheme such as ICD–10-AM), by reference to a source (such as the *ABS Directory of concepts and standards for social, labour and demographic statistics*, 1995), or by enumeration of the representation of the instances (for example, for 'compensable status' values are 1 = compensable, 2 = non-compensable).

Guide for use (optional): Additional comments or advice on the interpretation or application of the attribute 'data domain' (this attribute has no direct counterpart in the ISO/IEC Standard 11179 but has been included to assist in clarification of issues relating to the classification of data elements).

Verification rules (optional): The rules and/or instructions applied for validating and/or verifying elements occurring in actual communication and/or databases, in addition to the formal screening based on the requirements laid down in the basic attributes.

Collection methods (optional): Comments and advice concerning the actual capture of data for the particular data element, including guidelines on the design of questions for use in collecting information, and treatment of 'not stated' or non-response (this attribute is not specified in the ISO/IEC Standard 11179 but has been added to cover important issues about the actual collection of data).

Related data (optional): A reference between the data element (or data element concept) and any related data element/concept in the Dictionary, including the type of this relationship. Examples include: 'has been superseded by the data element…', 'is calculated using the data element…' and 'supplements the data element…'.

Administrative attributes

Source document (optional): The document from which definitional or representational attributes originate.

Source organisation: The organisation responsible for the source document and/or the development of the data definition (this attribute is not specified in the ISO/IEC Standard 11179 but has been added for completeness). The source organisation is not necessarily the organisation responsible for the ongoing development/maintenance of the data element definition.

National minimum data sets (optional): The name of any national minimum data set established under the auspice of the National Health Information Agreement (NHIA) which includes the particular data element. The date of effect is also included.

Comments (optional): Any additional explanatory remarks on the data element.

Appendix C: National Health Information Model entity definitions

Entity name	Entity definition
Accessibility factor	An instance of a factor that influences, determines or affects access to services, providers and information. For example, privacy of records, location of persons and providers, distance from medical services.
Accommodation characteristic	The living arrangements of a PERSON. For example, the type of dwelling, age of dwelling, number of bedrooms, modification of dwelling to account for restricted movement. In the National Health Information Model, accommodation/housing characteristic relates to where a PERSON usually resides. If information is being collected about accommodation characteristic at an instance in time—for example, while a PERSON is in receipt of care—the data element will fall within the SETTING entity.
Acute event	An acute illness-related LIFE EVENT experienced by a PERSON. For example, the diagnosis of a disease.
Address	The address at which a PERSON, PARTY or ORGANISATION may be contacted/located or where an item may be located. Address has been modified from Version 1.0 of the National Health Information Model. Address now encompasses all those elements of an address which were previously separated in Version 1.0 such as country, State/Territory, city, postcode and street or postal address, telephone, facsimile and electronic mail addresses.
Advocacy event	An EVENT associated with the act of communicating, defending and recommending a cause or position or acting as an agent.
Advocate role	A PERSON in their role as an advocate for another PARTY.
Aggregate health and wellbeing	A composite measure of the health and wellbeing of a PERSON. It generally involves measures/instruments which assess the multi-dimensional factors contributing to health and wellbeing. For example, measures currently in use in Australia include SF-36 and SF-12 scores, quality of life measures, health expectancies.
Aggregate resource item	An instance of aggregate or total resources. For example, total nursing staff or the total budget allocated to a program or organisation. While the National Health Information Model recognises the individual resource items (MATERIAL, FINANCIAL, HUMAN and INFORMATION RESOURCE ITEMs) the totals of these items are most commonly used in resource management.
Assessment event	An EVENT associated with the gathering and analysing of information concerning a PARTY. For example, an assessment of home-based care requirements, a diagnosis.
Attitude	The attitudes of a PERSON towards health, health care, and the health and welfare systems.
Availability factor	An instance of a factor that influences, determines or affects availability of services for a PERSON or group. For example, the availability of services such as employment assistance for a PERSON with a disability.
Belief	The beliefs of a PERSON about health, health care, and the health and welfare systems.
Benchmark	A criterion against which something is measured. Compare with STANDARD.
Birth event	The EVENT of being born. It describes EVENTs which happen to both the baby and the mother during the birth, but does not include descriptions of the health of the baby or mother; these elements are mapped to subtypes of the STATE OF HEALTH AND WELLBEING entity.
Built environment	The built (manufactured) environment in which a PERSON or community lives. For example, quality of housing, access to appropriate sanitation systems.

Entity name	Entity definition
Business agreement	An agreement or contract between parties which specifies the roles and responsibilities of each in relation to a health and welfare program. For example, purchaser-provider agreements, employment contracts, service contracts and other funding agreements.
Business program	A program conducted by a business or organisation.
Business statement	A policy statement or business plan.
Capital expenditure	Expenditure on capital items incurred by a PARTY. For example, expenditure on land, buildings, medical equipment.
Care plan	A sequenced list of treatments, other services, and resources that are prescribed to improve a PARTY's STATE OF HEALTH AND WELLBEING. For example, a rehabilitation program for a back injury. A care plan is a scheme which groups and specifies the roles of material or human resources, planned events and parties in providing health and welfare services to a PERSON or group. A care plan may not always be formally notified or even documented.
Carer role	A PERSON in their role as a carer of another PERSON/s who are ill or disabled and unable to perform the tasks of daily living for themselves. For example, a PERSON providing respite care.
Citizen role	A PERSON, about whom information may be required, but who is not engaged in a specific role within the HEALTH AND WELFARE sector. For example, the identification of an individual via a Medicare number or of an individual (often anonymously) who is participating in a population-based health or welfare survey.
Community event	An EVENT which is initiated by or affects members of a community. For example, meetings of support groups (e.g. SIDA), and actions or decisions by a community to undertake or not undertake a course of action on such subjects as curfews, right to life, use of alcohol and sex education. Extreme examples include protests, demonstrations and riots.
Community organisation	An ORGANISATION operating for the purpose of meeting community needs. For example, a religious, recreational, sporting or volunteer organisation.
Component health and wellbeing	Component health and wellbeing is a single measure/assessment of the health and wellbeing of a PERSON. For example, diagnosis of illness, disease or injury, self-assessed health status, enough money to buy food, ability to look after oneself.
Crisis event	An acute LIFE EVENT (such as the incidence or prevalence of disease or injury) experienced by a PERSON.
Cultural characteristic	A characteristic of a PERSON which identifies their religious, political, linguistic and ethnic affiliations.
Cultural wellbeing	Those aspects of a PERSON's or community's wellbeing that can be ascribed to cultural factors.
Death event	The EVENT of death. Attributes of this entity would normally include such data elements as date, time and cause of death. The death event does not necessarily imply the end of all events relating to a PERSON, since events such as organ donation and transmission of disease may still occur.
Demographic characteristic	A characteristic of a PERSON which contributes to the specification of the population or sub-population to which they belong. For example, sex, country of birth, year of arrival in Australia, Indigenous status.
Economic wellbeing	Those aspects of a PERSON's or community's wellbeing that can be ascribed to economic factors. For example, insufficient funds to support an acceptable standard of living.
Education characteristic	A characteristic of a PERSON which relates to their education. For example, highest qualification held, age when left school.
Education event	The instance of a PARTY educating another PARTY about the availability, knowledge and access of health and welfare services. For example, school-based drug and alcohol education programs.

Entity name	Entity definition
Educational system	The public or private provision of education services. For example, the availability of kindergarten, primary school, secondary school and tertiary education facilities in a locality or community.
Employment agreement	An agreement or contract for employing a PERSON and being employed by a PARTY. The employment agreement normally involves two parties, one in an employer role and the other as the employee.
Environmental event	A change in the environment which has an effect on one or more parties. Although all events occur within an 'environment', the concept of an environmental event is an event which has the environment (physical, chemical, biological, social, economic, cultural) as its principal focus. Examples of environmental events include storms, floods and droughts, riots and war, spillage of hazardous chemicals, liquids or gases, and economic recession.
Event	Something which happens to or with a PARTY. This entity reflects the emphasis in the model on events which happen, and which may trigger or influence other events. Since the model is also date/time stamped at different instances in time, the model can accommodate the development of people and their health and welfare status and wellbeing by tracking these events. Event is a major supertype entity in the National Health Information Model.
Exit/leave from service event	The instance of an exit or period of leave by a PERSON from a SERVICE DELIVERY SETTING. For example, a hospital separation, leave from a hospital/nursing home for an agreed period of time.
Expectation	The expectations of a PERSON about health, health care, and the health and welfare systems.
Expected outcome	A desired level of attainment to be achieved through one or more HEALTH AND WELFARE SERVICE EVENTs. An outcome in the National Health Information Model most commonly relates to a PERSON but may also be stated for a PARTY or ORGANISATION.
Expenditure	Expenditure on capital items (land, buildings) or indirect expenditure (patient transport, cleaning services) incurred by an ORGANISATION.
Family member role	A PERSON in their role as a family member. For example, mother, father, guardian, child. A family may or may not live within the same household.
Financial resource item	The existence of funds and budgets to undertake activities. While this entity has no subtypes in the National Health Information Model, it is a major component of health and welfare systems, and one which can and should be separately modelled.
Functional wellbeing	The ability of a person to perform the usual tasks of daily living and to carry out social roles.
Funding agreement	An agreement between parties for the provision and use of funds for a purpose.
Goal/objective	A statement of what is to be achieved in a shorter time frame, as compared with a longer term VISION/MISSION.
Health and welfare policy/plan	A statement or document which may include a vision, goals, objectives, directions for development, priorities for action, actions to be taken, expected outcomes and performance indicators in relation to health and welfare programs for particular parties, particular locations and particular periods in time. Health and welfare policy/plan is an entity subtype which reflects instances of policies and plans which are made up of components (HEALTH AND WELFARE POLICY/PLAN ELEMENTs). Other BUSINESS STATEMENTs will exist which are not created for or by the health and welfare sectors but which still impact on a PARTY's STATE OF HEALTH AND WELLBEING.
Health and welfare policy/plan element	A component part of a HEALTH AND WELFARE POLICY/PLAN.
Health and welfare program	A business program specifically created for or by the health and welfare sectors. Health and welfare program is an entity subtype which reflects instances of programs which are made up of components (HEALTH AND WELFARE PROGRAM ELEMENTs). Other BUSINESS PROGRAMs will exist which are not created for or by the health and welfare sectors but which still impact on a PARTY's STATE OF HEALTH AND WELLBEING.
Health and welfare program element	A component part of a HEALTH AND WELFARE PROGRAM.

Entity name	Entity definition
Health and welfare service event	An instance of an EVENT which is part of the delivery or receipt of health and welfare services or care. These EVENTs include delivery of community programs, consultations with service providers, diagnoses, treatment, operations, delivery of care and rehabilitation, delivery of palliative care, counselling services and voluntary care.
Health status	An instance of the state of health of an individual, group or population measured against accepted standards.
Human resource item	An instance of people with capacity, capability and availability as resources to provide health and welfare services. This entity will represent the instances of specialist service providers, nurses etc. but can also accommodate voluntary carers and the potential to provide services, i.e. a spouse who could care for a partner who became ill. The idea of skills and expertise is also included in this entity, providing a measure of both capacity and capability. Data elements within this entity reflect the view of the ORGANISATION or employer as compared with data elements within the PERSON ROLE entity which reflect the view of the PERSON in their role as a specialist service provider, nurse etc.
Illness event	An acute or chronic LIFE EVENT experienced by a PERSON but not involving a HEALTH AND WELFARE SERVICE EVENT. For example, the incidence or prevalence of disease.
Information resource item	An instance of information or knowledge which supports the health and welfare system. This broad concept includes what we know about the human body from a medical and scientific perspective, what we know about drugs and interventions, what we know about other factors affecting wellbeing etc. Research is a process which generates or refines instances of this entity.
Injury event	An acute LIFE EVENT experienced by a PERSON involving the occurrence of an injury but not involving a HEALTH AND WELFARE SERVICE EVENT.
Insurance/benefit characteristic	A characteristic of a PERSON which relates to their health insurance or social security status.
Judicial system	Provision, availability and access to legal services within a community.
Knowledge factor	An instance of a factor that influences, determines or affects a PARTY's state of knowledge or cognisance, particularly of elements of wellbeing, health and welfare, and their services. For example, factors that influence 'How much a person knows about the risks from smoking', 'How much a person knows about the availability of counselling services' and 'How much a service provider knows about the latest technique for treating a particular illness'.
Labour characteristic	A characteristic of a PERSON which relates to the nature of their employment and labour force status. It does not include information collected about a PERSON which relates to their role as a service provider such as usual number of hours worked in a week or hours of overtime. For example, their occupation, industry of employment.
Legal characteristic	A characteristic of a PERSON, which relates to their legal status. For example, ward of the State, held in custody.
Legal status event	An EVENT which changes a PARTY's legal status. For example, reaching 18 years of age, marriage or the decision by a Review Board or Tribunal to change an individual from an 'involuntary' to a 'voluntary' status under the Mental Health Act.
Legally constituted organisation	An ORGANISATION established under law. Legally constituted organisations may be ORGANISATIONs in a one-to-one relationship with a statute, (e.g. the Australian Institute of Health and Welfare and the Australian Institute of Health and Welfare Act) or ORGANISATIONs that are examples of a class of ORGANISATIONs established under and regulated by a statute (e.g. hospitals, incorporated bodies).
Life event	An instance of an EVENT which occurs to or with a PERSON during their life. The life event entity provides the means of identifying those things which happen during a person's life which affect their STATE OF HEALTH AND WELLBEING and occur between their BIRTH EVENT and their DEATH EVENT. This entity does not include events identified elsewhere, e.g. HEALTH AND WELFARE SERVICE EVENTs, COMMUNITY, ENVIRONMENTAL or RESEARCH EVENTs, but does include such things as puberty, the onset of disease and the loss of employment. While the actual date and time when some of these events occur may not need or be able to be known, this entity provides a means to consistently represent this information.

Entity name	Entity definition
Lifestyle characteristic	A behavioural attribute, trait or feature of a PERSON that describes an aspect of their lifestyle. For example, cigarette smoking, participation in regular physical exercise, dietary habits, use of illicit drugs.
Location	A site or position where something happens, or where a person, group or organisation is located, may be contacted, conduct their business. For example, an address or geographical region.
Material resource item	An instance of a material resource. For example, drugs, buildings, plants, operating theatres, organs, blood products.
Mental wellbeing	The wellbeing of a PERSON, based on their mental state. For example, test results, symptoms, diagnoses and self-perceived health status specific to the mental state of a PERSON.
Natural environment	The natural environment in which a PERSON or community lives. For example, the air we breathe, the quality of water, noise pollution.
Need/issue	The need for, or reason why, a PARTY is seeking access to health and welfare services. For example, the need for emergency accommodation. In the National Health Information Model this entity is not intended to represent assessed need (ASSESSMENT EVENT) as determined by a SERVICE PROVIDER. Nor does it represent a STATE OF HEALTH AND WELLBEING of a PARTY once the assessment has been made.
Non-acute event	A non-acute LIFE EVENT experienced by a PERSON but not involving a HEALTH AND WELFARE SERVICE EVENT. For example, the prevalence of chronic disease such as diabetes or asthma.
Organisation	A business or administrative concern created for particular ends.
Organisation characteristic	A characteristic of an ORGANISATION (but unrelated to business factors). For example, the nature of the business or reason for trading. This entity has been included in Version 2.0 of the National Health Information Model as a reflection of the need for descriptive information about an ORGANISATION.
Organisation role	An instance of an ORGANISATION participating in a specific role in the health and welfare sector. For example, an ORGANISATION as a receiver of services or as a provider of services.
Organisation sub-unit	A constituent part of an ORGANISATION. Organisation sub-units are normally the smaller components of organisations such as departments, divisions, units and sections. Organisation sub-units may exist in a hierarchical structure.
Organisational setting	An instance where an EVENT occurs, described in terms of the ORGANISATION. For example, a hospital, a government department.
Other agreement	A BUSINESS AGREEMENT other than a FUNDING AGREEMENT or EMPLOYMENT AGREEMENT. For example, purchaser-provider agreements, service contracts.
Other crisis event	An acute LIFE EVENT experienced by a PERSON but not involving an illness or injury, or a HEALTH AND WELFARE SERVICE EVENT. For example, emergency accommodation needs, crisis counselling.
Other enabling factor	Resources are a major ‘enabling’ factor in health and welfare. However, there are other important enabling factors, e.g. access, knowledge and availability, which are recognised by this entity.
Other event	An EVENT which is not a PERSON EVENT, HEALTH AND WELFARE SERVICE EVENT, COMMUNITY EVENT, LEGAL STATUS EVENT, RESEARCH EVENT or ENVIRONMENTAL EVENT.
Other health and welfare service event	A HEALTH AND WELFARE SERVICE EVENT other than a REQUEST FOR/ENTRY INTO SERVICE EVENT, SERVICE PROVISION EVENT, EXIT/LEAVE FROM SERVICE EVENT, ASSESSMENT EVENT, SCREENING EVENT, EDUCATION EVENT, ADVOCACY EVENT, PLANNING EVENT, SURVEILLANCE/MONITORING EVENT, SERVICE SUPPORT EVENT or PAYMENT/CONTRIBUTION EVENT.

Entity name	Entity definition
Other life event	A LIFE EVENT that a PERSON experiences other than a SELF HELP EVENT or CRISIS EVENT (such as illness or injury). For example, events relating to starting employment, beginning school, pregnancy, menstruation, adoption.
Other organisation role	An instance of an ORGANISATION ROLE within the health and welfare sector which is not a service provider, a service funder or a service purchaser.
Other person characteristic	A characteristic of a PERSON other than a DEMOGRAPHIC CHARACTERISTIC, PHYSICAL CHARACTERISTIC, LABOUR CHARACTERISTIC, LIFESTYLE CHARACTERISTIC, EDUCATION CHARACTERISTIC, SOCIAL CHARACTERISTIC, CULTURAL CHARACTERISTIC, PARENTING CHARACTERISTIC, ACCOMMODATION/HOUSING CHARACTERISTIC, INSURANCE/BENEFIT CHARACTERISTIC or LEGAL CHARACTERISTIC.
Other person role	The role of a PERSON other than as a citizen, family member, carer, advocate, service provider or as a provider of resources.
Other policy/plan element	Policy and planning elements other than those identified by the HEALTH AND WELFARE POLICY/PLAN ELEMENT subtypes (VISION/MISSION, GOAL/OBJECTIVE, PRIORITY, and PERFORMANCE INDICATORS).
Other role	A role other than a PARTY RELATIONSHIP ROLE, PERSON ROLE, PARTY GROUP ROLE, ORGANISATION ROLE, RECIPIENT ROLE, SERVICE PROVIDER ROLE or RESEARCH ROLE. An expanded list of subtypes relating to PERSONs, PARTY GROUPs and ORGANISATIONs can be found within the entities PERSON ROLE and ORGANISATION ROLE.
Other setting	An instance where, in generic terms, something happens which is not an ORGANISATIONAL SETTING or a SERVICE DELIVERY SETTING. For example, ‘at home’, ‘on a sports field’, ‘at work’.
Other social environment	The social environment in which a PERSON or community lives other than the JUDICIAL SYSTEM, the EDUCATIONAL SYSTEM or a COMMUNITY ORGANISATION. For example, the political, economic and cultural environments.
Outcome	A recorded change in the wellbeing of a PARTY which is expected or presumed to be, or to have been, caused by a HEALTH AND WELFARE SERVICE EVENT.
Parenting characteristic	A characteristic of a PERSON which relates to their role as parents. For example, breastfeeding a baby, number of children, use of child care facilities.
Party	Those PERSONs, groups or ORGANISATIONs who are part of the health and welfare systems, including those who are known to the system and those who are of interest to it. Essentially this includes all PERSONs in Australia. For example, a PARTY as a recipient of services, provider of services, purchaser of services, funder of services.
Party group	An instance of a number of parties, normally PERSONs, considered as a collective unit. For example, families, communities and tribes. The Australian population, or sub-populations within it, are represented in the model as a party group.
Party group characteristic	A characteristic of a PARTY GROUP (apart from those associated with an individual or those which are derived from aggregating PERSON data). For example, the main language spoken or religious affiliation of a community. This entity has been included in Version 2.0 of the National Health Information Model as a reflection of the possible need for descriptive information about a PARTY GROUP.
Party group role	An instance of a PARTY GROUP participating in a role within the health and welfare sectors.
Party role	An instance of a PARTY participating in a role in the health and welfare sectors. The concept of party role in the National Health Information Model provides for different PERSONs, groups and ORGANISATIONs to have different roles at different times. Some of these roles refer to service delivery, planning, resource allocation or agreements.
Party relationship role	An instance of a relationship between parties which is relevant to an EVENT. Many of these relationships have been expanded in Version 2.0 of the National Health Information Model and are now found within the expanded entities PARTY ROLE, PARTY GROUP ROLE and ORGANISATION ROLE.

Entity name	Entity definition
Payment/contribution event	The instance of a PARTY making a payment or contribution as part of their involvement in a HEALTH AND WELFARE SERVICE EVENT. For example, a Medicare payment or a private health fund payment.
Performance goal	A level of performance against which the performance of a PARTY ROLE will be judged.
Performance indicator	A measure of performance. A performance indicator is used to assess performance against goals and targets. Performance indicator includes the alternate term of key performance indicators or KPIs.
Person	An individual human being. A person is identified by the role they play. Refer subtypes within the entity PERSON ROLE. A person will possess a range of characteristics and views. Refer subtypes within the entity PERSON CHARACTERISTIC and PERSON VIEW, respectively.
Person characteristic	Features which characterise a PERSON. A person characteristic is either a DEMOGRAPHIC CHARACTERISTIC, PHYSICAL CHARACTERISTIC, LABOUR CHARACTERISTIC, LIFESTYLE CHARACTERISTIC, EDUCATION CHARACTERISTIC, SOCIAL CHARACTERISTIC, PARENTING CHARACTERISTIC, ACCOMMODATION/HOUSING CHARACTERISTIC, INSURANCE/ BENEFIT CHARACTERISTIC or LEGAL CHARACTERISTIC. This entity reflects the emphasis in the National Health Information Model on the PERSON.
Person event	An EVENT which happens to a PERSON which affects their STATE OF HEALTH AND WELLBEING from the time of their birth until their death.
Person role	An individual in a role as distinct from a PARTY GROUP in a role or an ORGANISATION ROLE. For example, a PERSON in a role as a receiver of services, as a provider of services, as a resource worker within the health and welfare sector. The expansion of the PERSON ROLE entity replaces PERSON IDENTIFIER as a subtype of PERSON CHARACTERISTIC from Version 1.0 of the National Health Information Model.
Person view	The attitudes, beliefs, expectations and values of a PERSON in relation to health, health care, and the health and welfare systems.
Physical characteristic	A characteristic of a PERSON which relates to their physical, chemical and biological characteristics. For example, height, weight, allergies.
Physical environment	The physical environment in which a PERSON or community lives. For example, air and water quality, noise pollution, quality of housing, sanitation.
Physical wellbeing	The wellbeing of a person based on their physical, chemical and biological state.
Planning event	The instance of a PARTY planning an EVENT.
Priority	Something given special attention, normally involving special precedence over others.
Program activity	An identified action to be taken as part of a program or plan. This is distinct from the National Health Information Model entity of EVENT, which is the actual instance or occurrence of these activities.
Program evaluation	A process to be conducted as part of a program or plan to determine the extent to which the program or plan achieved its GOAL/OBJECTIVE.
Program strategy	An intended course of action to be conducted as part of a program or plan.
Recipient role	An instance of a role, a PARTY (usually a PERSON) as a recipient of services or care, plays in EVENTs. For example, a patient, client, consumer, customer.
Recurrent expenditure	Expenditure incurred by a PARTY on a recurring basis for the provision of services, excluding CAPITAL EXPENDITURE, but including indirect expenditure.
Request for/entry into service event	An instance of a request for services or an entry into a SERVICE DELIVERY SETTING from one service provider to another.
Research event	An instance of a PARTY undertaking research of interest to the health and welfare sector.
Research role	An instance of a role a PARTY plays in research activities.

Entity name	Entity definition
Resource	The material necessary for an activity. For example, buildings, reusable and consumable items, financial resources and people, and the information or knowledge required.
Resource role	An instance of a role a PERSON plays in the management, allocation and use of RESOURCEs. For example, a manager, a cleaner, a computer programmer. A PERSON in a resource role excludes individuals providing health and welfare services.
Screening event	An instance of a PARTY's involvement in a screening event. For example, mammographic screening, a pap smear.
Self help event	A PERSON actively seeking help, education or assistance, or participating in activities of interest to the health and welfare sector. For example, attending a quit smoking course, modification of one's diet.
Service delivery setting	A description of a setting where health and welfare services are delivered. For example, a birthing centre, child care centre or hospital Emergency Department.
Service funder role	An instance of a role, an ORGANISATION, as a health and welfare service funder, plays in EVENTs.
Service provider role	The instance of a role a PERSON, PARTY GROUP or ORGANISATION plays in the provision of health and welfare services, or the health and welfare services that a PERSON, PARTY GROUP or ORGANISATION provides. This includes PERSONs, PARTY GROUPs and ORGANISATIONs who are formally nominated as service providers (e.g. nurses and general practitioners), and PERSONs, PARTY GROUPs and ORGANISATIONs who provide voluntary or informal care.
Service provision event	An instance of the provision of a HEALTH AND WELFARE SERVICE EVENT by a service provider to a PERSON or PARTY GROUP. For example, treatment, conduct of tests, counselling.
Service purchaser role	An instance of a role an ORGANISATION, as a health and welfare service purchaser, plays in EVENTs.
Service support event	A planned or actual event which occurs within the domain of a service provider but which is not directly related to the care of PERSONs. For example, recruitment, building material acquisition, building maintenance.
Setting	A description of where something happens. Setting differs from LOCATION in the National Health Information Model, as an EVENT may occur at the LOCATION of 'Corner of Jones and Smith Streets, SomeCity, WA' (the LOCATION), but it may be better known and more relevant as 'a hospital' (the setting).
Social characteristic	A specific social characteristic of a PERSON. For example, marital status, language spoken in the home, next of kin.
Social environment	The social environment in which a PERSON or community lives including the JUDICIAL SYSTEM, the EDUCATIONAL SYSTEM or a COMMUNITY ORGANISATION.
Social wellbeing	The wellbeing of a PERSON, based on their interaction with other people. For example, a PERSON's experience with discrimination, racism, violence, family-related matters, gambling or drinking problems.
Specific resource item	The resources used in the production and delivery of health and welfare services, be they material, financial, human or information. The specific resource item entity provides for the actual instances of these resources.
Spiritual wellbeing	The wellbeing of a PERSON, based on their perception of or relationship to sacred or religious theory.
Standard	An accepted or approved example of something against which others are judged or measured. Compare with BENCHMARK.

Entity name	Entity definition
State of health and wellbeing	The measured, assessed or perceived health and wellbeing of a PARTY (usually a PERSON) recorded in aggregate (e.g. the total wellbeing of a PARTY) or component terms (e.g. a diagnosed illness). For example, SF-36 instrument of health status measurement, an illness diagnosis, an injury, enough money to buy food, ability to look after oneself. The state of health and wellbeing entity replaces the STATE OF WELLBEING entity in Version 1.0 of the National Health Information Model.
Stated outcome	The information recorded by a PARTY in a role about an OUTCOME which has occurred, as distinct from an OUTCOME which was planned or expected. The stated outcome is distinguished as an entity from the EXPECTED OUTCOME.
Surveillance/monitoring event	The instance of a surveillance or monitoring EVENT within the health and welfare sectors. For example, the conduct of a national/State survey, the establishment of a cancer registry.
Value	The values of a PERSON about health, health care, and the health and welfare sectors.
Vision/mission	The highest level statement of why something is to happen or where a situation or ORGANISATION should be in a set period of time. Vision or mission statements normally contain the aspirations of those stating them.

Appendix D: Cross-classificatory variables—staffing category

The following definitions of staffing categories used in the data elements 'Full-time equivalent staff' and 'Salaries and wages' are presented in an abbreviated form in Version 8.0 of the Dictionary. A more detailed list is provided in Version 6 of the *National Health Data Dictionary*.

C1: Staffing category	Definition
C1.1: Salaried medical officers	Medical officers employed by the hospital on a full-time or part-time salaried basis. This excludes visiting medical offices engaged on an honorary, sessional or fee-for-service basis. This category includes salaried medical officers who are engaged in administrative duties, regardless of the extent of that engagement (e.g. clinical superintendent and medical superintendent).
C1.2: Registered nurses	Registered nurses include persons with at least a three-year training certificate and nurses holding postgraduate qualifications. Registered nurses must be registered with the State/Territory registration board. This is a comprehensive category and includes community mental health, general nurse, intellectual disability nurse, midwife (including pupil midwife), psychiatric nurse, senior nurse, charge nurse (now unit manager), supervisory nurse and nurse educator. This category also includes nurses engaged in administrative duties no matter what the extent of their engagement, for example, directors of nursing and assistant directors of nursing.
C1.3: Enrolled nurse	Enrolled nurses are second-level nurses who are enrolled in all States except Victoria where they are registered by the State registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some States).
C1.4: Establishment-based student nurses	Student nurses are persons employed by the establishment currently studying in years one to three of a three-year certificate course. This includes any person commencing or undertaking a three-year course of training leading to registration as a nurse by the State or Territory registration board. This includes full-time general student nurse and specialist student nurse, such as mental deficiency nurse, but excludes practising nurses enrolled in post-basic training courses.
C1.5: Trainee/pupil nurse	Trainee/pupil nurse includes any person commencing or undertaking a one-year course of training leading to registration as an enrolled nurse on the State/Territory registration board (includes all trainee nurses).
C1.6: Other personal care staff	This category includes attendants, assistants or home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants engaged primarily in the provision of personal care to patients or residents, who are not formally qualified or undergoing training in nursing or allied health professions.
C1.7: Diagnostic and health professionals	Qualified staff (other than qualified medical and nursing staff) engaged in duties of a diagnostic, professional or technical nature (but also including diagnostic and health professionals whose duties are primarily or partly of an administrative nature). This category includes all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff).
C1.8: Administrative and clerical staff	Staff engaged in administrative and clerical duties. Medical staff and nursing staff, diagnostic and health professionals and any domestic staff primarily or partly engaged in administrative and clerical duties are excluded. Civil engineers and computing staff are included in this category.
C1.9: Domestic and other staff	Domestic staff are staff engaged in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded. This category also includes all staff not elsewhere included (primarily maintenance staff, tradespeople and gardening staff).

Appendix E: Establishment—activity definitions

The objective of data definitions related to the activities of health care establishments is to enable a description of health service systems, including the type of care delivered by the establishment. The unit of enumeration is a separately administered establishment. The term establishment is used in a very broad sense to mean organisational units, whether institutions, organisations or community-based services, which provide health services. Establishments are considered to be separately administered if the finances, budget and activities are managed as an independent unit. The term establishment thus covers conventional establishments such as hospitals, residential aged care facilities and community health centres, but is also used to cover organisations providing services in the community (e.g. domiciliary nursing services) or support services to other establishments (e.g. a centralised pathology laboratory service). The situation where establishment-level data for components of an area health service are not available separately at a central authority is not grounds for treating such a group of establishments as a single establishment unless such data are not available at any level in the health care system.

Two major measures of service provision are defined for each establishment. They are the recording of services by type of episode (admitted patients) and by service type (non-admitted patients). As there are no nationally agreed data definitions at the person-level for non-admitted patients or for outreach/ community clients, definitions for non-admitted patient activity are based on a cost centre or functional unit approach; that is, where the service was performed rather than the procedure or the diagnosis of the patient.

The activity for acute care hospitals is represented as a count of separations and patient-days for admitted patients according to the treatment mode categories same-day and overnight-stay.

The number of separations for renal dialysis and endoscopy and related procedures are identified separately for admitted and non-admitted patients. This enables comparison of the provision of these services across institutional settings, whether these patients are admitted or treated as non-admitted patients.

Separations and patient-days for admitted patients are contrasted with an occasion of service or group session as a measure of non-admitted patient activity. It is recognised that the comparison of these as a measure of activity is not ideal but it will be used until a more comprehensive set of definitions is developed to describe patients treated and non-admitted patient activity.

The number of separations, patient days and occasions of service is the measure of activity for same-day establishments and for acute hospitals.

The definition and counting of separations and patient-days for public psychiatric and alcohol and drug treatment centres are the same as for the acute care hospitals, except that the treatment mode category is expanded to distinguish between short-stay and long-stay patients. This is to reflect the greater percentage of patients with extended lengths of stay in these institutions.

Appendix F: Establishment—resource use definitions

The use of resources (facilities, financial and human) in health services is a major focus of interest to all users of information published using the definitions contained in the *National Health Data Dictionary*. To enable a comprehensive picture of resource use to be obtained requires uniform data definitions on health care institutions of the States, Territories, the Commonwealth and the private sector. The main categories of resource data that are defined at the establishment level are:

- establishment characteristics (type and location);
- staffing data (full-time equivalent staff);
- recurrent expenditure (salary and non-salary); and
- revenue.

Significant measures of resources not included above are capital expenditure, physical details and monetary values of major buildings, facilities, equipment, plant and so on. Capital expenditure is included in the *National Health Data Dictionary* at the system level (see Appendix G), but the formation of detailed uniform data definitions to describe items relating to facilities and equipment is yet to be agreed on and implemented. The classification of the type of establishment is currently under review by a working group (Organisational Units Working Group), which is expected to report to the National Health Data Committee in 1999.

Financial aspects

The establishment of the National Minimum Data Sets was not seen as an appropriate vehicle for undertaking a review of national accounting practice. During the formation of the definitions it was inevitable that some aspects of accounting practice were discussed (e.g. offsetting practices). The *National Health Data Dictionary* makes reference to established accounting standards with Accounting Standard 17 in relation to financial and operating leases and Accounting Standard 4 in relation to the depreciation of non-current assets. The absence of completely uniform accounting standards and practices for health institutions between States and Territories, and within States and Territories, limits the comparability of financial data. The Directors of Finance of the State and Territory government health authorities are developing national expenditure reporting standards, particularly with regard to hospitals.

Standard national health expenditure definitions

The development of agreed definitions on the major areas of health expenditure is being undertaken under the National Health Information Work Program. A set of definitions has been adopted by the Australian Bureau of Statistics for use in public finance statistics and is being discussed and refined in consultation with key stakeholders, including State and Territory Government Directors of Finance.

Boundaries between capital and recurrent expenditure

Some differences exist in the practice of differentiating between capital and recurrent expenditure in the States and Territories. The definition of capital expenditure is included in the Dictionary and recurrent expenditure is implicitly defined as that part of total expenditure which is not capital expenditure. The major difference with regard to capital expenditure between the States and Territories is in regard to the level of capitalisation. The Dictionary states that 'the minimum level for capitalisation is no higher than $5,000', and some States use $5,000 but others use $1,000 or even lower in some cases.

Offsetting practices

As a general rule, offsetting revenue against related expenditure is not good accounting practice and both gross revenue and gross expenditure should be reported. However, it is recognised that there are circumstances (such as hospital to hospital transfers/services) where offsetting is done to avoid the duplication of costs. Where it is difficult to identify specific costs in relation to inter-hospital transfers, the practice of bringing in revenue to inter-hospital services through recoveries is considered acceptable.

Appendix G: System-level resource definitions

System-level definitions relate to all of a particular type of establishment, such as public hospitals, or community health centres, at the State, Territory or Commonwealth level (whichever is the highest level of overall administration of the system). The data definitions in the *National Health Data Dictionary* at the system or State health authority level are related to capital expenditure and indirect health care expenditure.

Capital expenditure

A working party of the National Health Data Committee developed a new definition of capital expenditure during 1994. The National Health Information Management Group agreed that both the new definition (previously known as item S1b) and the former definition (previously known as item S1a) will be current in the Dictionary until all relevant jurisdictions have implemented accrual accounting procedures.

Indirect health care expenditure

The system-level definitions represent expenditure on health care that cannot be directly related to programs operated by a particular establishment, but can be indirectly related to the admitted patients, residents, non-admitted patients, non-residents and community/outreach patients served by that establishment. These definitions are designed to improve the overall picture of health expenditure and to assist in understanding differences in costs for similar establishments in different States and regions. They are also designed to detect differences in the extent to which support services and other services to resident/admitted patients and non-admitted patients of an establishment may be provided by the establishment itself, at a State level or by other organisations.

Glossary of terms

The following glossary of terms supports the definitions of capital expenditure:

Asset

An asset is the service potential and/or future economic benefits controlled by the reporting entity as a result of past transactions or other past events including:

Physical assets

- current physical assets
- non-current physical assets
- intangible assets.

The 'service potential' of an asset is its economic utility to the entity, based on the total benefit expected to be derived by the entity from the use and/or through subsequent disposal of the asset.

Financial asset

A financial asset is an asset that has a counterpart liability in the books of another accounting entity. For the purpose of the *National Health Data Dictionary*, financial assets are excluded.

Control

The recognition of an asset is based on the test of control rather than ownership. This may result in assets being recognised by a reporting agency that is not the registered owner (e.g. denominational/third schedule/non-profit hospitals). Control is the capacity of the entity to benefit from the asset in pursuit of the entity objectives and to deny or regulate the access of others to that benefit. Ownership of an asset occurs when the asset is purchased by or donated to an accounting entity. Acquisition means undertaking the risks and receiving the rights to future benefits, as would be conferred with ownership, in exchange for a cost of acquisition.

Note: In cases where there is a building providing public health services under government control situated on land owned by a non-profit organisation, the value of the building should be included as a public asset, but not that of the land.

Asset capitalisation

Asset capitalisation occurs when an item of expenditure meets the criteria of an asset and is:

- recorded in the books of an accounting entity;
- recorded in an asset management system and depreciated; and
- the minimum level for capitalisation is no higher than $5,000.

Asset disposal

When an asset is considered unserviceable, obsolete or in excess of probable requirements it is disposed of using designated procedures. The asset is removed from both the accounting entity's asset management system and the book of accounts.

Asset enhancement

Expenditure on an existing asset is to be treated as an enhancement where there has been an affective and significant increase in the present or planned service potential of the asset. If the increase in service potential is incidental to some necessary maintenance and the incremental level will not be used in the foreseeable future, the expenditure would be more appropriately classified as maintenance.

Service potential has three components:

- *Service capacity*: the expenditure increases the capacity to provide services and meet increases in demand for the asset's services.
- *Service quality:* improvement in the standard of the service provided, including efficiency improvements such as cost reductions, can represent an enhancement to an existing asset.
- *Useful life*: the initial assessment of an asset's useful life will have assumed that certain maintenance expenditure (both routine and major periodic) would be necessary for the asset to achieve its anticipated useful life. An expenditure can only be accounted for as an enhancement if it increases (rather than assumes the achievement of) the asset's pre-determined useful life. This would include major work undertaken to extend the service potential of an asset, recognising that its function may change (e.g. refurbishment). It may result in a need to re-assess the life span of the asset.

Grouped assets

Most assets, particularly system assets, consist of a number of components. In principle, each component can provide service potential or future economic benefit and can therefore be classified as an asset. In practice, however, the key criterion for a separate asset is an independent operating unit whose components function as a cohesive whole to provide a common service. Such a unit is referred to as a 'grouped asset'.

For example, a computer network operates as a cohesive whole, yet it may contain individual personal computers that can also operate independently. A network of roads, a water sewerage system, an electricity distribution system and a communications network are examples of extensive and integrated components operating as part of a total asset system. Another example of a group of assets used together to provide a common service is office furniture and equipment.

Grouped assets (including network assets) should be primary units for accounting recognition because their components function as a cohesive whole to provide a common service. This is subject to the capitalisation threshold.

The threshold tests should be applied to individual assets as well as grouped assets. The cost of each item making up a set of office furniture or of each computer in a computer network may be less than the capitalisation threshold, but if the total cost of the network or grouped asset exceeds the threshold, each item should be capitalised.

Cost of acquisition

The purchase consideration (price) paid for an asset plus any costs incidental to the acquisition. The cost of an asset must include (where appropriate):

- installation
- commissioning
- transport
- customs duty
- any other incidental costs.

Interest and other finance costs incurred in acquiring the service potential embodied in an asset (e.g. exchange fluctuations on loans) should not be included in the acquisition cost of that asset.

Asset construction

The following costs should be included in relation to construction of an asset:

- costs that relate directly to the construction of an asset, including:
  - direct labour and material costs;
  - depreciation of physical non-current assets used on construction of the asset; and
  - set up costs directly related to the construction of an asset.
- costs that are reliably attributable to the construction activity and are capable of being allocated on a reasonable basis to specific assets, including:
  - purchasing administration costs;
  - insurance;
  - costs of design and technical activities; and
  - project overheads (such as direct administration and holding costs of the project).

The following costs, which are related to activities of the agency or asset construction generally, but not specific to the asset being constructed, should be excluded as they cannot be reliably attributed to the asset:

- general administration costs; and
- depreciation of plant and equipment not related to construction activities (including idle plant and equipment).

Lease

A grant or possession of an asset for a stated period of time at specified rentals and subject to various conditions. The register proprietor has certain re-entry rights if the lessee defaults by not observing the conditions of the lease or by not paying the specified rentals.

Appendix H: Data elements listed by previous 'P', 'A', 'E' and 'S' numbers

This section contains data elements from Version 6 that are included in Version 9, listed by the old 'P', 'A', 'E' and 'S' numbering system. This list does not include data element concepts, and new elements introduced since Version 7.0, as these do not have P, A, E or S numbers allocated to them.

DE #	DATA ELEMENT NAME
'A' Items	
A1	Separations, version 2
A4	Occasions of service, version 1
A5	Group sessions, version 1
A6	Day program attendances, version 1
A9	Type of non-admitted patient care, version 1
A10	Type of non-admitted patient care (public psychiatric, alcohol and drug), version 1
A11	Type of non-admitted patient care (residential aged care), version 1
A12	Individual/group session, version 1
'E' Items	
E1	Establishment type, version 1
E2	Geographic location of establishment, version 2
E3	Number of available beds for admitted patients, version 2
E4	Specialised service indicators, version 1
E5	Teaching status, version 1
E7	Full-time equivalent staff, version 2
E8	Salaries and wages, version 1
E9	Payments to visiting medical officers, version 1
E10	Superannuation employer contributions (including funding basis), version 1
E11	Drug supplies, version 1
E12	Medical and surgical supplies, version 1
E13	Food supplies, version 1
E14	Domestic services, version 1
E15	Repairs and maintenance, version 1
E16	Patient transport, version 1
E17	Administrative expenses, version 1
E18	Interest payments, version 1
E19	Depreciation, version 1
E20	Other recurrent expenditure, version 1
E21	Patient revenue, version 1
E22	Recoveries, version 1
E23	Other revenues, version 1
'P' Items	
P1	Establishment identifier, version 2
P1	Establishment number, version 2
P1	Establishment sector, version 2
P1	Region code, version 2

DE #	DATA ELEMENT NAME
P1	State identifier, version 2
P2	Person identifier, version 1
P3	Medicare number, version 1
P4	Sex, version 2
P5	Date of birth, version 2
P6	Country of birth, version 2
P71	Indigenous status, version 2
P81	Marital status, version 3
P9	Area of usual residence, version 3
P10	Type of usual accommodation, version 1
P12	Period of residence in Australia, version 1
P13	Need for interpreter service, version 1
P14	Employment status—public psychiatric hospital admissions, version 2
P14	Employment status—acute hospital and private psychiatric hospital admissions, version 1
P17	Aged care assessment status
P18	Compensable status, version 2
P19	Hospital insurance status, version 3
P20	Pension status—residential aged care residents, version 2
P20	Pension status—psychiatric patients, version 2
P21	Care type, version 4
P22	Level of care
P24	Admission date, version 3
P25	Number of contacts (psychiatric outpatient clinic/day program), version 1
P27a	Total leave days, version 3
P27b	Number of leave periods, version 3
P28	Type of residential aged care admission, version 1
P29	Source of referral to public psychiatric hospital, version 3
P30	Location immediately prior to admission to residential aged care, version 1
P31	Mode of separation, version 2
P32	Referral to further care (psychiatric patients), version 1
P35	Principal diagnosis, version 3
P36	Additional diagnosis, version 4
P39	External cause—admitted patient, version 4
P39	External cause—non-admitted patient, version 4
P39	External cause—human intent, version 4
P40	Place of occurrence of external cause of injury—admitted patient, version 4
P40	Place of occurrence of external cause of injury—non-admitted patient, version 3
P41	Diagnosis related group, version 1
P42	Minutes of operating theatre time, version 1
P43	Behaviour-related nursing requirements—at residential aged care admission
P44	Behaviour-related nursing requirements—at residential aged care, current status
P45	Functional profile of residential aged care resident—at admission
P46	Functional profile of residential aged care resident—current status

DE #	DATA ELEMENT NAME
P47	Continence status (faeces) of residential aged care resident—at admission
P47	Continence status (urine) of residential aged care resident—at admission
P48	Continence status (faeces) of residential aged care resident—current status
P48	Continence status (urine) of residential aged care resident—current status
P49	Specialised nursing requirements—at residential aged care admission
P50	Specialised nursing requirements—current status
P51	Infant weight, neonate, stillborn, version 3
P52	Major diagnostic category, version 1
P53	Intended length of hospital stay, version 1
P54	Inter-hospital same-day contracted patient, version 1
P55	Waiting list category, version 3
P56	Listing date, version 2
P57	Census date, version 2
P58	Patient listing status, version 3
P60	Clinical urgency, version 2
P61	Category reassignment date, version 2
P62	Overdue patient, version 3
P63	Surgical specialty, version 1
P64	Indicator procedure, version 3
P65	Scheduled admission date, version 2
P66	Reason for removal, version 2
P67	Profession labour force status of health professional, version 1
P68	Principal role of health professional, version 1
P69	Classification of health labour force job, version 1
P70	Principal area of clinical practice, version 1
P71	Type and sector of employment establishment, version 1
P72	Hours on-call (not worked) by medical practitioner, version 2
P72	Hours worked by health professional, version 2
P72	Hours worked by medical practitioner in direct patient care, version 2
P72	Total hours worked by a medical practitioner, version 2
P73	Narrative description of injury event, version 1
P74	Nature of main injury—non-admitted patient, version 1
P75	Bodily location of main injury, version 1
P76	Activity when injured, version 1
P77	State/Territory of birth, version 1
P78	Intended place of birth, version 1
P79	Actual place of birth, version 1
P80	Previous pregnancies, version 1
P81	Date of completion of last previous pregnancy, version 1
P82	Outcome of last previous pregnancy, version 1
P83	First day of the last menstrual period, version 1
P84	Gestational age, version 1
P85	Maternal medical conditions, version 2
P86	Complications of pregnancy, version 2

DE #	DATA ELEMENT NAME
P87	Onset of labour, version 1
P88	Type of labour induction, version 1
P89	Type of augmentation of labour, version 1
P90	Analgesia administered during labour, version 1
P91	Anaesthesia administered during labour, version 1
P92	Presentation at birth, version 1
P93	Method of birth, version 1
P94	Perineal status, version 1
P95	Complication of labour and delivery, version 2
P96	Postpartum complication, version 2
P97	Birth plurality, version 1
P98	Birth order, version 1
P99	Status of the baby, version 1
P100	Apgar score at 1 minute, version 1
P100	Apgar score at 5 minutes, version 1
P101	Resuscitation of baby, version 2
P102	Number of days in special/neonatal intensive care, version 2
P103	Neonatal morbidity, version 2
P104	Congenital malformations—BPA code, version 1
P105	Date of first contact, version 2 *(formerly Date of first contact with community nursing service)*
P107	Date of first delivery of service, version 2 *(formerly Date of first community nursing visit)*
P108	Date of last contact, version 2 *(formerly Date of last community service contact with client/family)*
P109	Carer availability, version 2
P110	Nursing diagnosis, version 2
P111	Goal of care, version 2
P112	Nursing Interventions, version 2
P113	Dependency in activities of daily living, version 2 *(formerly Client dependency)*
P114	Total psychiatric care days, version 2
P115	Mental health legal status, version 3
P116	Department of Veterans' Affairs file number, version 1
P119	Length of stay, version 1
'S' Items	
S1a	Capital expenditure, version 1
S1b	Capital expenditure—gross (accrual accounting), version 2
S1b	Capital expenditure—net (accrual accounting), version 2
S2	Indirect health care expenditure, version 1

Appendix I: Data elements—by Knowledgebase number

Knowledgebase ID no.	Data element name
000001	Indigenous status, version 3
000002	Activity when injured, version 2
000003	Actual place of birth, version 1
000004	Acute care episode for admitted patients, version 1 *(concept)*
000005	Additional diagnosis, version 4
000007	Admission, version 3 *(concept)*
000008	Admission date, version 4
000009	Number of days in special/neonatal intensive care, version 2
000010	Infant weight, neonate, stillborn, version 3
000011	Admitted patient, version 3 *(concept)*
000013	Anaesthesia administered during labour, version 1
000014	Analgesia administered during labour, version 1
000016	Area of usual residence, version 3
000017	Aged care assessment status, version 1
000018	Behaviour-related nursing requirements—at residential aged care admission, version 1
000019	Birth order, version 1
000020	Birth plurality, version 1
000021	Birthweight, version 1 *(concept)*
000022	Carer availability, version 2
000023	Classification of health labour force job, version 1
000024	Clinical review, version 1 *(concept)*
000025	Clinical urgency, version 2
000026	Compensable status, version 3
000027	Complication of labour and delivery, version 2
000028	Complications of pregnancy, version 2
000029	Congenital malformations—BPA code, version 1
000030	Congenital malformations, version 2
000033	Continence status (faeces) of residential aged care resident—at admission, version 2
000034	Continence status (faeces) of residential aged care resident—current status, version 2
000035	Country of birth, version 3
000036	Date of birth, version 3
000037	Date of completion of last previous pregnancy, version 1
000038	Date of first delivery of service, version 2
000039	Date of first contact, version 2
000040	Date of last contact, version 2
000042	Diagnosis related group, version 1
000043	Separation date, version 5
000046	Elective surgery, version 1 *(concept)*

Knowledgebase ID no.	Data element name
000050	Establishment identifier, version 3
000053	External cause—admitted patient, version 4
000056	First day of the last menstrual period, version 1
000057	Functional profile of residential aged care resident—at admission, version 1
000058	Functional profile of residential aged care resident—current status, version 1
000059	Gestational age, version 1 *(concept)*
000060	Gestational age, version 1
000061	Health labour force, version 1 *(concept)*
000062	Health outcome, version 1 *(concept)*
000063	Health outcome indicator, version 1 *(concept)*
000064	Hospital, version 1 *(concept)*
000065	Hospital boarder, version 1 *(concept)*
000066	Hospital census, version 1 *(concept)*
000067	Hospital waiting list, version 1 *(concept)*
000073	Indicator procedure, version 3
000075	Hospital insurance status, version 3
000076	Intended length of hospital stay, version 2
000077	Intended place of birth, version 1
000078	Intensive care unit, version 1 *(concept)*
000079	Inter-hospital contracted patient, version 2
000082	Listing date for care, version 3
000083	Live birth, version 1 *(concept)*
000084	Location immediately prior to admission to residential aged care, version 1
000085	Overdue patient, version 3
000086	Bodily location of main injury, version 1
000087	Nature of main injury—non-admitted patient, version 1
000088	Major diagnostic category, version 1
000089	Marital status, version 3
000090	Maternal medical conditions, version 2
000091	Medicare number, version 1
000092	Mental health legal status, version 5
000093	Method of birth, version 1
000094	Minutes of operating theatre time, version 1
000096	Mode of separation, version 3
000099	Narrative description of injury event, version 1
000100	Need for interpreter service, version 1
000101	Neonatal death, version 1 *(concept)*
000102	Neonatal morbidity, version 2
000103	Neonate, version 1 *(concept)*
000104	Non-admitted patient, version 1 *(concept)*
000105	Non-elective care, version 1 *(concept)*

Knowledgebase ID no.	Data element name
000107	Number of leave periods, version 3
000110	Nursing diagnosis, version 2
000111	Goal of care, version 2
000112	Nursing interventions, version 2
000113	Onset of labour, version 2
000114	Outcome of last previous pregnancy, version 1
000116	Overnight-stay patient, version 2 *(concept)*
000117	Patient, version 1 *(concept)*
000119	Length of stay, version 3
000120	Patient listing status, version 3
000124	Perinatal period, version 1 *(concept)*
000125	Perineal status, version 1
000126	Period of residence in Australia, version 1
000127	Person identifier, version 1
000131	Postpartum complication, version 2
000132	Preferred language, version 2
000133	Presentation at birth, version 1
000134	Previous pregnancies, version 1
000135	Principal area of clinical practice, version 1
000136	Principal diagnosis, version 3
000137	Procedure, version 5
000138	Principal role of health professional, version 1
000139	Previous specialised treatment, version 3
000140	Profession labour force status of health professional, version 1
000141	Number of contacts (psychiatric outpatient clinic/day program), version 1
000141	Number of service contact dates, version 2
000142	Reason for removal from elective surgery waiting list, version 3
000143	Referral to further care (psychiatric patients), version 1
000145	Resuscitation of baby, version 2
000146	Same-day patient, version 1 *(concept)*
000147	Scheduled admission date, version 2
000148	Separation, version 3 *(concept)*
000149	Sex, version 2
000150	Source of referral to public psychiatric hospital, version 3
000153	Specialised nursing requirements—at residential aged care admission, version 1
000154	Specialised nursing requirements—current status, version 1
000155	State/Territory of birth, version 1
000159	Status of the baby, version 1
000160	Stillbirth (foetal death), version 1 *(concept)*
000161	Surgical specialty, version 1
000163	Total leave days, version 3

Knowledgebase ID no.	Data element name
000164	Total psychiatric care days, version 2
000166	Type and sector of employment establishment, version 1
000167	Type of augmentation of labour, version 2
000168	Care type, version 4
000171	Type of labour induction, version 1
000172	Type of residential aged care admission, version 1
000173	Type of usual accommodation, version 1
000173	Type of accommodation, version 2
000174	Census date, version 2
000176	Waiting list category, version 3
000204	Department of Veterans' Affairs file number, version 1
000205	Separations, version 2
000206	Patient days, version 3
000208	Patients in residence at year end, version 1
000209	Occasions of service, version 1
000210	Group sessions, version 1
000211	Day program attendances, version 1
000230	Occupation of person, version 2
000231	Type of non-admitted patient care, version 1
000233	Type of non-admitted patient care (public psychiatric, alcohol and drug), version 1
000234	Type of non-admitted patient care (residential aged cares and hostels), version 1
000235	Individual/group session, version 1
000236	Payments to visiting medical officers, version 1
000237	Superannuation employer contributions (including funding basis), version 1
000238	Drug supplies, version 1
000239	Medical and surgical supplies, version 1
000240	Food supplies, version 1
000241	Domestic services, version 1
000242	Repairs and maintenance, version 1
000243	Patient transport, version 1
000244	Administrative expenses, version 1
000245	Interest payments, version 1
000246	Depreciation, version 1
000247	Other recurrent expenditure, version 1
000248	Capital expenditure, version 1
000252	Full-time equivalent staff, version 2
000254	Salaries and wages, version 1
000255	Number of available beds for admitted patients, version 2
000260	Geographical location of establishment, version 2
000294	Level of care, version 1
000295	Recoveries, version 1

Knowledgebase ID no.	Data element name
000296	Patient revenue, version 1
000309	Dependency in activities of daily living, version 2
000313	Hours worked by health professional, version 2
000317	Employment status—public psychiatric hospital admissions, version 2
000321	Specialised service indicators, version 1
000322	Teaching status, version 1
000323	Other revenues, version 1
000325	Capital expenditure—gross (accrual accounting), version 2
000326	Indirect health care expenditure, version 1
000327	Establishment type, version 1
000337	Contracted hospital care, version 1 *(concept)*
000342	Date of change to qualification status, version 1
000343	Newborn qualification status, version 2
000344	Apgar score at 1 minute, version 1
000345	Apgar score at 5 minutes, version 1
000346	Number of qualified days for newborns, version 2
000347	Emergency Department waiting time to service delivery, version 1
000348	Elective care, version 1 *(concept)*
000349	Patient presentation at Emergency Department, version 1 *(concept)*
000350	Date patient presents, version 2
000351	Time patient presents, version 1
000352	Type of visit to Emergency Department, version 2
000353	Date of triage, version 1
000354	Time of triage, version 1
000355	Triage category, version 1
000356	Date of commencement of service event, version 2
000357	Time of commencement of service event, version 2
000358	Admission time, version 2
000359	Departure status, version 1
000360	Non-salary operating costs, version 1
000361	Adult height, version 1 *(concept)*
000362	Adult height—measured, version 1
000363	Adult height—self-reported, version 1
000364	Adult weight, version 1 *(concept)*
000365	Adult weight—measured, version 1
000366	Adult weight—self-reported, version 1
000367	Adult body mass index, version 1
000368	Adult body mass index—classification, version 1
000369	Adult hip circumference, version 1 *(concept)*
000370	Adult hip circumference—measured, version 1
000371	Adult abdominal circumference, version 1 *(concept)*

Knowledgebase ID no.	Data element name
000372	Adult abdominal circumference—measured, version 1
000373	Adult abdomen to hip ratio, version 1
000374	Behaviour-related nursing requirements—at residential aged care, current status, version 1
000375	Continence status (urine) of residential aged care resident—at admission, version 2
000376	Continence status (urine) of residential aged care resident—current status, version 2
000377	Establishment number, version 3
000378	Region code, version 2
000379	Establishment sector, version 3
000380	State identifier, version 2
000381	External cause—non-admitted patient, version 4
000382	External cause—human intent, version 4
000383	Pension status—residential aged care residents, version 2
000384	Place of occurrence of external cause of injury, version 5
000385	Mode of admission, version 4
000391	Category reassignment date, version 2
000392	Hours worked by medical practitioner in direct patient care, version 2
000393	Hours on-call (not worked) by medical practitioner, version 2
000394	Total hours worked by a medical practitioner, version 2
000395	Employment status—acute hospital and private psychiatric hospital admissions, version 2
000396	Capital expenditure—net (accrual accounting), version 2
000397	Emergency Department waiting time to admission, version 1
000398	Diagnosis, version 1 *(concept)*
000399	Clinical intervention, version 1 *(concept)*
000400	Extended wait patient, version 1
000401	Service contact, version 1 *(concept)*
000402	Service contact date, version 1
000403	Tobacco smoking—consumption/quantity (cigarettes), version 1
000404	Tobacco smoking—duration (daily smoking), version 1
000405	Tobacco smoking—ever daily use, version 1
000406	Tobacco smoking—frequency, version 1
000407	Tobacco smoking—product, version 1
000408	Tobacco smoking—quit age (daily smoking), version 1
000409	Tobacco smoking—start age (daily smoking), version 1
000410	Tobacco smoking status, version 1
000411	Tobacco smoking—time since quitting (daily smoking), version 1
000412	Waiting time at a census date, version 1
000413	Waiting time at admission, version 1
000414	Medicare eligibility status, version 1
000415	Admitted patient election status, version 1
000416	Contract establishment identifier, version 1
000417	Contract procedure flag, version 1

Knowledgebase ID no.	Data element name
000418	Contract role, version 1
000419	Contract type, version 1
000420	Contracted care commencement date, version 1
000421	Department of Veterans' Affairs patient, version 1
000422	Cessation of treatment episode for alcohol and other drugs, version 2 *(concept)*
000423	Reason for cessation of treatment episode for alcohol and other drugs, version 2
000424	Date of cessation of treatment episode for alcohol and other drugs, version 2
000425	Urgency of admission, version 1
000426	Client type, version 1
000427	Commencement of treatment episode for alcohol and other drugs, version 2
000428	Contracted care completion date, version 1
000429	Total contract patient days, version 1
000430	Date of commencement of treatment episode for alcohol and other drugs, version 2
000431	Estimated date flag, version 1
000432	Injecting drug use, version 1
000433	Method of use for principal drug of concern, version 1
000434	Multi-disciplinary team status, version 1
000435	New/repeat status, version 1
000436	Non-admitted patient service event—patient present status, version 1
000437	Non-admitted patient service event count, version 1
000438	Non-admitted patient service event, version 1 *(concept)*
000439	Non-admitted patient service mode, version 1
000440	Non-admitted patient service type, version 1
000441	Organ procurement—posthumous, version 1 *(concept)*
000442	Other drugs of concern, version 1
000443	Principal drug of concern, version 1
000444	Source of referral to alcohol and other drug treatment service, version 1
000445	Episode of care, version 1 *(concept)*
000631	Anticipated patient election status, version 1
000632	Funding source for hospital patient, version 1
000633	Hospital in the home care, version 1 *(concept)*
000635	Length of stay (antenatal), version 1
000636	Length of stay (including leave days), version 1
000637	Length of stay (postnatal), version 1
000638	Main language other than English spoken at home, version 1
000639	Main treatment type for alcohol and other drugs, version 1
000640	Number of days of hospital in the home care, version 1
000641	Number of service contacts within a treatment episode for alcohol and other drug, version 1
000642	Other treatment type for alcohol and other drugs, version 1
000643	Proficiency in spoken English, version 1
000644	Separation time, version 1

Knowledgebase ID no.	Data element name
000646	Treatment delivery setting for alcohol and other drugs, version 1
000647	Treatment episode for alcohol and other drugs, version 1 *(concept)*

Appendix J: Data elements in common with other NMDSs

Data element	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Comm-unity mental health care	Comm-unity mental health establish-ments	Elective surgery waiting times	Emerg-ency Dept. waiting times	Health labour force	Injury surveil-lance	Perinatal	Public hospital establish-ments
Activity when injured, version 2	√									√		
Actual place of birth, version 1											√	
Additional diagnosis, version 4	√	√	√									
Administrative expenses, version 1												√
Admission date, version 4	√	√	√									
Admitted patient election status, version 1	√	√										
Area of usual residence, version 3	√	√	√		√							
Birth order, version 1											√	
Birth plurality, version 1											√	
Bodily location of main injury, version 1										√		
Capital expenditure, version 1												√
Capital expenditure—gross (accrual accounting), version 2												√
Capital expenditure—net (accrual accounting), version 2												√
Care type, version 4	√	√	√									
Category reassignment date, version 2							√					
Census date, version 2							√					
Classification of health labour force job, version 1									√			
Client type, version 1				√								
Clinical urgency, version 2							√					
Country of birth, version 3	√	√	√	√	√						√	

Data element	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Comm-unity mental health care	Comm-unity mental health establish-ments	Elective surgery waiting times	Emerg-ency Dept. waiting times	Health labour force	Injury surveil-lance	Perinatal	Public hospital establish-ments
Date of birth, version 3	√	√	√	√	√				√		√	
Date of cessation of treatment episode for alcohol and other drugs, version 2				√								
Date of commencement of treatment episode for alcohol and other drugs, version 2				√								
Date of service event, version 1								√				
Date of triage, version 1								√				
Date patient presents, version 1								√				
Departure status, version 1								√				
Depreciation, version 1												√
Diagnosis related group, version 1	√	√										
Domestic services, version 1												√
Drug supplies, version 1												√
Emergency Department waiting time to service delivery, version 1								√				
Employment status—acute hospital and private psychiatric hospital admissions, version 2		√										
Employment status—public psychiatric hospital admissions, version 2		√										
Establishment identifier, version 3	√	√	√	√	√	√	√				√	√
Establishment number, version 3								√				
Establishment type, version 1	√			√								√
Extended wait patient, version 1							√					
External cause—admitted patient, version 4	√									√		
External cause—human intent, version 4										√		
First day of last menstrual period, version 1											√	

Data element	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Comm-unity mental health care	Comm-unity mental health establish-ments	Elective surgery waiting times	Emerg-ency Dept. waiting times	Health labour force	Injury surveil-lance	Perinatal	Public hospital establish-ments
Food supplies, version 1												√
Full-time equivalent staff, version 2						√						√
Funding source for hospital patient, version 1	√	√	√									
Geographical location of establishment, version 2				√		√						√
Gestational age, version 1											√	
Group sessions, version 1												√
Hospital insurance status, version 3	√											
Hours on-call (not worked) by medical practitioner, version 2									√			
Hours worked by health professional, version 2									√			
Hours worked by medical practitioner in direct patient care, version 2									√			
Indicator procedure, version 3							√					
Indigenous status, version 3	√	√	√	√	√						√	
Indirect health care expenditure, version 1												√
Individual/group session, version 1												√
Infant weight, neonate, stillborn, version 3	√										√	
Injecting drug use, version 1				√								
Intended length of hospital stay, version 2	√											
Interest payments, version 1												√
Inter-hospital contracted patient, version 2	√											
Listing date for care, version 3							√					
Main treatment type for alcohol and other drugs, version 1				√								
Major diagnostic category, version 1	√	√										
Marital status, version 3		√			√							

Data element	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Comm-unity mental health care	Comm-unity mental health establish-ments	Elective surgery waiting times	Emerg-ency Dept. waiting times	Health labour force	Injury surveil-lance	Perinatal	Public hospital establish-ments
Medical and surgical supplies, version 1												√
Medicare eligibility status, version 1	√											
Mental health legal status, version 5	√	√			√							
Method of birth, version 1											√	
Method of use for principal drug of concern, version 1				√								
Mode of admission, version 4	√	√	√									
Mode of separation, version 3	√	√	√									
Narrative description of injury event, version 1										√		
Nature of main injury—non-admitted patient, version 1										√		
Newborn qualification status, version 2	√											
Non-salary operating costs, version 1						√						
Number of available beds for admitted patients, version 2						√						√
Number of leave periods, version 3	√	√										√
Number of qualified days for newborns, version 2	√											
Number of service contact dates, version 2					√							
Number of service contacts within a treatment episode for alcohol and other drugs. version 1				√								
Occasions of service, version 1												√
Onset of labour, version 1											√	
Other drugs of concern, version 1				√								
Other recurrent expenditure, version 1						√						√
Other revenues, version 1												√
Other treatment type for alcohol and other drugs, version 1				√								
Overdue patient, version 3							√					

Data element	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Comm-unity mental health care	Comm-unity mental health establish-ments	Elective surgery waiting times	Emerg-ency Dept. waiting times	Health labour force	Injury surveil-lance	Perinatal	Public hospital establish-ments
Patient days, version 3												√
Patient listing status, version 3							√					
Patient revenue, version 1												√
Patient transport, version 1												√
Payments to visiting medical officers, version 1						√						√
Person identifier, version 1	√	√	√	√	√						√	
Place of occurrence of external cause of injury, version 5	√									√		
Preferred language, version 2				√								
Previous specialised treatment, version 3		√	√									
Principal area of clinical practice, version 1									√			
Principal diagnosis, version 3	√	√	√		√							
Principal drug of concern, version 1				√								
Principal status of health professional, version 1									√			
Procedure, version 5	√											
Profession labour force status of health professional, version 1									√			
Reason for removal from Emergency Department waiting list, version 3							√					
Recoveries, version 1												√
Repairs and maintenance, version 1												√
Salaries and wages, version 1						√						√
Separation date, version 5	√	√	√								√	
Separations, version 2						√						√
Service contact date, version 1					√							
Sex, version 2	√	√	√	√	√						√	

Data element	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Comm-unity mental health care	Comm-unity mental health establish-ments	Elective surgery waiting times	Emerg-ency Dept. waiting times	Health labour force	Injury surveil-lance	Perinatal	Public hospital establish-ments
Source of referral to alcohol and other drug treatment services, version 1				√								
Source of referral to public psychiatric hospital, version 3	√	√										
Specialised service indicators, version 1												√
State/Territory of birth, version 1											√	
Status of the baby, version 1											√	
Superannuation employer contributions (including funding basis), version 1												√
Surgical specialty, version 1							√					
Teaching status, version 1												√
Time of triage, version 1								√				
Time patient presents, version 1								√				
Total full-time equivalent staff, version 1												√
Total hours worked by medical practitioner, version 2									√			
Total leave days, version 3	√	√										
Total psychiatric care days, version 2	√	√										
Treatment delivery setting for alcohol and other drugs, version 1				√								
Triage category, version 1								√				
Type and sector of employment establishment, version 1									√			
Type of accommodation, version 2		√										
Type of non-admitted patient care (public psychiatric, alcohol and drug), version 1												√
Type of non-admitted patient care, version 1												√
Type of usual accommodation, version 1		√										
Type of visit to Emergency Department, version 2								√				

Data element	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Comm-unity mental health care	Comm-unity mental health establish-ments	Elective surgery waiting times	Emerg-ency Dept. waiting times	Health labour force	Injury surveil-lance	Perinatal	Public hospital establish-ments
Urgency of admission, version 1	√											
Waiting list category, version 3							√					
Waiting time at a census date, version 1							√					
Waiting time at admission, version 1							√					

Appendix K: Subject/key word index to data elements

Legend: *data elements in italics font*

NMDS in bold font

other entries in regular font

D

E

F

G

H

I

L

M

N

O

P

R

S

T

U

W